Addressing the Challenge of Women's Health in Africa

Report of the Commission on Women's Health in the African Region

World Health Organization
REGIONAL OFFICE FOR Africa

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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.

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The President's Foreword

H.E. Mrs. Ellen Johnson Sirleaf

In my capacity as the Honorary President, I had the singular pleasing duty and honour of launching the Women's Health Commission on April 14th 2010 in Monrovia, Liberia.

In the context of Africa, paramount among the major roles and responsibilities of women is usually the lead role played by them in the development of health and welfare for their families, leading to the overall health and socioeconomic development of nations as well as families. Women face many challenges including a heavy burden of ill health which results in high morbidity and mortality rates among them; they are also subjected to many societal injustices and harmful sociocultural practices which further impact on their health and development.

The launching ceremony provided an opportunity for Africa and the rest of the world to reflect on the health of women, a reminder that the health of women in the Region is deplorable because every minute a woman dies in labour or suffers lifetime complications from pregnancy and delivery.

I am hereby calling on all governments to reinforce their commitments and dedication to accelerating the reduction of maternal and newborn mortality as a fundamental right to life and development. We must also remember to actively involve women in all decisions related to their health and well-being.

I have the utmost pleasure to introduce to everyone this Report of the Women's Health Commission in the African Region, *Addressing the Challenge of Women's Health in Africa.* The Report highlights the dire situation African women face throughout their lifetimes and gives recommendations for advancing the health of women in the Region.

It would be most inappropriate were I to conclude without leaving you with these words: "a nation thrives when mothers survive; we must strive to keep them alive". Though the task ahead may appear daunting, I encourage Africa to ensure that *"No Woman Dies While Giving Life"*. Let us all work assiduously together to reduce ill health, improve lifestyles and reduce deaths in the African Region.

H.E. Mrs. Ellen Johnson Sirleaf
President of the Republic of Liberia

The Regional Director's Foreword

Dr. Luis G. Sambo

I am pleased to share with you this Report which draws on a wide range of facts to demonstrate that the role of women in society goes far beyond childbearing and which also makes the fundamental point that women have – first and foremost – a right to good health. The Report goes on to argue that Africa needs to invest more in women's health, and, in particular, to give women the opportunity to unleash their potential for their own fulfilment and for the prosperity of their families and nations.

The Report was produced by a multidisciplinary Commission on Women's Health in the African Region established in 2009 in response to a resolution adopted by the WHO Regional Committee for Africa at its 58th Session in Yaoundé, Cameroon, 1–5 September 2008. The President of the Republic of Liberia, H.E. Mrs. Ellen Johnson Sirleaf, a Nobel Peace Prize laureate, is the Honorary President of the Commission.

The Commission, consisting of 16 experts, was mandated to gather evidence on the key factors influencing women's health in the African Region, and to recommend the appropriate actions across all sectors of society in order to achieve rapid and sustainable improvements in women's health. The Commission was also mandated to make the case for extensive investment in women's health as a contribution towards social and economic development.

The life course approach to understanding the evolution of health over time is used to identify interventions for improving women's health. The Report emphasizes women's right to health, and argues that healthy women represent an important resource of human capital that is largely untapped.

It is recognized that good scientific evidence on women's health in Africa is limited. It is also noted that during the various stages of their lives, women experience changes in their health needs. There is, thus, a need to generate disaggregated data to monitor the status of women's health, to support advocacy and to provide evidence for decision-making.

The Report shows that the African Region promotes women's empowerment and entrepreneurship. However, in respect to maternal health, the situation in the African Region is dismal, with the Region accounting for more than half of maternal deaths worldwide each year. It further shows that considerable socioeconomic benefits could be derived from improvement in women's health, which can be expressed in terms of labour productivity and national income.

This Report recommends an extensive review of the current approach to improving women's health in the African Region. To that end, governments should strongly promote investments in women's health and should take vigorous action to develop inter-sectoral initiatives and programmes that improve women's health and women's role in development.

The target audience of this Report comprises three categories of people. The first category consists of policy makers and senior government officials who have influence at the national level for the deployment

of resources for activities that can improve women's health and their social status. They include parliamentarians, senior civil servants and ministers of health, education, finance, planning and women's affairs. The second category of audience comprises representatives of local and international non-governmental organizations, UN agencies, civil society, communities, media organizations, pro-women activists, trade unions and professional associations. These audiences are important for the promotion of women's rights to good health. The third category of audience includes health workers, economists, sociologists, academics, research institutions and the business community who can influence events and opinions in favour of women's health.

In presenting this Report, it is my hope that it will serve to scale up actions by Member States, agencies and development partners focused on investing substantially in the physical, social and mental well-being of women, and on creating innovative approaches that will help improve the health and quality of life for all girls and women in Africa.

Dr. Luis G. Sambo
Regional Director

Acronyms, Abbreviations and Definitions

Acronyms and Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral
ART	Antiretroviral Therapy
CARMMA	Campaign for Accelerated Reduction of Maternal Mortality in Africa
CEDAW	Convention on Elimination of all forms of Discrimination Against Women
DALYs	Disability-Adjusted Life Years
FAMPOP	Family Planning Options Project
FGM	Female Genital Mutilation
GBD	Global Burden of Disease
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
ILO	International Labour Organization
IITA	International Institute of Tropical Agriculture
IT	Information Technology
ITN	Insecticide Treated Nets
MDGs	Millennium Development Goals
MYWO	*Maendeleo Ya Wanawake* Organization, Kenya
MTCT	Mother-to-Child Transmission
NCDs	Noncommunicable Diseases
NGO	Nongovernmental Organization
NPCs	Non-Physician Clinicians
NUWODU	National Union of Women with Disabilities in Uganda
OOP	Out-of-pocket Payment
PHC	Primary Health Care
PMTCT	Prevention of Mother-to-child Transmission
ROSCAS	Rotating Savings and Credit Associations
STI	Sexually Transmitted Infection
STD	Sexually Transmitted Diseases
TB	Tuberculosis
UNECA	United Nations Economic Commission for Africa
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Definitions

Adolescent	A female aged 10–19 years
Adult woman	A female aged 20–59 years
Badienou Gokh	A health care mentor/honorary aunt
Best practice	Knowledge about what works in specific situations and contexts, without using inordinate resources to achieve the desired results, and which can be used to develop and implement solutions adapted to similar health problems in other situations and contexts
Customary laws	Written or unwritten laws developed on the basis of traditions and customs of societies
Community health worker	A worker in the community who has received training in some elements of primary health care
Community-based distributor	A community health worker employed specifically for village-level distribution of family planning commodities
Determinant	A factor such as a personal characteristic, an environmental or a socioeconomic condition that affects health
Elderly woman	A female aged 60 years or more
Female Genital Mutilation	A procedure carried out on girls or young women in which parts of the external sexual organs are removed or reconstructed for social reasons
Girl child	A female aged 0–9 years
Gender	A social construct on roles of men and women in society, based mainly on biological and sexual characteristics of individuals
Human capital	The stock of competencies, knowledge and personality attributes embodied in the ability to perform work in order to produce something of economic value
Life course	A construct of physiological and social transitions in an individual's life from birth to death
Maternal death	The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes
Multisectoral	A strategy of planning and implementation of approach programmes that involves many sectors of the economy
Non-physician clinicians	Health workers who are trained to acquire competencies so that they can provide the care normally given by doctors
Social capital	Connections within and between social networks that yield benefits
Skilled birth attendants	Health workers who have undergone a certifiable course and acquired a set of internationally recognized competencies in maternal and newborn care
Unsafe abortion	A procedure for terminating an unintended pregnancy carried out either by persons lacking necessary skills or in an environment that does not conform to minimal medical standards, or both
User fees	Out-of-pocket fees paid by clients for health care and related services
WHO Africa Region	Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome & Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe

Interventions to improve women's health that focus solely on public health issues miss the fundamental interconnectedness of health with other factors in society. Recognizing this interconnectedness is the starting point for the multisectoral rethinking of health care strategies that the Commission is calling for in the African Region.

Executive Summary

Overview

This report argues that women's health is the foundation for social and economic development in the African Region. Women's health is recognized as a human rights issue and should be promoted and defended as such. Women in Africa represent slightly over 50% of the continent's human resources and so women's health has huge implications for the Region's development. Focusing in particular on the unacceptably high level of maternal mortality in sub-Saharan Africa, the report calls for a fundamental rethinking of approaches to improving women's health informed by an understanding of the sociocultural determinants that are so important in shaping it.

A core contention of the report is that a range of adverse socioeconomic pressures including inadequate health care prevents African women from realizing their full potential. Interventions to improve women's health, focusing solely on "public health" issues miss the fundamental interconnectedness of health with other factors in society; recognizing this interconnectedness is the starting point for emphasizing the multisectoral approach required in the African Region.

To shed light on the often complex relationships between women's health and their socioeconomic status, the report takes a multidisciplinary approach to evidence gathering and analysis, and adopts a life course approach to women's health to reveal the specific challenges faced by African women at different stages of their lives. The approach shows how key interventions at early stages of women's lives can have a positive impact both on their health and, subsequently, on their socioeconomic status.

The report broadly surveys the main issues related to women's health without being exhaustive. Indeed, where there are gaps in the available data and research the report draws attention to them. Most importantly, the report sheds light on the interconnections between issues that have often been neglected when drawing up and implementing public health policies directed at improving women's health, while at the same time underlining the many development opportunities in Africa which, with appropriately targeted and sustained investment, can have a profound impact on women's health their well-being and their socioeconomic status.

Key findings of the report

A. African women bear an unacceptably huge burden of disease and death

> **"The state of maternal health in Africa is dismal, with the Region accounting for more than half of all maternal deaths worldwide, each year; and, sadly, the picture is not improving significantly."**

The state of maternal health in Africa is dismal, with the Region accounting for more than half of all maternal deaths worldwide, each year; and, sadly, the situation is not improving significantly. Although MDG 5 targets a 75% reduction of global maternal mortality between 1990 and 2015, requiring an average annual reduction of 5.5%, the actual annual average reduction in the African Region from

1990 to 2010 was 2.7%. More than half of maternal deaths occur within 24 to 48 hours after delivery due to complications ranging from postpartum haemorrhage to sepsis and hypertensive disorders. Some African mothers simply bleed to death after delivery because no skilled health care professional is present to help. It is estimated that about a quarter of maternal deaths could be prevented through emergency obstetric care. The situation is even more tragic considering that maternal mortality is largely preventable as evidenced by the global disparity in maternal health outcomes. Indeed, in Europe maternal mortality is a rare event, occurring in only 20 out of 100 000 live births, compared to 480 per 100 000 in the African Region, the highest ratio of all the regions in the world.

While HIV/AIDS and maternal mortality continue to predominate in the morbidity and mortality statistics of the Region, other problems loom. In their advanced ages, African women suffer increasingly from noncommunicable diseases (NCDs), notably cardiovascular diseases, cancers, diabetes and chronic respiratory diseases. The report notes that NCD prevalence rates are generally not recorded by the health services in Africa, but the few studies undertaken suggest that they are high and even increasing. According to WHO, if nothing is done to address the issue of NCDs, they will represent at least 50% of mortality in the African Region by 2020.

B. *Underinvestment in women's health care is one of the many challenges to be overcome*

The report shows that the failure of health systems in the majority of African countries to provide accessible care of adequate quality is one of the main drivers of the adverse trends in women's health indicators. This situation stems from underinvestment in women's health and also from other factors such as inadequate empowerment of women and poor health systems design. Since 2003, average health spending as a percentage of total spending by African countries has hovered around 10%, i.e., two thirds of the level to which African leaders committed themselves in Abuja in 2001. It is worth noting that over ten years after Abuja only Botswana, Burkina Faso, Democratic Republic of Congo, Liberia, Rwanda, Tanzania and Zambia are delivering on their pledges, while 13 African countries actually allocate less of their total government budgets to health now than they did prior to 2001.

However, even with adequate funding, health systems in the Region will struggle to meet the needs of women unless fundamental changes are made in health systems design. The majority of modern health care services provided in the Region are clinic-based, physician-oriented and urban-centred, leaving the predominantly rural population woefully underserved.

"The majority of modern health care services provided in the Region are clinic-based, physician-oriented and urban-centred, leaving the predominantly rural population woefully underserved."

It is therefore crucial that policy makers rethink health systems design, placing greater emphasis on

primary health care (PHC). The organization of maternal health care delivery in particular needs to be reconsidered and reorganized with a view to improving access to basic and comprehensive emergency obstetric care.

One of the biggest problems faced by the Region's health systems is insufficient numbers of qualified and motivated health workers. According to WHO data, 36 of the 57 countries worldwide facing a critical shortage of health workers are located in Africa. Poor working conditions and inadequate pay are two of the main reasons for this, but staff recruitment and retention are also compromised by political instability, ongoing financial crises and the HIV/AIDS epidemic.

A number of African countries are exploring a variety of options for maximizing the efficient use of available resources, including task-shifting to allow mid-level staff to perform essential procedures such as emergency obstetric care. However, more evidence is required to establish the value of these approaches. Women are the main providers of health care in the Region. They are the primary caregivers at home and in the formal health care system. However, they are rarely represented in executive or management level positions, and tend to carry out lower level tasks which, though essential, do not match their full managerial potential and other abilities. This situation needs to change, notably by ensuring that girls have the same educational opportunities as their male siblings in their youth, and are able to pursue their studies to specializations leading to senior positions within the health system and other areas.

"Women are the main providers of health care in the Region. They are the primary caregivers at home and in the formal health care system. However, they are rarely represented in executive or management level positions, and tend to carry out lower level tasks which, though essential, do not match their full managerial potential and other abilities."

Out-of-pocket (OOP) payment for health care punishes the poor and penalizes women in particular. There is overwhelming evidence that OOP payment for health care, the most significant form of health system financing in the Region, has led to an overall decline in the utilization of health services. As the report shows, even when the fees charged are low, they discourage utilization. OOP payment presents a particular problem for women in Africa because the women are often dependent on men financially, and so their access to purchased health services depends on men's decisions. The report shows that where OOP payment is discontinued, utilization rates rise. However, OOP payment should not be discontinued without careful planning because the replacement of OOP payment with financing systems based on prepayment and pooling of resources presents considerable organizational and governance challenges.

C. A multisectoral approach is imperative to improve women's health

Ill health is both a symptom and a cause of women's disempowerment – one driver of the cycle of disempowerment of African women. Lack of information and economic poverty also play an important part, feeding into sickness just as they are fed by it. Crucially, therefore, policy makers should adopt multisectoral measures in dealing with women's health issues. For example, several of the major health issues affecting women in Africa are associated with poor living conditions, and addressing them requires their root causes to be addressed. As the main gatherers and sources of firewood and water, and the principal producers and processors of food in African households, women are exposed to particular health risks. There is ample evidence that improving infrastructure such as access to roads

and providing safe and accessible water sources 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 to improve the fuel and water situations in African homes and should, in general, be involved in development processes at all levels of society.

"Lack of information and economic poverty play an important part, feeding into sickness just as they are fed by it. Crucially, therefore, policy makers should adopt multisectoral measures in dealing with women's health issues."

The report shows that simple changes within the household can lead to dramatic improvement in women's lives. For example, procuring household appliances is a labour-saving investment that will enable girls to spend more time on their education, and women to focus on their children or work in more economically productive activities; improved wood- or charcoal-burning stoves already in use in some African countries reduce kitchen pollution by up to 50%, decreasing the exposure of girls and women to indoor pollution.

D. Women's socioeconomic empowerment is essential to achieve better health outcomes

One of the most important actions for positive change in the African Region is improving women's education. Policy makers need to commit more resources to improve girls' access to schools. They must challenge the social stereotyping that keeps girls at home. This is yet another issue requiring multisectoral consultation on the need for attitudinal change in households and communities. For example, boys and girls should be assigned the same share of household chores instead of leaving such tasks to girls alone.

"Educating women promotes socioeconomic empowerment. However, the empowerment will be incomplete unless women are also facilitated to participate fully in the job market and can enjoy the fruits of their own labour."

Sub-Saharan Africa has the lowest percentage of female youth literacy, the lowest primary school enrolment ratio and the lowest primary school attendance ratio in the world, while the net secondary school attendance among girls in sub-Saharan Africa is 22%, compared with 52% in South Asia for example. Some African countries are already trying to address this issue, notably by waiving payment of school fees for girls and introducing free lunch programmes. These simple initiatives have led to significant increases in school attendance but much more can be done.

Educating women promotes socioeconomic empowerment. However, the empowerment will be incomplete unless women are also facilitated to participate fully in the job market and can enjoy the fruits of their own labour. Limited access to credit, land and agricultural extension services hampers women's contribution to the well-being of households in many settings. Women's associations in rural and urban areas have significantly contributed to the creation of social networks capable of mobilizing investment resources for women in rural localities; but much more can be done, and the same applies

to women's entrepreneurial activities. As the report shows, there are many striking examples of highly successful business women in Africa, yet the continent lags behind other developing regions in promoting women's entrepreneurship. In particular, African women face considerable challenges in accessing business credit and basic social services such as health care and education. Women's right to ownership of property also needs greater support, notably through legislative change and enforcement of existing laws.

The granting of property rights to women not only increases their socioeconomic standing but also enhances their participation in civic activities, an important aspect of women's empowerment. Although some countries have achieved representation of 50% or more, on the whole women are significantly under-represented in politics in Africa as most countries in the Region have fewer than 10% female members of parliament. This deficit begins at the grassroots level because gender discrimination, especially the absence of educational opportunities, gives women the impression that they have no voice. Fortunately this situation is changing for the better in some countries. The picture is also bleak with regard to women holding cabinet posts or senior appointments in the civil service. Women's participation in the highest political structures of government is clearly key to the mainstreaming of women's health issues and has already been important in supporting the enactment of laws against gender-based discrimination and harmful cultural practices such as female genital mutilation.

E. Violence against women is an unacceptable degradation of women's rights

At its worst gender discrimination takes the form of male-on-female violence. Sexual coercion and sexual violence are prevalent in many countries and tend to increase in crisis situations such as natural disasters and armed conflicts. Violence against women becomes particularly pernicious in certain harmful traditional practices such as female genital mutilation, estimated to be inflicted on more than two million girls between the ages of four and twelve, every year, while over 92 million girls and women above the age of 10 are thought to be living with the indignity and pain resulting from such abuse. Many countries of sub-Saharan Africa have passed laws penalizing the practice but legislation needs to be 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 perpetuation of this practice.

“Violence against women becomes particularly pernicious in certain harmful traditional practices such as female genital mutilation, estimated to be inflicted on more than two million girls between the ages of four and twelve, every year.”

F. There are immense socioeconomic benefits from improving women's health

As this report shows, a large socioeconomic benefit is derived from improving women's health. This benefit finds expression in greater productivity by a healthy workforce. Because women are the dominant source of farm labour in the Region, and the mainstay of Africa's economy as a whole, investing in their health would generate significant economic gains. Similarly, it is evident that improving maternal health has socioeconomic benefits. The health of mothers is vital to the health of their unborn children. Investing in maternal health is therefore an investment in the health of future generations.

Mothers in Africa not only nurture, feed, clean and clothe their children in non-market settings such as homes and farms; they also direct household resources to the care and upbringing of their children in

market settings, such as day care centres, schools and clinics. Where women earn incomes they are more likely, than men, to spend their earnings on goods and services that benefit the household and the children. Evidently any society that limits the role of women to childbearing and child rearing, constraining them only to the home environment, has a heavy price to pay in socioeconomic terms.

The health of mothers is crucial to the health of their unborn children. Investing in maternal health is therefore an investment in the health of future generations.

Family planning has been shown to have direct socioeconomic benefits. World Health Organization estimates that in a number of low-income settings, including sub-Saharan Africa, investing one dollar in family planning can save four dollars that would otherwise have been spent on subsequently addressing the complications resulting from unplanned pregnancies. Other benefits are less easily quantified but no less important. For example, by reducing the number of unplanned births among adolescents, policy makers can expect more young women to stay in school, which in turn improves women's social status and economic output. Limiting conception can also benefit the home by giving the mother time to recuperate between pregnancies, and by allowing her to devote more time and resources to each of her children.

What happens at the household level is often reflected in the broader economy. For example, controlling fertility reduces the demand for resources needed for health care, education and social welfare systems, and eases pressure on natural resources such as arable land and water, and on demand for food that these resources produce. If population growth is unchecked, undue pressure is exerted on all available resources. Sub-Saharan Africa has the highest fertility rate in the world, estimated at 5.2 children. Reducing the fertility rate will, other things being equal, help improve women's health and regional development, and the key to achieving this is greater use of contraception. Unfortunately progress on this front on the continent has been relatively slow.

G. There is an urgent need for better data

Most importantly, data and research specific to women's health are lacking. Women's health needs change during the various stages of their lives. There is therefore a need for age and sex disaggregated data to monitor women's health status across age categories. Demographic and Health Surveys are useful sources of information on reproductive health indicators since they are disaggregated by age and sex, but do not contain enough information about cancers and other morbidities affecting elderly women. Because women bear a large burden of disease during the reproductive period, monitoring their health outcomes at this phase, and evaluating the quality of care provided to them is especially important. The report therefore strongly advises policy makers to improve information management systems for women's health by shifting from manual to electronic data collection and by conducting multipurpose national household surveys on a regular basis.

Conclusion

While the report calls for a profound rethinking of approaches to improving women's health in Africa, that rethinking will have to result in changes in the way things are done. For this to happen, governments have to be involved in women's health matters because only they can coordinate the various initiatives needed to bring about change on a large scale in this area. It is essential, therefore, to mobilize political will and political commitment at the highest level possible to support large scale investments in women's health. Political will is needed to initiate and coordinate the required investments and long term political commitment is required to sustain them.

Finally, policy makers seeking to improve the health and socioeconomic status of African women have no better ally than the African women themselves. Though African women are already making an enormous contribution to social and economic activities of the continent, the evidence presented in this report shows that they can achieve much more. However, they cannot do it alone. They need the support and commitment of policy makers to break the cycle of poverty, disease and disempowerment that prevents them from enjoying the health and socioeconomic status that is their birthright, and restricts the tapping of their immense physical and intellectual potential. Only when the importance of the role of African women in the Region's development is understood will the Region begin to realize its full potential in terms of political stability, economic prosperity and better health outcomes for all.

"African women are already making an immense contribution to the social and economic activities of the continent, but the evidence presented in this report shows that they can achieve much more. However, they cannot do it alone."

See pages 80–85 for the Recommendations of the Commission,
which focus on the following topics:

1. ***Good governance and leadership to improve, promote, support and invest in women's health***
2. ***Policy and legislative initiatives to translate good governance and leadership into concrete action***
3. ***Multisectoral interventions needed to improve women's health***
4. ***Empowering girls and women to be effective agents of their own interests***
5. ***Improving the responsiveness of health care systems to address the health needs of women***
6. ***Data collection for monitoring progress made towards achieving targets for girl's and women's health***

Taking a holistic, life-course approach to the analysis of women's health, the report addresses not just public health issues but also the sociocultural factors underlying the prevailing women's health status. It also identifies the interventions most likely to raise the social status of women, promote gender equity and enable women to contribute fully to social and economic development.

Introduction

This report was produced by the Commission on Women's Health in the African Region in response to Resolution AFR/RC58/RI of the WHO Regional Committee of Ministers of Health of Africa, which called for the establishment of a commission to generate evidence on the importance of women's health as a foundation for social and economic development. The Group was also mandated to document and analyse the key determinants of women's health in Africa and to make recommendations for its improvement; particular emphasis was put on the unacceptably high level of maternal mortality in sub-Saharan Africa, which is a matter of great concern to the World Health Organization and its Member States in the African Region.

Taking a holistic, life-course approach to the analysis of women's health, the report addresses not just public health issues but also the social, economic and cultural factors underlying the prevailing women's health status. It also identifies the interventions that are most likely to raise the social status of women, promote gender equity and enable women to contribute fully to social and economic development. This multisectoral analysis required a multidisciplinary approach to evidence gathering and evaluation in order to shed light on the often complex relationships between women's health and women's socioeconomic development in the African Region.

The data used to generate the evidence presented in the report are drawn from a wide range of sources including the World Health Organization, African Development Bank, United Nations Economic Commission for Africa, United Nations Children Fund and World Bank. Additional analysis of the burden of disease was done using Global Burden of Disease (GBD) databases. Data on women were selected from the above mentioned sources, and health status comparisons were made between the WHO African Region and other WHO regions. In our review of the relevant literature, high priority was given to articles published in peer-reviewed journals from the fields of anthropology, epidemiology, sociology, economics, demography and public health. Because it is important to have a full understanding of the methodology used in the preparation of this Report in order to view the recommendations that it makes in their proper perspective, a detailed description of the methodology is provided in the Appendix on pages 87–89.

To elucidate contextual specificity and local views, a survey on women in Africa was undertaken using e-mails, questionnaires and telephone interviews which served to gather qualitative information on local perceptions regarding pregnancy, childbirth, maternal mortality, roles of gender in health care and women's experiences in using health facilities. Important sources of this qualitative data included women themselves, particularly those who had extensive local knowledge of traditional health practices and women's health conditions. These women were required to have experience of local health facilities as patients. They were recruited from countries in various subregions in the African Region, namely, Burkina Faso, Côte d'Ivoire, Ghana and Guinea-Bissau (West Africa); Democratic Republic of Congo (Central Africa); and Kenya, Rwanda and South Africa (East and Southern Africa).

This report seeks to shed light on the interrelationships between issues that have often been neglected in the drawing up and implementation of public health policy aimed at improving women's health. Where significant gaps in knowledge regarding the relationships between women's health, and cultural and socioeconomic factors exist, the report identifies them and encourages other stakeholders to strive to fill them. Most importantly, the report draws attention to the many ways in which policy makers, with appropriately targeted and sustained investment, can have a profound impact on the health, well-being and empowerment of women in the African Region.

"Protecting and promoting the health of women is crucial to health and development, not only for the health of today's citizens, but also for the health of future generations."

Dr Margaret Chan, Director-General
World Health Organization[1]

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]

> **"Women in Africa bear a disproportionately huge share of the global burden of disease and death, particularly in maternal morbidity and mortality."**

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 capita recommended by the Taskforce on Innovative International Financing for Health Systems[6] 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 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.”

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.

"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."

Poor quality care has also been shown to be an important determinant of the poor health outcomes for women on the continent as it has often limited women's access to and use of services. Even when services are available and affordable, they are often lacking in addressing gender and cultural sensitivities for women. For example, a requirement that women deliver in dorsal positions in many health facilities instead of in the traditional squatting positions has prevented many women from accessing skilled attendance at delivery. Unwillingness to be examined by male care providers has prevented some African women from using services, whilst many young unmarried adolescent girls are denied access to family planning services because of unfriendly care provider attitudes to premarital sex.

"Poor quality care has also been shown to be an important determinant of the poor health outcomes for women on the continent as it has often limited women's access to and use of services."

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 Oyéronké 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.

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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]

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 Delamonica[29] 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.

> **Economic development provides the resources needed to improve women's health, and improved women's health drives economic development.**

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 soley the ministries of health, should support the advancement of women's health issues.

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Chapter 2:
The health status of women in the African Region: from birth to the onset of sexual activity

An unacceptably heavy burden of disease and death at all stages of the life course

Women living in the African Region face a daunting range of threats to their health throughout their lives. Given the importance of the mother's health for the foetus she carries, it is clear that for the growing infant, whether a girl or a boy, the challenges begin at the moment of conception. If a mother is malnourished, her child is more likely to suffer growth retardation in the uterus and to be born undersize and underweight. This in turn increases the chances of the baby dying in the first few days of life. Even for children who survive, this has consequences for their subsequent development. Of the 40 countries worldwide reporting child stunting prevalence of 40% or more, 23 are in Africa.[1]

The hazards of childhood

Where the child survives birth, whether girl or boy, he or she is exposed to the same environmental and social challenges with similar health outcomes during infancy. The child will depend on its mother for food. Breast milk is the ideal food for newborns and infants, it improves their health and chances of survival. The African Region is characterized by generally low rates of exclusive breastfeeding (31%),[2] complementary feeding is untimely and foods are nutritionally inadequate and unsafe. The contamination of complementary food, including infant "formula" and the water with which it is mixed, is estimated to cause up to five episodes of diarrhoea per child per year in the Region,[3] and each episode exposes the child to the risk of dehydration and death. Oral rehydration therapy (ORT), the simplest treatment for diarrhoea and also the most effective, should be within reach of all including the poorest of mothers. However, only 37% of children in the Region receive it, mothers often preferring to treat diarrhoea with substances and medicines unsuited for the purpose, most notably antibiotics.

For mothers living with HIV, there is another source of confusion because of the belief that the risk of transmission makes breastfeeding too dangerous. Recent research evidence, however, shows that providing antiretroviral (ARV) interventions to either the HIV-infected mother or the HIV-exposed infant can reduce the risk of postnatal transmission of HIV through breastfeeding to less than 2%.[4] Even in the absence of ARV interventions exclusive breastfeeding carries a lower risk of transmission than mixed feeding.[5] The greatest declines in breastfeeding have taken place in countries where there has been extensive distribution of food aid – South Africa being a prime example.

Low breastfeeding rates – the South African experience

In South Africa, 20% of infants under the age of three months are not breastfed at all, making it a country with one of the highest rates of non-breastfeeding in sub-Saharan Africa. This situation has arisen partly as a result of lack of health workers with the skills needed to offer good counselling and support when problems arise, as they often do; breastfeeding may be natural, but is not always simple. Too often mothers are told to stop breastfeeding altogether and to give artificial substitutes. This advice is even more likely to be given where representatives of formula companies, in violation of the International Code of Marketing of Breast-milk Substitutes, engage with health workers to promote the sale and use of their products. Furthermore, food, including infant formula, was also distributed to prevent the transmission of HIV from mother-to-child, an initiative which inevitably undermined breastfeeding, including among mothers not infected with HIV.[6]

Unfortunately formula milk is not a sterile product and is easily contaminated. Most children born of HIV-infected mothers and raised on formula die not from HIV but from undernourishment, diarrhoea and other non-HIV-related ailments.[4]

Diarrhoea is closely followed by malaria as a cause of premature death in girls aged 0–4 years (see **Figure 2.1**); malaria being responsible for 16% of under-five deaths in the African Region, compared to a 7% average globally. Malaria is also an indirect cause of maternal mortality as discussed below, and contributes to stillbirth, premature delivery and low birth weight.[5]

Because of the infant's dependence on the mother, the mother's health is also a measure of the child's health. Indeed in the case of mothers living with HIV, the mother herself represents a direct threat. Mother-to-child transmission (MTCT) is a significant risk in sub-Saharan Africa. In 2009 MTCT occurred in an estimated 370 000 live births.[7] Indeed almost all HIV infections in children are the result of infection from the mother. In 2009 alone, of all new HIV infections among children worldwide, 91% occurred in the African Region.[1]

"Because of the infant's dependence on the mother, the mother's health is also a measure of the child's health."

Fortunately, this is an area where some progress is being made. So far 43 countries in the Region have implemented programmes for the prevention of mother-to-child transmission (PMTCT) of HIV. The percentage of pregnant women living with HIV who received ARV interventions for PMTCT of HIV in sub-Saharan Africa increased from 15% in 2005 to 45% in 2008 and 54% in 2009. Most of this progress has been made in East and Southern Africa where HIV prevalence is highest.

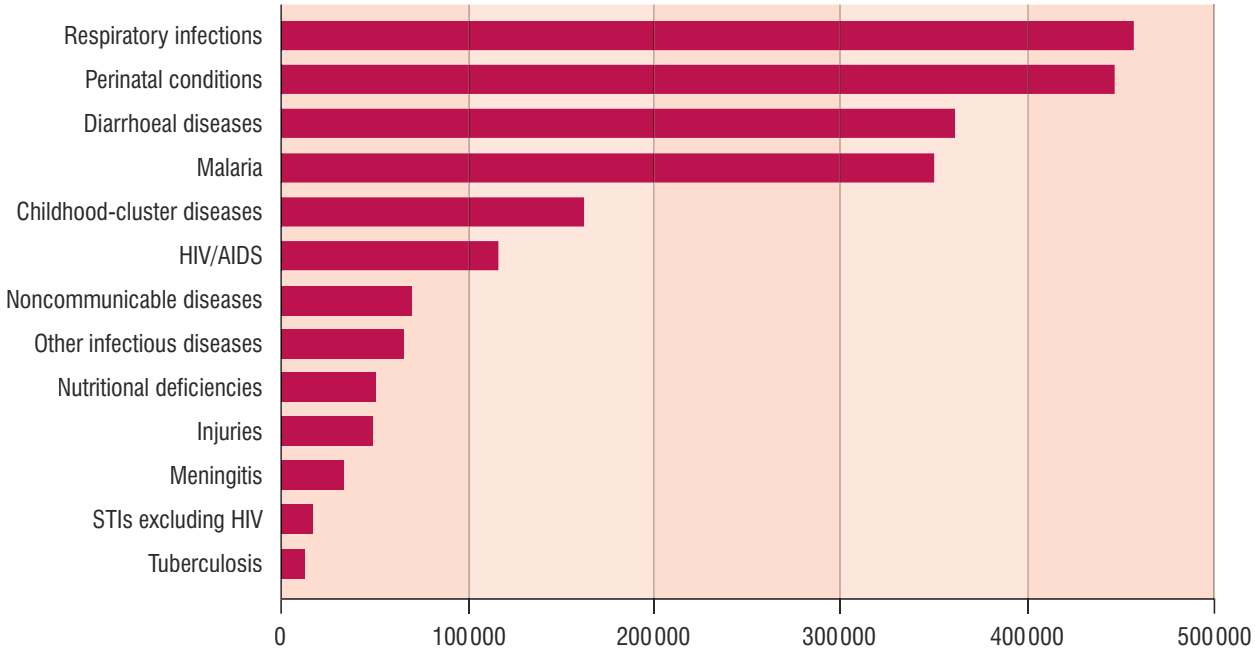
Even without the threat of infection or the challenge posed by being born undernourished and underweight, birth itself exposes the child, whether a girl or a boy, to the danger of asphyxiation and trauma – risks that increase dramatically if the mother is denied access to appropriate care administered by skilled birth attendants. Unfortunately this is too often the case in the Region. In general,

coverage of skilled birth attendance in the Region remains low at around 47%, although rates vary widely among African countries. For the Region as a whole, perinatal conditions such as asphyxiation and trauma are the second leading cause of premature death and disability among children under-five years after acute respiratory infections, mainly pneumonia, and account for about one in five deaths in this age group.[8,9]

Given the range of adversity with which the child must cope, it is perhaps not surprising that under-five mortality in the African Region remains the highest in the world, despite its decrease from 172 per 1000 in 1990 to 119 per 1000 in 2010. Over the same period the global average rate fell from 88 per 1000 to 57 per 1000.[10]

Child mortality in the Region has been declining at an average rate of 1.2% per year between 1990 and 2000, and 2.4% between 2000 and 2010 compared to the required decrease of 8% in order to meet MDG 4 by 2015. That requirement is unlikely to be met without a massive increase in investment over the next four years. Eight countries are on track to achieve this target; 27 countries are making progress, although it is insufficient; and 12 countries have made no progress.[11] Algeria, Cape Verde, Eritrea, Liberia, Madagascar, Malawi, Mauritius and Seychelles are all estimated to be on track.

Figure 2.1 The main causes of death in the African Region, females 0–4 years in 2004



Source: Constructed from World Health Organization, GBD 2004 Summary Tables, Health Statistics and Informatics Department, World Health Organization, Geneva, Switzerland, October 2008.

As the girl child in the African Region grows she must cope with challenges comparable to those faced by her male siblings especially exposure to malaria and malnutrition. In some settings, especially matrilineal societies and some bilinear societies with a strong matrilineal historical background, girls are actually given preferential treatment when it comes to feeding. This is true of the Wolofs of West Africa who believe that a girl child brings luck to the family particularly if she is the

first born. However, generally speaking, there is a marked preference for boys in the Region typically in some ethnic groups in Nigeria where, according to some studies, boys are better fed than girls because of their belief that the survival of the lineage depends on the male.[12,13] Some cultures also maintain food consumption hierarchies in which women are at the bottom of the pecking order. The past two decades have seen no change in the percentage of children suffering from malnutrition in the Region and an estimated 30 000–50 000 children die as a result each year.

Unsafe drinking water and poor sanitation pose another threat and many waterborne pathogens cause diseases such as diarrhoea, which is one of the leading child killers in the Region. The percentage of the world's population using "improved" drinking water sources increased from 77% to 87% between 1990 and 2008, a rate sufficient to achieve the MDG 7 target globally. However, in the African Region, despite the increase in the percentage from 50% in 1990 to 61% in 2008, it still falls short of the MDG 7 target and the percentage of the population using improved sanitation facilities is increasing too slowly – from 30% in 1990 to 34% in 2008.[2]

The challenges of childhood and adolescence

After the hardships of early childhood, the African girl actually starts to face the challenges that will distinguish her from her male siblings for the rest of her life as she begins to approach womanhood and starts sexual activity. Early in this period, the girl child begins to suffer the gender discrimination that is one of the socioeconomic determinants so crucial to women's health outcomes. From the earliest years the girl is likely to be assigned day-to-day housework such as cleaning, washing, fetching of water and fuel, and food processing and cooking.

In many settings girls are involved in household chores as soon as they are physically capable. They are given tasks outside the home, such as going to market to sell or trade food and goods. Should the mother die or become disabled through illness, the burden of the household work often falls on daughters who may also be given the responsibility of caring for the elderly or the mentally ill. Obviously, such work often jeopardizes girls' schooling.

As already noted in Chapter 1 there is evidence of correlation between the education and health status of girls. For example, several studies on HIV/AIDS undertaken by Jean Vandemoortele and Enrique Delamonica in Zambia[14] found that HIV/AIDS spread faster among uneducated girls compared to educated girls.[15] While there is no clear causal relationship, available data and information show that in Africa the education of girls works at a number of levels that are beneficial to the health of girls and the health of the women they later become. This is notably the case with issues of social empowerment where education can enhance young women's negotiating position with regard to sex. In Kenya, girls who stay in school have been shown to be more likely to postpone their sexual debut than those who drop out of school.[15]

In the African Region as a whole illiteracy among adults remains high and sub-Saharan Africa has the lowest ratio of female to male adult literacy worldwide apart from South Asia. It also has the lowest percentage of female youth literacy, the lowest primary school enrolment ratio and the lowest primary school attendance ratio. When it comes to secondary education, the gap compared with the rest of the world, including South Asia, really increases: in the period from 2000 to 2007 net secondary school attendance for girls in sub-Saharan Africa was 22%, compared with 43% for South Asia (see **Table 2.1**).

Table 2.1 Educational attainment of females in Africa relative to other world regions, 2000–2007

Region and subregions	Adult literacy rate: females as a % of males	Youth (15–24 yrs) literacy rate		Primary school				Secondary school			
				Enrolment ratio		Attendance ratio		Enrolment ratio		Attendance ratio	
		M	F	M	F	M	F	M	F	M	F
Sub-Saharan Africa	75	77	68	75	70	64	61	28	24	26	22
Eastern and Southern Africa	79	78	69	83	81	66	66	30	27	20	18
West and Central Africa	72	77	66	67	58	63	56	26	20	31	26
Middle East and North Africa	78	93	85	86	81	88	85	67	62	54	52
South Asia	71	84	74	88	83	81	77	–	–	51	43
East Asia and Pacific	93	98	98	98	97	92	92	60	62	60	63
Latin America and Caribbean	99	97	97	94	95	90	91	69	74	–	–
CEE/CIS*	97	99	99	92	90	93	91	79	75	79	76

*Central and Eastern Europe and the Commonwealth of Independent States; M = male; F = female

Source: UNICEF. *Rapport sur la situation des enfants dans le monde.* New York: UNICEF; 2009.

“Societies limiting girls’ access to education pay a huge price...”

Furthermore, girls are excluded from education for other reasons including inability of families to pay school fees, and familial preference to commit resources to the education of sons. Early marriage can also be a factor as well as school environments that are not designed to cater for girls’ physical needs, e.g. absence of toilet facilities specifically designed for girls.[16,17] Societies limiting girls’ access to education pay a huge price not only in terms of the obvious economic burden imposed by the relatively poor health of adult women later in life, but also in terms of the attendant loss of economic development as roughly 50% of the population is excluded from professional advancement. The latter part of this terrible equation cannot be overstated and will be discussed further in Chapter 5.

Just as girls often experience cultural pressure to do domestic tasks, so are they prepared for their role as bearers of children. In some countries this preparation finds expression in ritual practices some of which are harmful. Female genital mutilation (FGM), which involves partial or total removal of the female external genitalia by cutting, burning or scraping,[18] is inflicted on more than two million girls between the ages of four and twelve, notably in Ethiopia, Kenya, Nigeria and Uganda. Meanwhile roughly 92 million females above the age of ten are thought to be living with the indignity and pain of genital mutilation, more than 12 million of whom are girls between the ages of 10 and 14.[19] Female genital mutilation is

indeed harmful to the health of women, the psychological and physical trauma often being accompanied by profuse bleeding, wound sepsis, HIV infection and, subsequently, complications of childbirth. It is a condemnable human rights violation warranting prosecution.

Many sub-Saharan African countries including Benin, Burkina Faso, Ghana, Senegal, Tanzania and Uganda have passed laws penalizing the practice, but laws alone have seldom led to sustainable behavioural change. People – women as well as men – continue to mutilate young women in spite of the law or simply cross the border to perform the procedure beyond the reach of the judicial authorities. There is also evidence that the procedure is sometimes "medicalized" in order to circumvent the law and that an increasing number of girls are being mutilated before the age of five.

Female genital mutilation elimination efforts have been most successful when made jointly and in partnership with the perpetrators, i.e. the custodians of such traditions. For example, since 1993, *Maendeleo Ya Wanawake* Organization (MYWO) of Kenya in collaboration with an NGO (PATH) has worked with traditional leaders to persuade communities to replace the traditional cutting ceremonies with symbolic gift giving, while preserving other aspects of the traditional rite of passage. The number of girls participating in this alternative ceremony thus grew from 79 in 1996 to over 1000 in 1998.[20] As horrifying as FGM may be, the good news is that, it is not part of every African girl's experience.

Unfortunately, violence against girls in this age group is relatively common, often linked to forms of sexual predation. Indeed sexual coercion and sexual violence are prevalent in many African countries and affect girls from an early age as evidenced by data on early unplanned pregnancies.[21,22] This violence becomes more acute in crisis situations such as natural disasters or armed conflicts when girl children and adolescents are most vulnerable. Unfortunately, such situations abound in the Region and Africa has one of the highest burdens of internally displaced people in the world. Such movements of displaced people are also commonly associated with human trafficking, especially of young girls. Roughly 80% of the victims of trafficking are women and children and 43% of them are sexually exploited and otherwise oppressed.[23]

Young women in conflict situations

The collapse of social structures resulting from protracted conflicts exposes children of both sexes to a range of health risks from cholera to malnutrition and from deliberate mutilation to sexual abuse. According to Pernille Ironside, a child protection specialist working with UNICEF, 'most' of the girls returning from conflict zones have experienced extensive sexual violence which she describes as systematic rape often accompanied by mutilation over extended periods, sometimes years. According to the United Nations, between June 2007 and June 2008, in Ituri province in eastern Democratic Republic of Congo, 6766 cases of rape were reported – a number which probably represents only a fraction of the assaults actually taking place in that province. Of these reported cases, 43% involved children, mostly girls.

The psychological trauma resulting from these experiences is accompanied by an elevated risk of sexually transmitted infections particularly HIV/AIDS. Traumatic fistula, the rupturing of tissues caused by violent sexual assault, is also widely reported as is obstetric fistula.

“...more than half of all maternal deaths occur in women between 16 and 19 years, and this age group also bears the greatest burden of disease due to violence.”

In the African Region, the onset of sexual activity, an activity largely considered as one of the richest, life-affirming human experiences is too often a source of misery, death and disease. Among young women aged between 16 and 19 years HIV/AIDS accounts for almost a third of deaths, while complications of pregnancy and childbirth account for 28%. It is also worth noting that more than half of all maternal deaths occur in this age group which also bears the greatest burden of disease due to violence.

In some settings the onset of sexual activity happens remarkably early. In Lusaka, for example, one study revealed that 16% of all deliveries were by girls aged 12–19 years.[24] The same study showed that 10% of all patients undergoing manual vacuum aspiration due to abortion-related complications were between 12 and 19 years old. Moreover, among the women hospitalized in Lusaka University Teaching Hospital for abortion-related complications, 60% were aged between 15 and 19 years.

For African girls who, for various reasons, decide not to carry their baby to term, there is the danger of unsafe abortion which accounted for 35 592 deaths in the African Region in 2004 and is thought to be increasing, particularly among unmarried young women in urban areas.[25] The prevalence of unplanned pregnancies will predictably increase in sub-Saharan Africa over the next few decades, driven by the problems of early sexual activity and low use of contraception.[25]

The challenges relating to reproductive health in the Region will be further addressed in detail in the next chapter which details the reproductive years.

Key considerations and points for action

a) Addressing the many health challenges faced by young women in sub-Saharan Africa in their early years requires a multisectoral approach.
b) Gender discrimination begins at an early age with young girls being forced to take responsibility for household work which is often a hindrance to their education.
c) Education, associated with better health outcomes, has a number of other beneficial effects.
d) Violence against young women is widespread particularly in conflict situations and is often a part of sexual coercion. In some cases violence is expressed in harmful practices such as female genital mutilation.
e) The onset of sexual activity is associated with morbidity and mortality especially from HIV infection and maternal mortality.

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Chapter 3:
The health status of women in the African Region: the reproductive years

As a girl grows, so does the work she must do and the roles she must fulfil. The responsibilities she begins to shoulder as a young girl increase through adolescence until eventually she is involved in a wide range of daily tasks that are indispensable to the family's survival, including food production, processing, cooking and preservation. It is estimated that women in Africa produce up to 80% of the food needs of the continent.[1] Women are also the main care givers for sick or disabled members of the family and play a critical role in taking care of those suffering from mental illness.[2] The workload of women is greatest in childbearing and nurturing.

High fertility rate

Sub-Saharan Africa has the highest fertility rate worldwide, estimated at 5.2. In some countries, e.g., Chad, Democratic Republic of Congo, Niger and Uganda, fertility rates may be as high as 6.0 and beyond.[3] A high fertility rate is associated with low contraceptive prevalence.[4] According to WHO one in four women wishing to delay or stop childbearing in the African Region does not use any family planning method.[5] The reasons for this include the poor quality of available services and the limited choice of methods on offer. The low uptake of contraception is often blamed on knowledge of and attitudes toward family planning, the accessibility of contraception and gender relations as regards women's power to negotiate the terms of sexual activity.[6] However, this issue is also significantly influenced by cultural constructs that should be taken into account in any meaningful discussion of women's health. Indeed in many African cultures, motherhood is at the very core of the social nexus and high expectations are placed on women of reproductive age regarding the children they must bear.[7] Thus, a woman's identity is often associated with her capacity to give birth and in some traditional settings the main purpose of socialization of women is to enable them to give birth, to serve as a midwife to others, and to nurture children. Therefore, under cultural pressure to bear children, women tend to regard contraception not so much as a way of avoiding pregnancy but as a means to manage their reproductive life in ways that will secure their position in a society dominated by their in-laws. They may even

use contraception in order to bear all the children that God might give them by adjusting the timing and circumstances of their pregnancies.[8]

Though such considerations do not apply in equal measure in all settings, for many African women, and certainly for women living in rural areas, the approach of adulthood and motherhood brings with it sociocultural pressures that began to inform their experience as a child but now harden into the ineluctable determinants of their health.

The neglected problem of unsafe abortion

Although unsafe abortion is preventable, it continues to pose undue risk to the lives of African women. Unsafe abortions account for about 14% of maternal deaths on the continent. Thirty-one out of 1000 African women aged 15–45 years are estimated to experience unsafe abortion annually. The Eastern and Middle African countries are reported to have the highest rates of unsafe abortion, 36 per 1000, whilst the lowest rates are in Southern Africa (9 per 1000).[9]

In general, sub-Saharan African countries have some of the most restrictive abortion laws. Although laws limit access to abortion services, it is important to note that many sociocultural factors on the continent push women towards unsafe abortions. Moreover, the stigma associated with abortion discourages women experiencing abortion complications from seeking professional care. Unfavourable health provider attitudes to such patients have sometimes resulted in neglected care and unnecessary deaths. Preventing death and disability from unsafe abortion requires preventing unintended pregnancies through enhanced access to family planning services and improved access to safe abortion services.

The scourge of HIV

According to WHO statistics, at the global level, HIV is the leading cause of illness and death of women in their reproductive years (15–44), accounting for 19% of all female mortality.[10] It is a matter of particular concern that the prevalence of HIV infection in women has increased in the past two decades and that this trend is most pronounced in sub-Saharan Africa where women account for 60% of

Table 3.1 HIV prevalence in Africa and other regions of the world, 2007

Region	Estimated number of women above 15 years living with HIV (thousands)	HIV prevalence among young people aged 15 to 24 %
Sub-Saharan Africa	12000	3.2
Eastern and Southern Africa	8970	4.5
West and Central Africa	3000	1.9
Middle East and North Africa	220	0.2
South Asia	930	0.2
East Asia and the Pacific	750	0.1
Latin America and the Caribbean	660	0.4
CEE/CIS (Central and Eastern Europe and the Commonwealth of Independent States)	460	0.5

Source: UNAIDS: Geneva; 2008.

people living with the virus.[11] With very few exceptions, the same holds true at the regional level where girls and women in the 15–24 year age group are particularly vulnerable; HIV/AIDS prevalence in the Region is estimated at 3.2% (see **Table 3.1**), i.e., more than five times the global prevalence rate for the same age bracket.[12–14] In sub-Saharan Africa as a whole, women are also more likely to become infected with HIV than men, a fact confirmed by the most recent prevalence data indicating that 13 women become infected for every 10 men. Here too the pattern is repeated at the subregional level despite different types of epidemics and modes of transmission.[15] Female-to-male ratios of new HIV infections range from 2.22:1 in West and East Africa to 1.33:1 in Southern Africa.[16]

A number of factors underlie this trend and one of them is biological. The female genital tract has a larger surface area than the male genital tract and is thus more exposed to the virus. Moreover, because there are higher levels of HIV in semen than in vaginal fluids and more semen is exchanged during heterosexual sex than vaginal fluids, women are more exposed to the virus. Finally, because the delicate genital tissue of young women is easily damaged, coercive or forced sex represents a particular risk. A recent study conducted in Southern Africa showed that, compared with men, women are more likely to have HIV infection from an infected partner during unprotected heterosexual intercourse.[17] Even so, socioeconomic factors also interplay especially in cultures that limit women's knowledge about HIV or undermine their ability to make themselves heard in discussions on safe sexual practices. It has been shown that fewer young women than young men know that condoms can provide protection against HIV.[18] Clearly disempowerment of women is far more likely where poverty, lack of education or social status are factors. In settings where women are confined exclusively to domestic work, excluded from education and subjected repeatedly to violence, including sexual violence, women are further exposed to the risk of HIV infection.

“The exposure of young women to HIV is a matter of particular concern in the Region.”

The exposure of young women to HIV is a matter of particular concern in the Region. Not only do they face barriers to information about HIV, and in particular what can be done to avoid infection, but in some settings they engage in sexual activity with men who are older and are more likely to be infected. Data on this phenomenon are lacking, but demographic and health surveys of selected countries in the Region show that infection rates increase substantially in the 20–24 age group compared with the 15–19 age bracket. While the levels of HIV infection among men rise slowly and peak when they are in their mid- to late thirties, the prevalence among women rises rapidly and peaks when they are in their late twenties.[19]

Male-on-female violence or the threat of violence also plays a major role in driving the epidemic as shown by a 2010 study in South Africa which suggests that violence between intimate partners increases the risk of HIV infection among young South African women.[20] Violence further undermines women's ability to protect themselves from HIV infection, including making themselves heard in sexual negotiations. Once infected, women are also more likely to find themselves victimized by violent assault.[21] In Swaziland which has the highest level of HIV prevalence in the Region a study carried out in 2007 found that 33% of females aged 13–24 years reported having experienced some form of sexual violence before reaching 18 years of age.[22] Thus far, few countries have undertaken focused actions to prevent violence or to empower women survivors of violence.[21,23] It is also notable that while many countries have laws in place to punish rape, few have legislation that penalizes domestic violence.

Apart from the risk of violence, women living with HIV/AIDS in the African Region often bear serious social consequences for their infection. Positive HIV diagnosis of a woman often leads to the break-up of the family, abandonment by her husband and the denial of her rights in matters of inheritance, where these exist. It can even lead to outright social exclusion. HIV/AIDS has also contributed to marginalization of categories of women who were already victims of social exclusion, such as sex workers who suffer stigma, discrimination and other punitive actions that only exacerbate their vulnerability.

"Positive HIV diagnosis of a woman often leads to the break-up of the family, abandonment by her husband and the denial of her rights in matters of inheritance..."

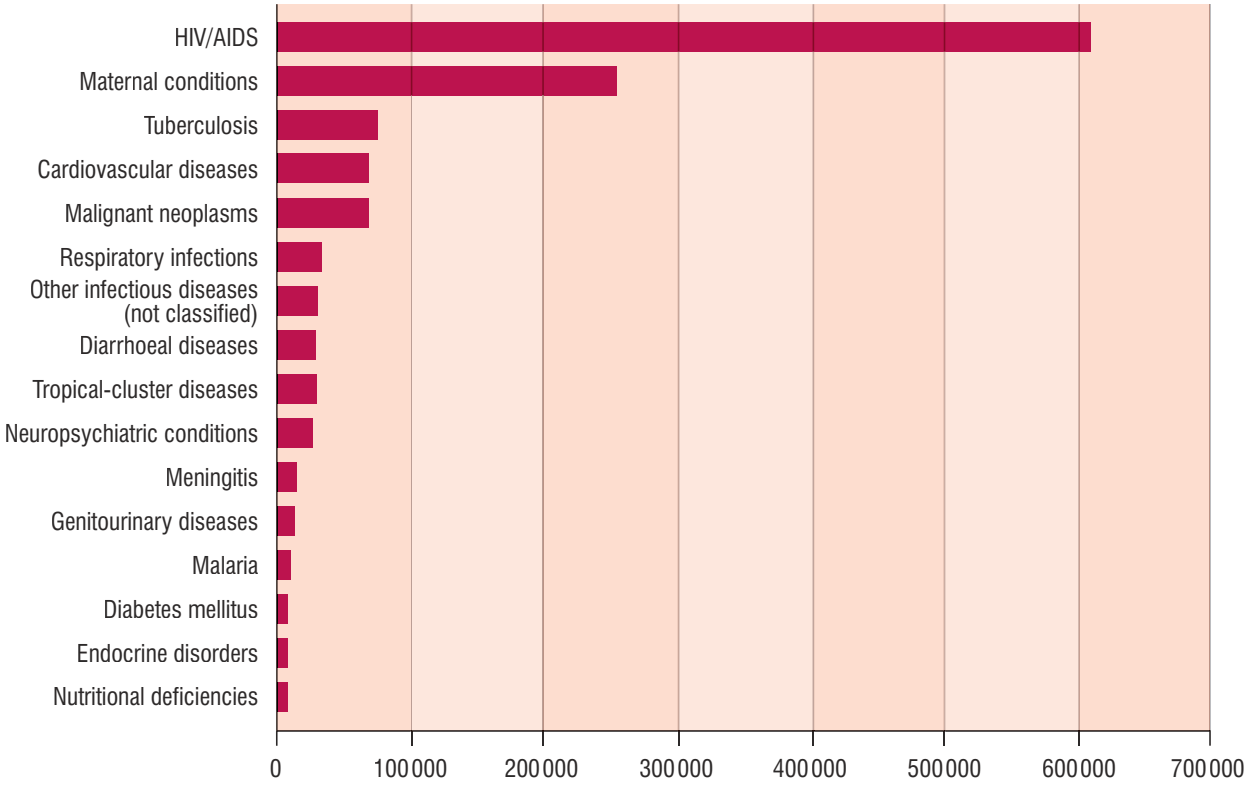
The high unmet sexual and reproductive health needs especially of young women, a population that is severely affected by both HIV and violence, underscores the urgent need to address MDGs 3, 4, 5 and 6 put together, i.e., to take a multisectoral approach to what is truly a multisectoral problem. This also means embarking upon a wide consultation on women's health issues and actively bringing together stakeholders from multiple sectors to convince leaders to allocate more resources for women's health.[24] In some countries this process has already started. 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.[25]

Improving the distribution of antiretroviral therapy (ART) to women is an important goal and the increase in the number of men and women receiving ART in the Region from 100 000 in 2003 to just under three million in 2008 is laudable even though much more can be done to change the social determinants driving the epidemic.[26] High prevalence of violence and HIV infections often go together and again call for integrated multisectoral responses that address particularly the issue of women's empowerment.

Poor maternal health care

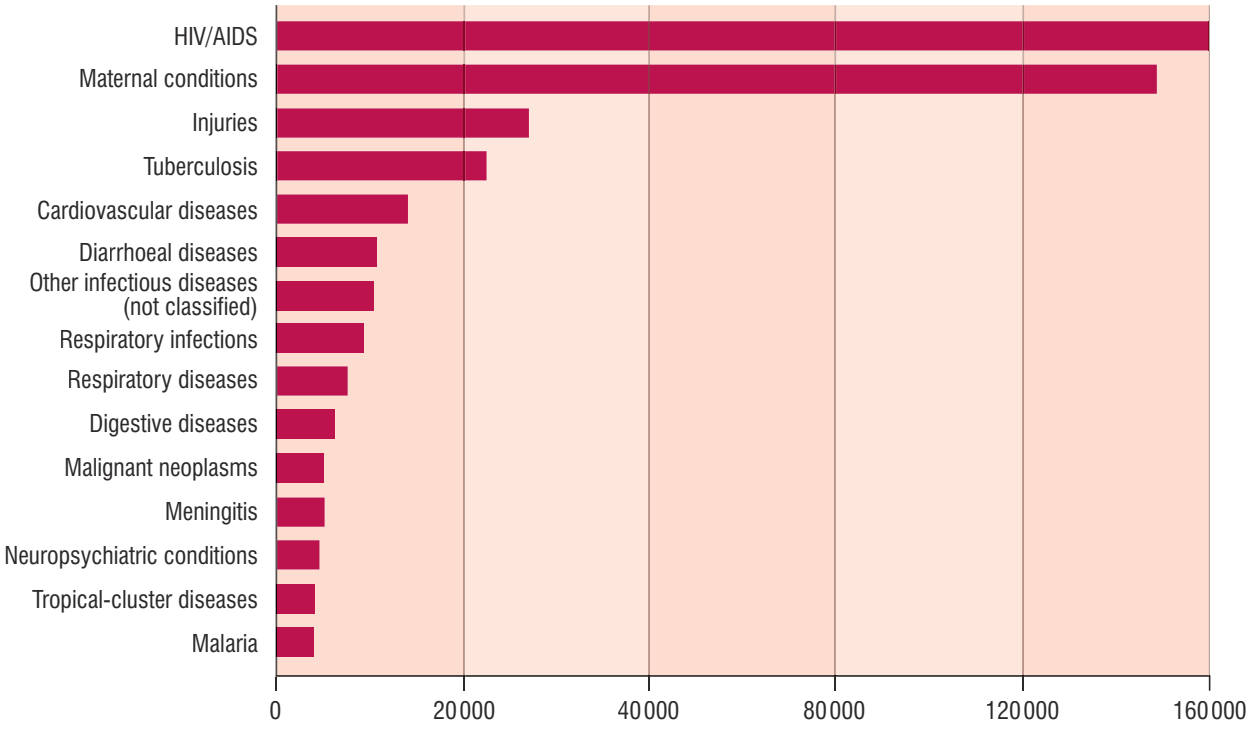
While HIV/AIDS may be the leading cause of death of African women in their reproductive years, maternal conditions also take their toll (**Figure 3.2**). Particularly in the 15-to-29 age bracket (**Figure 3.3**), the incidence of maternal mortality is even greater. In fact, roughly 51% of all maternal deaths involve African women aged from 15 to 29 years.

Figure 3.2 Causes of death in the African Region among women aged 15–44 years, 2004



Source: World Health Organization. GBD 2004 Summary Tables, Health Statistics and Informatics Department, World Health Organization, Geneva, Switzerland, October 2008.

Figure 3.3 Causes of death in the African Region among women aged 15–29 years, 2004



Source: World Health Organization, GBD 2004 Summary Tables, Health Statistics and Informatics Department, World Health Organization, Geneva, Switzerland, October 2008.

Skilled care is one of the requirements for safely following the mother and baby through pregnancy and birth. Antenatal care is essential to assess risks and to screen for and treat conditions. Here too African women are woefully underserved. In Burkina Faso, Chad, Mali, Mauritania, Niger, Rwanda and Senegal, for example, fewer than 25% of pregnant women make the WHO-recommended four antenatal visits with a trained doctor, nurse or midwife. Skilled attendance at birth is known to be crucial for maternal and newborn survival; however, the majority of African women do not have access to skilled attendance at birth. The same is true of postpartum care which is needed to detect and treat infection and other conditions including postpartum depression. Postpartum care is also crucial for providing advice on family planning and other issues such as breastfeeding (**Table 3.2**).

Table 3.2 Antenatal and delivery care coverage

Region/subregions	Antenatal care coverage (%) 2000–2007		Delivery care coverage (%) 2000–2007	
	Attended clinic at least once	*Attended clinic at least four times*	*Skilled attendant present at birth*	*Delivered at health institution*
Sub-Saharan Africa	72	42	47	40
Eastern and Southern Africa	72	40	40	33
West and Central Africa	71	44	49	46
Middle East and North Africa	72	–	81	71
South Asia	68	34	41	35
East Asia and the Pacific	89	66	87	73
Latin America and the Caribbean	94	83	85	86
CEE/CIS*	90	–	94	89

* Central and Eastern Europe and the Commonwealth of Independent States

Source: UNICEF. *Progress for Children,* New York; 2007.

Shortage of skilled care

The shortage of skilled birth attendants is just one of the problems regarding human resources for health in the Region. In many countries it is difficult to have a clear picture of the situation because of lack of reliable data,[27] but of the 57 countries worldwide suffering a critical shortage of health workers 36 are in the African Region.[28] Where health workers have been trained, their retention is problematic due to poor working conditions especially low salaries. Furthermore, some are compelled to leave their positions because of political instability, military conflicts or the HIV/AIDS epidemic.[29,30]

Staff shortages are not the only problem faced by health care systems in the Region. Inadequate or non-existent clinical facilities, limited access to good-quality essential medical products and technologies, clinical laboratory services and diagnostic imaging services are also an issue. These systemic shortcomings obviously affect the health of both men and women, but because of women's particular health care needs especially maternal care, they are bound to suffer relatively more when health systems lack the necessary resources. It is estimated that comprehensive emergency care is required for the 15% of women who develop complications while giving birth.

This may include expensive interventions such as Caesarean section that can often make the difference between life and death of a mother and/or her baby. Caesarean sections are performed in fewer than 3% of deliveries in the Region, well below the 5–15% estimated by WHO to meet women's childbirth needs.

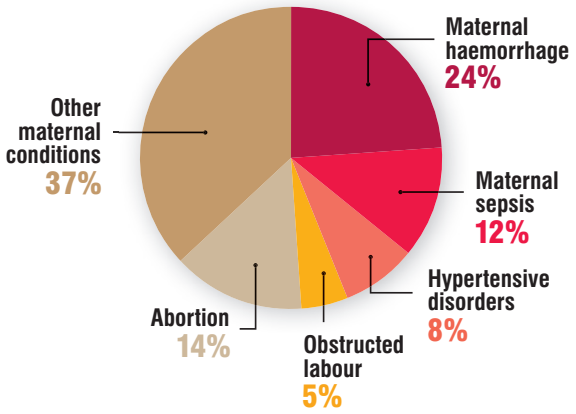
In order to begin to redress these problems national governments and international development partners clearly need to meet the funding commitments they made in the past. Inadequate budgetary allocation to the health sector is one of the key impediments to the training and retention of motivated health workers. African health training institutions lack the capacity to replenish human resources on an ongoing basis. Meanwhile, health workers in the field are faced with heavy workloads, low salaries, inadequate equipment and diminishing opportunities for advancement. All of these problems are more acute in rural settings.

High maternal mortality

Worldwide more than half a million maternal deaths occur each year of which 99% are in developing countries, and more than half of those are in the African Region.[5] MDG 5, as already stated, targets 75% reduction of the global maternal mortality ratio between 1990 and 2015, requiring an average annual reduction of 5.5%. In the African Region, the annual average reduction from 1990 to 2010 was 2.7%. The situation in the African Region is even more tragic because maternal mortality is largely preventable as evidenced by the global disparity in maternal health outcomes (**Figure 3.4**). Indeed in Europe maternal mortality is a rare event, occurring in only 20 out of 100 000 live births, compared to 480 per 100 000 in the African Region (see **Table 3.3**), the highest ratio of all the regions of the world.[31]

In the African Region where women bear many children (the overall fertility rate in the Region is 5.2), women have a 1 in 42 risk of dying prematurely from childbearing compared with the 1 in 2900 risk faced by women in Europe. In some parts of the Region, the statistics are even more chilling. One out of every 32 girls born in West and Central Africa will die because of a pregnancy-related complication in their lifetime. In addition, for every maternal death in the Region, there are at least thirty women who suffer short- or long-term disabilities.

Figure 3.4 Causes of maternal death in the African Region



Source: World Health Organization, Geneva; 2008.

More than half of maternal deaths occur within 24–48 hours after delivery due to complications ranging from postpartum haemorrhage to sepsis and hypertensive disorders.[32,33] Some mothers in the African Region bleed to death after delivery because no skilled health care professional was present to help. The availability of skilled birth attendants varies widely from country to country but generally coverage is low at around 47%.[26] It is estimated that around a quarter of maternal deaths could be prevented by emergency obstetric care (**Table 3.4**).

Table 3.3 Estimates of maternal mortality ratio (maternal deaths per 100 000 live births), maternal deaths and lifetime risk by WHO region, 2010

Region	Maternal mortality ratio	Number of maternal deaths	Lifetime risk of maternal death (1 in :)
Africa	480	148 000	42
Americas	63	9 700	710
Eastern Mediterranean	250	39 000	120
Europe	20	2 200	2 900
South-East Asia	200	76 000	190
Western Pacific	49	12 000	1 200
World	**210**	**287 000**	**180**

Source: WHO, UNICEF, UNFPA and The World Bank. *Trends in Maternal Mortality: 1990 to 2010.* Geneva: WHO; 2012.

Table 3.4 Emergency obstetric care facilities in selected countries in the African Region

Country and year	Five emergency obstetric care facilities per 500 000 population as a percentage (%) of the total number required
Cameroon (2000)	29
Mauritania (2000)	31
Mozambique (1999)	34
Malawi (2000)	36
Mali (2002)	38
Senegal (2002)	39
Chad (2002)	40
Uganda (2002)	44
Benin (2002)	67
Niger (2002)	68
Rwanda (2003)	86

Source: Shah IH, Say L. Maternal Mortality and Maternity Care from 1990 to 2005: Uneven but Important Gains. *Reprod Health Matters* 2007;15(30):17–27.

The importance of keeping promises to African mothers

Over the past several decades the United Nations General Assembly, the World Health Assembly, the WHO Regional Committee for Africa and other international conferences have adopted a number of resolutions designed to promote the health of African women. National governments, working with their development partners in Africa, have also made global, regional and national commitments. The right to health is enshrined in several core international human rights treaties† to which most countries in the African Region are State Parties. As previously stated in this report, specific to women's health is the United Nations Convention on the elimination of All Forms of Discrimination Against Women (CEDAW), which specifies state 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), together with the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, 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.

In 2000 the United Nations adopted the Millennium Declaration which sets eight Millennium Development Goals (MDGs) to be achieved by 2015 including: (a) MDG 5A which is specifically aimed at reducing maternal mortality by three quarters between 1990 and 2015; and (b) MDG 5B which aims to achieve universal access to reproductive health. It is important to note that the other goals also relate, directly or indirectly, to women's health particularly MDG 3 which seeks to promote gender equality and the empowerment of women, and MDG 4 which targets the reduction of child mortality. More recently, in May 2010, the World Bank announced a five-year Reproductive Health Action Plan to reduce maternal deaths, and fertility rates in 58 low-income countries. Under the plan the Bank pledges to increase its lending to help expand access to contraception, antenatal care and education for women and girls. The lending will also help provide training for health workers on the common causes of maternal death.

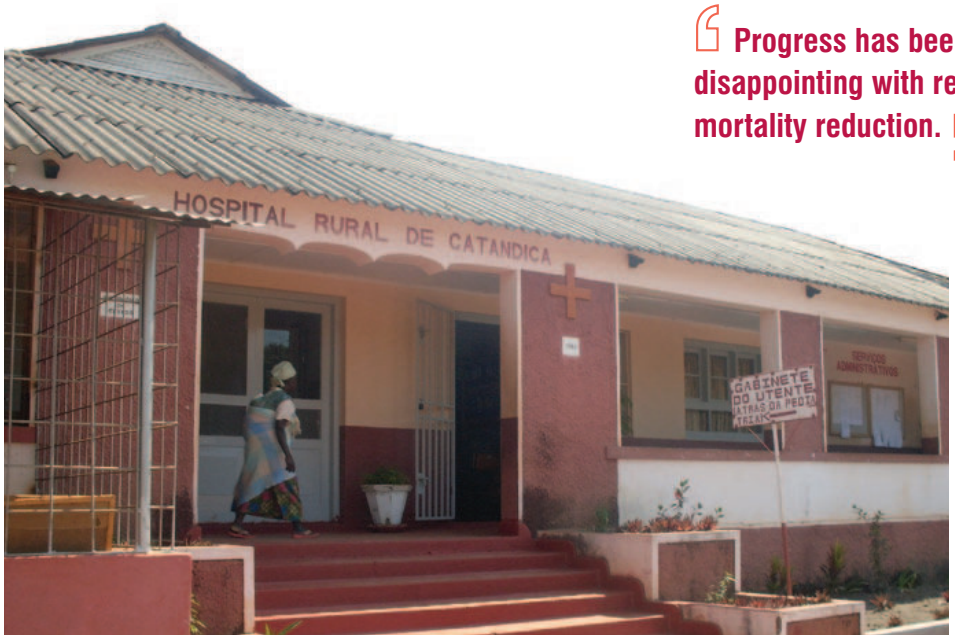
African countries have also made numerous regional and subregional commitments to improving women's health, the most recent of which is the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA) launched in May 2009 with the slogan – *Africa Cares: No woman should die while giving life.* The African Union, in collaboration with UNFPA, UNICEF, and WHO, had launched CARMMA in 34 countries in the Region by the end of 2011.

† *Which include the International Covenant of Economic, Social and Cultural Rights (ICESCR), the Convention on the Rights of the Child (CRC), and the Elimination of all Forms of Discrimination Against Women (CEDAW).*

However, despite the impressive roll call of conventions and initiatives, only a few of which are mentioned here, the good intentions have often failed to result in change. This is true, for example, of The Safe Motherhood Initiative that was launched at a conference in Nairobi, Kenya, in 1987, calling for the halving of maternal mortality by the year 2000 and urging countries to improve the status and education of women. Following the Nairobi meeting, many African countries made commitments to reduce maternal mortality and morbidity, and initiated National Safe Motherhood Programmes, but little concrete progress was achieved.

While many countries review and revise their laws and policies, for example to conform to the MDG declarations, a large gap still exists between stated policy priorities and the financial commitments required for implementation. Progress has been particularly disappointing with regard to maternal mortality reduction. One way of gauging this is to look at progress on MDG 5 requiring an average 5.5% annual reduction of maternal mortality between 2000 and 2015. In the African Region, the actual annual average reduction over the period between 1990 and 2010 was 2.7%. By 2010, only two countries in the African Region were on track to achieve MDG 5.

At a meeting of the African Union in Kampala in July 2010, leaders again made pledges, this time to invest more in community health workers and to re-commit to the Abuja Declaration target on health spending. As noted in Chapter 1, to date, only seven countries are meeting their Abuja Declaration target. Some leaders at the Kampala summit expressed concern about lacking the resources to be able to prioritize health care, and funding is clearly an issue.[34]



“Progress has been particularly disappointing with regard to maternal mortality reduction.”

African leaders at the Kampala Summit also pledged to reduce OOP health care expenditure stating their intention to do so through strategies such as free provision of obstetric care and care for children under five. One way to ensure that these decisions are fully implemented at the national level would be to introduce monitoring mechanisms. African leaders could also help by publicly setting and announcing time frames with clear deadlines for achieving the targets in the run-up to the 2015 MDG deadline.

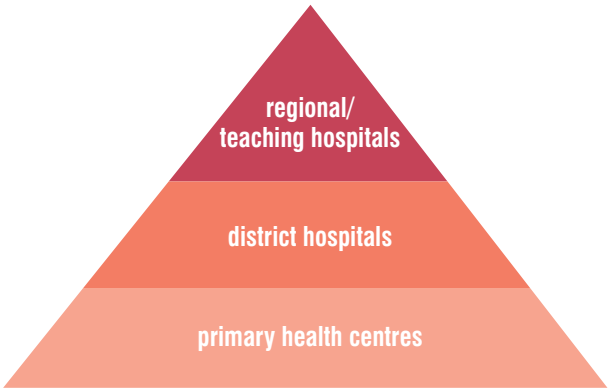


Figure 3.5 **The three levels of health care in the African Region**

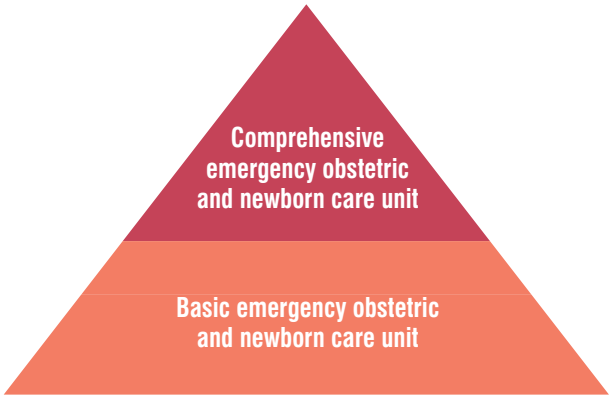


Figure 3.6 **Optimal maternity care model**

Evidently, building and staffing new clinics alone will not be enough. As stated in Chapter 1, there is need for a change in thinking about health system design, with greater emphasis on a primary health care (PHC) approach informed by the principles of social justice, equity, solidarity, effective community participation and multisectoral action. The prevailing tiered pyramidal health systems (see **Figure 3.5**) in which health facilities typically provide rudimentary care at the base are failing to meet the needs of African women many of whom are actually excluded from the care provided in sophisticated urban hospitals by distance, cost and subtle barriers such as staff attitudes towards the rural poor.

The optimal system design for the delivery of maternal health services in the African Region comprises two levels (see **Figure 3.6**) providing basic and comprehensive obstetric care.[35] This is because even basic obstetric care, if delivered effectively at the time of need, can save lives. The failure of district hospitals to provide life-saving treatment for obstetric emergencies – part of the so-called "third delay" in care – has contributed largely to the high maternal mortality ratios in the African Region.

The importance of PHC approaches to the delivery of health care in Africa is now understood as evidenced by the adoption of the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa which was endorsed by the Regional Committee for Africa in 2008 and which re-affirmed the principles of the 1978 Alma Ata declaration. However, much remains to be done in terms of political will and political commitment if the Ouagadougou Declaration is not to become just another declaration on a list of declarations dating back to several decades. There are also signs that maternal health care is now being prioritized in some places. According to the World Health Organization, over the past three years concerted maternal and perinatal death reviews have started in 27 countries in the Region, while 17 countries have started the work of improving the skills of health workers in essential newborn care using WHO course materials. WHO has also published a guide to clinical practice of emergency obstetric and newborn care and "home-based" newborn care training materials for community health workers.[26]

User fees penalize poor women

Obviously, even physically accessible, properly equipped and adequately staffed clinics and hospitals will do little to serve the health needs of African women unless the women themselves feel they can actually walk in to seek help. Where a woman has to pay out of her own pocket to see a doctor, she may forego medical consultation until it is too late to provide effective treatment. User fees were introduced in most African countries in the aftermath of the global recession in the 1970s, which

resulted in structural adjustment policies restricting government expenditures.[36,37]

An influential World Bank report published in 1987 suggested that charging fees was not only a good way to generate revenue, but would reduce overuse and encourage the provision of services at low charges and costs.[38] The report also argued that user fees would improve equity because the money raised in cities and towns could be used to subsidize the poor in rural areas. However, as already noted in Chapter 1, the African experience with user fees has not been positive.

User fees were introduced in a number of countries in the 1980s and 1990s, in many cases as part of conditions for the granting of loans by the World Bank and International Monetary Fund. In 2007, 90% of global financial catastrophe (defined as the forced disbursement of more than 40% of household income after basic needs have been met) resulting from user fees occurred in the Region where borrowing and the sale of assets to finance health care are common practices.[39] Even when the fees charged are quite low they can discourage the use of health services. In this regard, a recent study in Kenya showed that introducing a US$ 0.75 fee for previously free insecticide-treated bednets reduced demand by 75%.[40]

The barrier to access created by user fees presents a particular problem for women in the African Region because they are often dependent financially on men. As a result, their access to purchased health services depends on men's decisions on how financial resources are to be used. The effect of such gender imbalance is greatly amplified in cultural contexts where fear of divorce or abandonment, violence, or stigma prevents women from using reproductive health services.

The alternative to user fees is some form of pooling of financial resources so that the risk of paying for health care is borne by all members of the pool and not only by the individual when she or he falls ill. For pooling to materialize, funds must be prepaid either in the form of taxes or insurance contributions.[41] Some African countries, notably Ghana and Rwanda, have already started to move in this direction, and there are many examples worldwide of low- and middle-income countries that have adopted prepayment and pooling as the basis for financing universal health care.

However, it should be noted that the problem posed by user fees cannot be solved by simply dropping them. When Uganda abandoned user fees in 2001 the incidence of catastrophic health spending among the poor did not fall immediately, the most likely explanation being that frequent unavailability of medicines at government facilities after 2001 forced some patients to go to private pharmacies.[42] Without proper planning the abandonment of user fees can also lead to an increase in the charging of unauthorized user fees by health workers. Therefore, the transition must be handled with care if policy makers want to prevent unpaid staff abandoning clinics. A recent UNICEF study of six sub-Saharan countries that have discontinued user fee payment revealed that the process is facilitated where there is clear leadership from high up in the political establishment, and where there has been dialogue between political leaders and national technicians.[43] Where politicians have been tempted to abandon fees too quickly, often for political reasons, technicians have sometimes struggled with the formulation and implementation of reform. According to WHO, 17 countries in the Region have removed financial barriers to emergency obstetric and newborn care since 2008.

Health care that is lacking in gender and cultural sensitivity

African women's lack of financial resources and the geographical isolation of a significant proportion of the Region's population are often cited as explanations for the low uptake of maternal health services. Less attention is given to attitudes to pregnancy that may result from deep-rooted cultural beliefs but are at variance with current best medical practice. For example, the Annang of Nigeria favour the squatting posture during childbirth as opposed to the "lithotomy" posture generally adopted by health systems.[44] This posture has cosmological and philosophical connotations and takes advantage of gravity to help the infant's passage through the birth canal. Along with kneeling, squatting is one of the most widely chosen birthing postures worldwide, particularly in cultures where women are in control of the way they give birth.[45] Part of the challenge faced by policy makers is thus to make an argument for current practices that is informed by an awareness of these traditions. It is not enough to simply say "this is how it is done" – there is need for a degree of cultural sensitivity if low utilization rates are to change. Other constraints on women seeking the care they need may include conventions regarding early pregnancy. In many traditional African societies, pregnancies are hidden as much as possible during the early months and some refer to this period using words that translate literally as "the unsaid". Here too, outreach and education about the importance of antenatal visits needs to be designed with an awareness of the traditional perspective.

Efforts to engage and educate communities on maternal health issues need to be designed with an awareness of the fact that the pregnant woman is part of a social network and that her status and connections within this network often determine her ability to respond to public health campaigns. In the African context, pregnant women often relate to health care facilities through a complex social web that reflects power struggles within the kinship, the circle of alliances and the community.

As stated in Chapter 1 traditional beliefs about health in Africa are generally informed by the notion that individual and communal health are intertwined, which makes it problematic to discuss one element without the other. The Nguni people of Southern Africa sum this up in the words: *"umuntu ngumuntu ngabantu"* – a person is a person through persons. Consequently, efforts to address a young woman's antenatal care needs are often best directed at older women in the community. Older women – mothers-in-law, mothers and aunts – are often perceived and acknowledged as having the necessary experience and social responsibility to manage a young woman's pregnancy. As a result, campaigns to encourage breastfeeding might do better if there were an awareness that it is the grandmothers rather than the mothers who take key decisions about how the baby feeds, a phenomenon that has been commented on in the South African context for example.[46] Unfortunately, most of the time, the views of these older women are not taken into account in the formal health systems.

Moreover, awareness of traditional belief systems and the social organization that supports them provides considerable opportunities to improve maternal outcomes, as has been demonstrated by ethnographic studies in Malawi showing that health authorities can use social support structures, existing beliefs and knowledge, and cultural practices during pregnancy to improve care for women.

African women are a valuable resource and should be empowered wherever possible; this holds true for their role in supporting their sisters through the often challenging and, in the African context, high-risk process of carrying a child to term and giving birth. The modification of traditional practices and the use of those deemed appropriate can enhance efficiency in service provision and increase service affordability. Moreover, understanding cultural concepts about pregnancy, childbirth and postpartum care will not only help to design new responses targeting maternal mortality, but will also have synergistic effects on the health issues of other women.

In the African Region women are key providers of care within the family and occupy a position of paramount importance in public and private health systems. Indeed, women predominate in the formal health workforce of many African countries. However, they tend to be concentrated in occupations such as nursing, midwifery and community health service. The more technical roles – doctor, surgeon, anaesthetist – tend to be occupied by men and with the exception of Burundi, Guinea and Mozambique, where the ratio of male physicians to female physicians is between 0.7 and 1, the ratio is typically between 0.2 and 0.3 women to men in other African countries.

“In the African Region women are key providers of care within the family and occupy a position of paramount importance in public and private health systems.”

The analysis of our qualitative findings in this area reveal that in many cases African women are unwilling to be examined by male practitioners during pregnancy and delivery, and thus male domination of that category of health workforce acts as a barrier to access. This finding is confirmed by a number of studies conducted around the world, including in industrialized countries, showing that the sex of the physician is an important factor in effective communication between patients and doctors, and in the overall rating of service quality by patients.[47,48] Evidence regarding utilization rates among patients with cervical cancer, a major problem in the Region, also suggests that women sometimes delay screening due to embarrassment about being seen by a health care provider of the opposite sex.[49] The findings of our studies in the Democratic Republic of Congo suggest that, in war and conflict zones, women who have been victims of rape or sexual violence prefer to be treated by a female health worker. To improve utilization among women patients it is therefore crucial to empower female health personnel in the Region and to increase women’s participation at all levels of health governance particularly in decision-making, since the effective participation of women in the design and implementation of health services is so essential.[50]

Increasing the numbers of highly trained female health care providers is a complex problem that may take decades to address. There is thus a case for initiating education programmes to change women’s attitudes to receiving treatment from men pending the development of a more gender-balanced health workforce. In the

medium-to-long term, however, the integration of women into the higher levels of the health system must be a priority and governments should make a commitment to recognizing the value of the work they already do through pre-service and in-service training, and mentoring programmes, and by actively encouraging women to aim higher. As already discussed, the education of women in Africa is one of the keys to their empowerment and a driver of broader socioeconomic development. This subject will be revisited in Chapter 5.

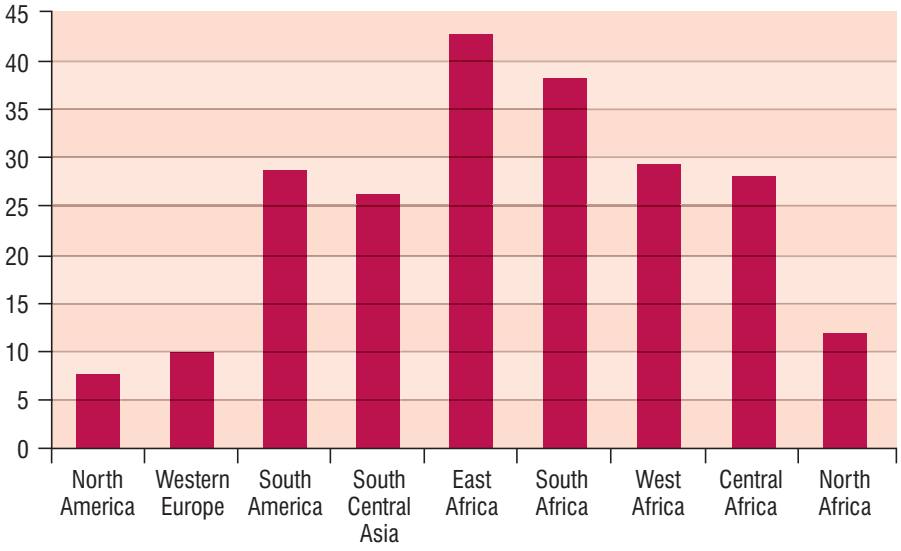
Cervical cancer

Sub-Saharan Africa has the highest incidence of cervical cancer in the world (**Figure 3.7**).[51] This is the most common cancer among African women, representing over a fifth of all cancer cases. Cervical cancer is on the increase in many African countries, notably in Mali, Uganda and Zimbabwe, but the true size of the problem is unknown due to under-reporting and lack of reliable data. In almost every case cervical cancer is linked to genital infection with the human papillomavirus (HPV), a common sexually transmitted infection (STI) found in 10% of women worldwide, but estimated to affect one woman in five in the African Region.[52] Despite the fact that a highly effective vaccine against HPV exists and cervical cancer itself can be prevented through regular screening and appropriate treatment, women continue to die from the disease in the African Region because they have no access to either.

According to a study conducted in four countries in West Africa,[49] less than 1% of women have ever been screened for the disease. As a result only 21% of African women survive the disease compared to 70% and 66% in the United States and Western Europe, respectively.

The toll of cervical cancer in the African Region is particularly high as the disease tends to affect women at a time of their lives when being in good health is so critical to the social and economic stability of families.

Figure 3.7 Age-standardized incidence of cancer of the cervix per 100 000 population of women by world region



Source: Adapted from Anorlu RI. Cervical cancer: the Sub-Saharan African perspective. *Reprod Health Matters* 2008;16(32):41–9.

In many ways patterns of HPV infection typify the African woman's experience of sexually transmitted diseases which are characterized by late diagnosis and treatment for the socioeconomic reasons already discussed. Due to late treatment and women's greater biological vulnerability to complications of untreated infection, women suffer a far greater burden of these particular diseases than men in the African Region. Perfectly treatable infections like gonorrhoea, chlamydia, syphilis and trichomoniasis result in acute symptoms and chronic infection and can lead to infertility, ectopic pregnancy and cancers as well as increased vulnerability to HIV infection which, as already mentioned, is the biggest killer of women in this age group. It is estimated that approximately one in four women in sub-Saharan Africa has one of the four treatable killer infections at any point in time.

Infertility and other gynaecological and obstetric pathologies of reproductive age in the African Region

A couple are generally considered to have an infertility problem if no pregnancy occurs after 1 year of regular intercourse without contraception.[53]

Infertility is a major public health problem in the African Region, as failure to conceive often generates frustration and emotional stress as well as a sensation of guilt and resentment; infertility may even lead to divorce.

Unfortunately in many African settings the woman is often the one who is blamed for infertility. This could lead to several adverse social and economic consequences for the woman including neglect and divorce.

Determining factors of infertility include age of the partners, duration of sexual exposure, normal genital organs and STI, as well as taboos.

The treatment of infertility is individualized in response to the identified causal factors. The most cost-effective approach to infertility is the prevention of sexually transmitted infections and improved education. Assisted reproductive technologies can aid in the management of infertility and sterility. Some countries in the African Region have successfully established assisted reproduction clinics.

Other gynaecological and obstetric problems prevalent in the Region include hypertensive disorders of pregnancy, diabetes in pregnancy, cardiac disease in pregnancy, uterine myomas, urinary infections in pregnancy, anaemias and gynaecological cancers, such as cervical, breast, endometrial, vulvar and vagina cancers.

Other risks

This chapter has focused on the main causes of disease and death among women in the African Region during their reproductive years. But HIV/AIDS and the wide range of life-threatening maternal conditions are just two of the challenges faced by African women in this age group. Other notable risks include the threat of infectious diseases such as tuberculosis, a disease that is very often associated with HIV/AIDS to the extent that 35% of tuberculosis cases in the Region are co-infected with HIV and tuberculosis accounts for approximately 40% of deaths in people living with HIV/AIDS. Noncommunicable diseases (NCDs) including violence and injuries are also a matter of considerable concern.

Women of childbearing age in the African Region are confronted by a complex of health determinants, many of which can only be addressed through a multisectoral approach to reform. The Commission on Social Determinants of Health, in 2008, called for action in three main areas including improving daily living conditions and tackling the inequitable distribution of power, money and resources.

Key considerations and points for action

a) Prevailing high fertility rates are only partly a reflection of the low levels of contraceptive use. Traditional beliefs around childbearing must also be taken into account and used to inform policy.
b) HIV infection in women has increased in the past two decades in sub-Saharan Africa, driven largely by socioeconomic factors. Only a multisectoral response to this crisis will be effective.
c) There is an urgent need to provide adequate funding for health systems, focusing on primary health care.
d) User fees should be replaced by prepayment and pooling, but this should not be undertaken without careful consideration of local conditions. Unplanned discontinuation of the payment of users' fees is not an option.
e) Maternal mortality continues to take a huge toll on the lives of women largely because of inadequate health care provision. Here too policy response must take into account the multisectoral nature of the problem.
f) The two-tier system is the optimal model for achieving MDG 5.
g) Adequate attention must be paid to the diagnosis, treatment and, especially, prevention of infertility in the African Region.

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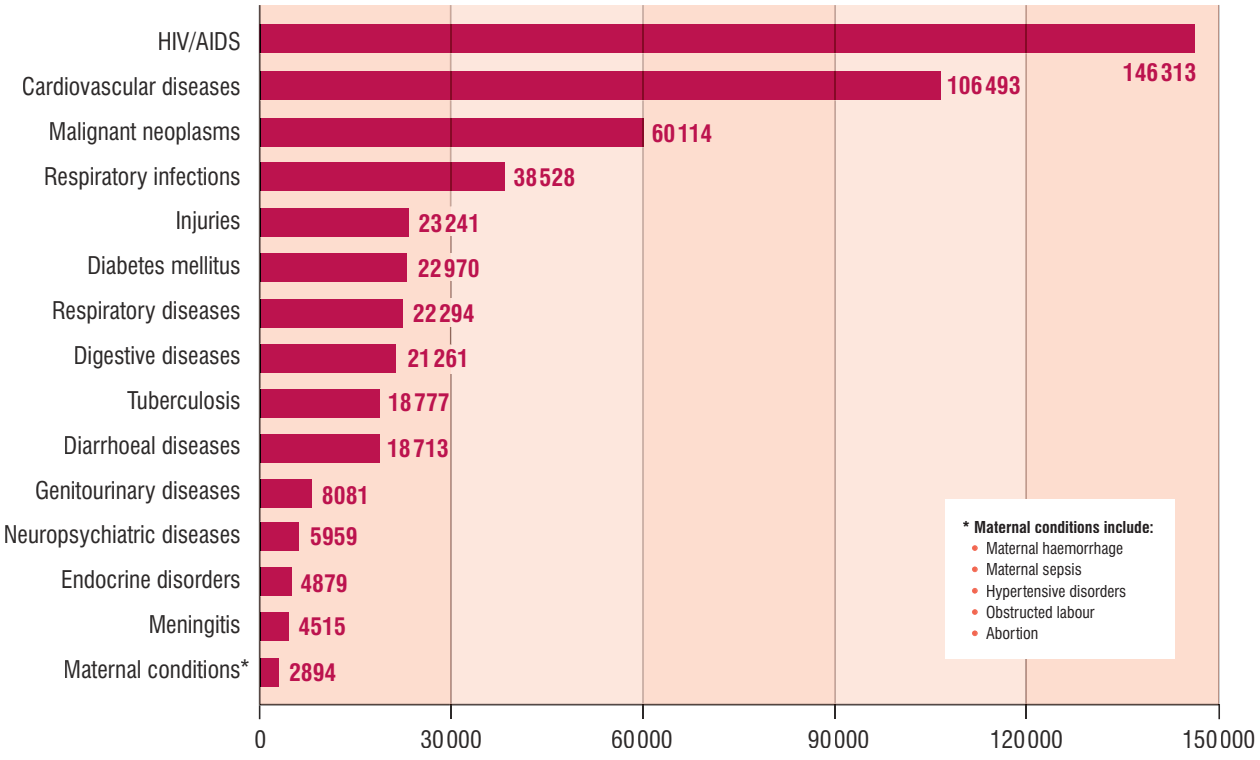
Chapter 4:
The health status of women in the African Region: beyond the reproductive years

Major risk factors for diseases

Just as the childbearing years bring a variety of pressures (biological, sociocultural and economic) to bear on the health of women in the African Region, so do the years that follow. Many of these pressures are a continuance of stresses that have existed since birth. Health problems such as malnutrition, malaria or diarrhoeal diseases precede the onset of sexual activity and continue through the reproductive years and beyond. Then, as the life course continues, African women are faced with new risks and their morbidity and mortality profile begins to alter. HIV/AIDS continues to take the greatest toll on lives in the 45–59 year age group, but as can be seen in **Figure 4.1** noncommunicable diseases (NCDs) start to weigh quite heavily, notably diseases of the heart, cancers and chronic respiratory diseases.

Figure 4.1 Main causes of death among women aged 45–59 in the African Region, 2004



Source: Constructed from World Health Organization, GBD 2004 Summary Tables, Health Statistics and Informatics Department, World Health Organization, Geneva, Switzerland, October 2008.

Some of these health problems are the result of exposure to risks first encountered in youth, including tobacco and alcohol use and a diet with high content of cholesterol, saturated fat and salt, but lacking in fresh fruits and vegetables. Health problems in this age group may also reflect a lack of physical exercise, excessive

physical stress especially in farming, in gathering and carrying food commodities, wood, water and other goods, and in nurturing children. They may also reflect a lifetime of exposure to violence and accidents in farms, the streets, or homes.

Overweight and obesity that are major risk factors for a range of chronic NCDs including diabetes, high blood pressure and heart disease, affect women disproportionately in the Region as indicated by a recent STEPS Survey undertaken in Malawi. The survey revealed that 28% of women are overweight compared to just over 16% of men.[1] A STEPS Survey in Sierra Leone showed similar results, reporting obesity in 10.8% of women.[2] In South Africa overweight and obesity are now major components of the malnutrition epidemic and one in every three women is considered obese.[3,4]

Like other public health issues in the Region, the obesity epidemic needs to be understood in the broad sociocultural context. In some settings obesity and overweight are admired as a beauty desirable in women, making it hard for women to adopt healthy lifestyles.[5] Obesity may also result from forced feeding of pregnant women in some traditional settings. Furthermore, the obesity epidemic may reflect a transition in the Region, both economically and socially. This transition is affecting the way women live. One of the key drivers of the NCDs epidemic in sub-Saharan Africa is the growth of its cities. In the Region as a whole the annual average urban population growth rate is 4.5%[6] and, as in other parts of the world, this rapid urbanization is largely to blame for the increasing levels of obesity.

“According to WHO, if nothing is done to address the issue of NCDs, they will account for at least 50% of mortality in the African Region by 2020.”

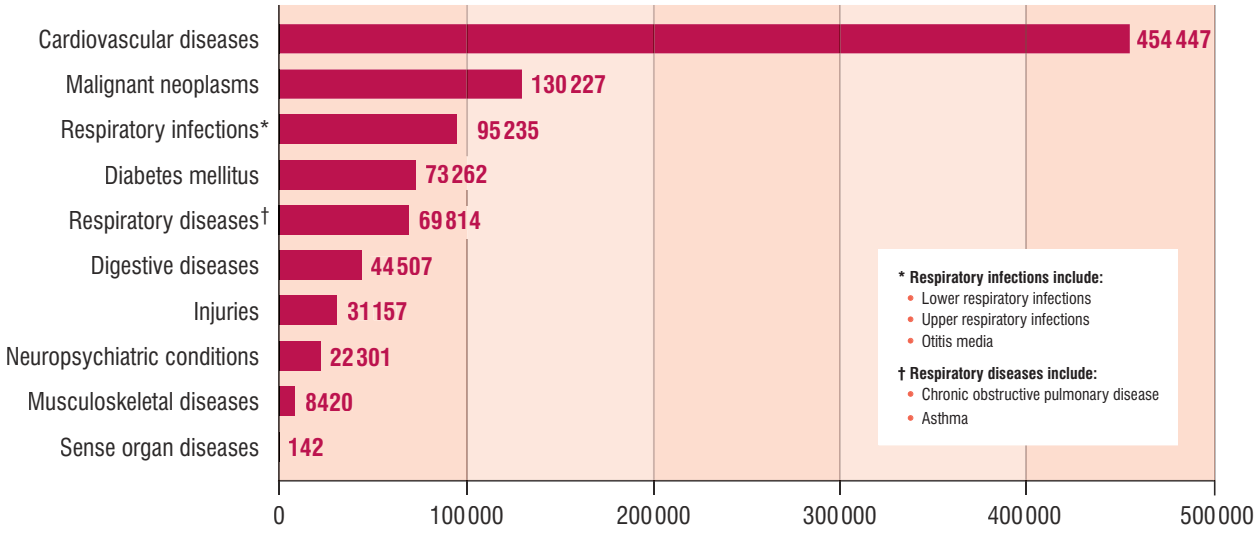
NCDs are high among women above 60 years

Urban population growth is also associated with diabetes and cardiovascular diseases[7] which killed over 106 000 women in the 45–59 age group in the Region in 2004, making it the second biggest killer after HIV/AIDS. Heart disease continues to take its toll on African women in their late years and accounted for more than 450 000 of deaths in 2004 (**Figure 4.2**). Far from being a disease of affluence, cardiovascular disease kills twice as many women aged 60 and above in low- and middle-income countries compared with high-income countries.[8] The same applies to NCDs generally. Contrary to the conventional wisdom that NCDs are a problem of the rich world, they are in fact a matter of growing concern in low-income countries where they are also the second leading cause of death of women.[5] NCD prevalence rates are generally not recorded by health systems in the Region, but selected studies suggest that they are high and increasing. According to WHO, if nothing is done to address the issue of NCDs, they will account for at least 50% of mortality in the African Region by 2020.[9]

Cancers are another significant cause of disease and death as African women age, accounting for more than 60 000 deaths annually in the 45–59 age group and well over 120 000 in the 60-plus group.

The particular sociocultural determinants driving the high prevalence of cervical cancer were discussed in the preceding chapter, but are revisited here as an example of the unique challenge sub-Saharan Africa faces in regard to the rapid increase in NCD prevalence against the backdrop of high morbidity and mortality

Figure 4.2 Causes of death among women aged 60 and above in the African Region, 2004



Source: Constructed from the World Health Organization, GBD 2004 Summary Tables, Health Statistics and Informatics Department, World Health Organization, Geneva, Switzerland, October 2008.

from communicable diseases. In old age in most countries worldwide, death and disability begin to be driven by NCDs, but in the African Region communicable diseases remain the chief cause of female deaths up to the age of 60 years.[10] Sometimes, this double jeopardy gives rise to interactions between communicable and noncommunicable diseases, adding to the burden of female morbidity and mortality. Human papillomavirus and cervical cancer are one example[11] and schistosomiasis is another.

Gender norms and disease

Because many African cultures tend to restrict women to domestic tasks including care-giving, women, more than men, are at a higher risk of suffering from a number of specific diseases. For example, as the main providers and processors of food, women and girls are often present as solid fuels burn in poorly ventilated houses, making them inhale large quantities of particulates and carbon monoxide.[12] Sub-Saharan Africa is one of the two regions with the highest domestic fuel-related disease burdens.[13]

Because many African cultures tend to restrict women to domestic tasks including care-giving, women, more than men, are at a higher risk of suffering from a number of specific diseases.

Women are at a higher risk of poor health relative to men partly because they have limited access to treatment but also because of social roles that predispose them to diseases.[14,15] For example, women are at greater risk of suffering from trachoma, the leading cause of blindness in Africa. The prevalence of trachoma infection in women in the African Region is about 2–3 times higher than in men. Because of their role in fetching water women are more exposed to schistosomiasis infections than men. Schistosomiasis is primarily associated with frequent and prolonged exposure to water infested with snails as can be found in lakes, swamps and slow moving waters. In one study, the proportion of bladder cancer attributable to

schistosomiasis was estimated at 28%. In areas where schistosomiasis is endemic, women are 1.5 times more likely to contract bladder cancer than men.[16]

There were an estimated 313 000 deaths from cancers of the breast, the uterus, and the ovary in 2004, a number partly reflecting exposure to tobacco smoke and indoor pollution (also causing chronic obstructive pulmonary diseases) as well as limited access to screening, late diagnosis and inadequate access to effective treatment.[17]

The economic and social cost of NCDs are discussed in greater detail in Chapter 5, suffice it to note meanwhile that NCDs are expensive to treat and are thus a considerable burden on health systems already struggling to cope with the epidemic of communicable diseases. Moreover, because the treatment of NCDs does nothing to reduce their incidence, they present policy makers with the prospect of yearly increases in expenditure with little to show for it in terms of improved outcomes. At the social level NCDs are also potentially devastating, notably for elderly women who play such an important role in many African societies, especially as care givers for HIV/AIDS orphans.

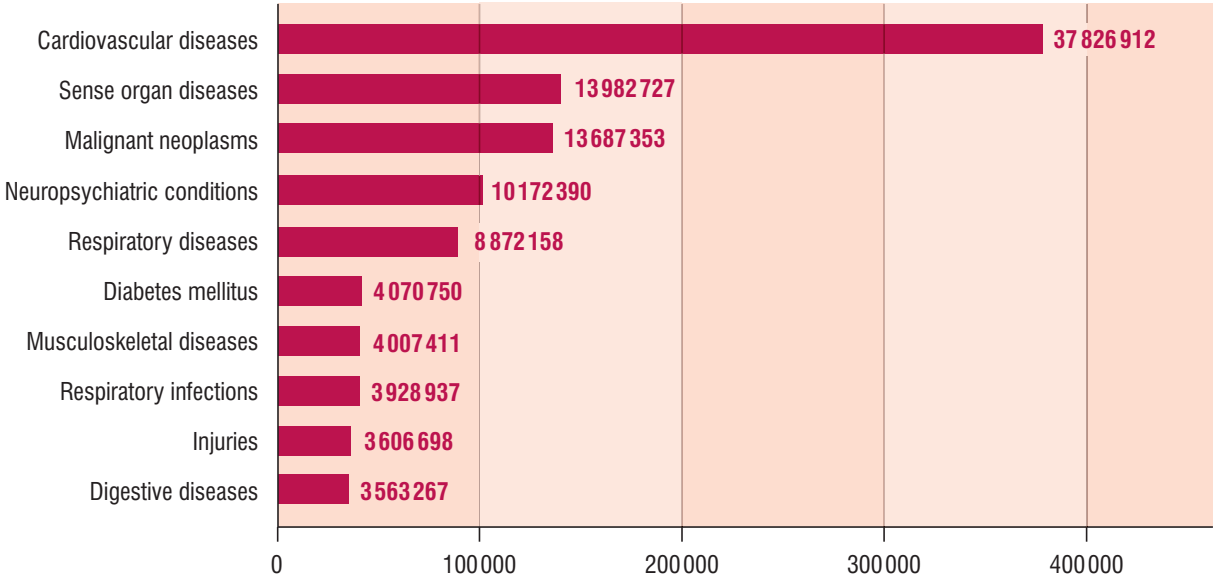
Fortunately, because many NCDs can be prevented through changes in lifestyle, governments have various tools at their disposal to fight this epidemic. Advocacy and well thought out policy reform, backed up by effective legislation can largely contribute to positive change. However, women should be empowered through health education in their early years so that they at least have the information required to lead a healthy life. Finally, it is important for policy makers to make an appropriate balance between public health and commercial interests, notably with regard to tobacco and alcohol.

Understandably, no amount of healthy living can postpone indefinitely the onset of senescent change and its attendant vulnerability. In old age women (and indeed men) are exposed to a range of health issues – vision or hearing may be impaired; mental acuity may diminish – posing a threat to well-being in the final years of life (**Figure 4.3**).

These problems often arise when many elderly women face financial hardships if they are unable to work and have no formal old age benefits. In sub-Saharan Africa the vast majority of women are in an informal type of occupation that is not covered by any form of pension scheme.

This problem affects both men and women since sub-Saharan Africa has less than 19% of elderly people benefiting from a contributory pension.[18] Consequently women (and men) live their final years depending largely on family members and the community. As already stated, in traditional African societies elderly women often play important roles and can count

Figure 4.3 Main causes of DALYs in the African Region, women aged 60 years and above, 2004



Source: Constructed from the World Health Organization, GBD 2004 Summary Tables, Health Statistics and Informatics Department, World Health Organization, Geneva, Switzerland, October 2008.

on the support of their children or their extended family. However, with increasing urbanization in the Region, migration of young people to cities, and the emergence of nuclear family structures, elderly women often find themselves isolated. Because women tend to marry older men, whom they generally outlive, many find themselves living as widows without any support in their late years.[18]

"Because women tend to marry older men, whom they generally outlive, many find themselves living as widows without any support in their late years."

Where elderly people are cared for in non-institutional settings, that care is provided by female family members who then bear an additional burden hampering their socioeconomic empowerment and posing a threat to their health including increased risk of depression.[19] Caring for the elderly at home can also be a substantial financial burden. In this regard, a study in Uganda showed that households with members over 65 years of age are more likely to face catastrophic health expenditure than households with no elderly members.[20]

Clearly these are complex and painful issues faced in many countries worldwide, even in wealthy countries with fully developed pension schemes. However, it is clear that systems providing universal coverage through prepayment and pooling whether from general taxation or forms of social health insurance have a better chance of supporting vulnerable subgroups within their populations, including elderly women.

In the African Region, elderly people have always been seen as a resource, a repository of wisdom and experience. In many African contexts elderly women are accorded certain privileges in their community or may have some distinct roles that promote social cohesion. As already noted, they are often responsible for decisions that affect health, such as granting young women and girls permission to seek health care. They are also the custodians of practices and traditions governing the

feeding of infants, in addition to being the providers of postpartum care. Their other roles include caring for babies and children within the home. The development of modern African societies, especially if that development involves urbanization, threatens this resource.

Part of the solution to this problem in the sub-Saharan context may lie in investing in household and community support services that can relieve domestic caregivers of some of the burden, but the reality is that an increasing number of elderly African women will probably spend their last years in institutions.[21] Policy makers must therefore take responsibility for designing and building institutions in which the most vulnerable can live their final years in dignity and with the respect of their carers.

Key considerations and points for action

a) Many of the NCDs faced by African women as they age are the consequence of habits established in their earlier years, including smoking and the consumption of foods that have a high content of cholesterol, saturated fat and salt, especially in urban areas. Policy makers can thus make a significant impact on the health of elderly women by focusing on the lifestyle choices they make in the early years.
b) Access to adequate care, particularly screening and treatment programmes for diabetes, cancer, hypertension and heart disease would also have a significant impact on the Region's burgeoning NCD epidemic.
c) Women are exposed to certain risk factors for poor health because of the social roles they have to play.
d) The economic and social transitions taking place in many parts of the Region pose a particular problem for women as they age; a multisectoral response to this issue is required, and should be founded on some form of universal health care provision if the most vulnerable members of society are not to face exclusion from the health system.
e) No amount of healthy living can completely stave off senescent change. Governments should plan for the support of the elderly and recognize the burden placed on young women in their domestic care-giving roles. These plans should also acknowledge that the roles occupied by elderly women in African societies are being challenged by 'modernization' and urbanization on the continent.
f) An increasing number of women are likely to spend their lives in their late years in institutions. Policy makers should ensure that these institutions respect the rights of the individuals entrusted to their care to enable them to live with dignity and respect.

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Chapter 5:
The socioeconomic benefits of investing in women's health

The role of women goes beyond childbearing

Any country that limits women's contribution to society to only childbearing pays a heavy price in terms of its socioeconomic development. However, the fundamental importance of childbearing and child raising for development makes it an obvious place to start the analysis of the socioeconomic benefits of investing in women's health. Undertaking this analysis does not mean that the argument for investing in women's health is primarily utilitarian. As stated in Chapter 1, women's health is above all a human rights issue and should be supported and promoted as such but for policy makers faced with the reality of interministerial discussions, an awareness of the underlying economics of women's health in the Region may be considered valuable.

"Any country that limits women's contribution to society to only childbearing pays a heavy price in terms of its socioeconomic development."

In sub-Saharan Africa, as in every other region of the world, mothers are the primary caregivers of their children.

Older women, e.g., aunts or grandmothers, play important supporting roles, but it is the mother who shoulders most of the responsibilities and it is her health and her well-being that largely determines the health and well-being of her children.[1] Where the mother thrives the children are better fed and better educated. Where the mother becomes sick or even dies the children suffer. In sub-Saharan Africa, children who survive their mothers while being born have a vastly reduced chance of surviving their first year.[2] When a mother dies or has protracted illness, her children are likely to be sent into foster care where they may be exposed to serious health risks.[3,4]

Mothers not only care for their children by nurturing, feeding, bathing and clothing them, but also by protecting them. When they are in a position to do so, women also direct household resources to the care and upbringing of their children. Studies in a variety of low-income settings have shown that where women are income earners they are more likely than men to spend their earnings on goods and services that benefit the household, e.g., food, education and medicine.[5,6] If women borrow, the pattern is repeated as evidenced by research on microcredit showing that household consumption increases roughly two-fold when women borrow compared to when men borrow.[1]

Mothers not only care for their children by nurturing, feeding, bathing and clothing them, but also protecting them.

Borrowing by women has also been shown to have a greater positive impact on the children's nutrition.[7] Studies undertaken in Gambia and Rwanda show that in households led by women more calories are consumed per person per day than in households led by men. Meanwhile, women traders in Dakar and Bamako have been shown to spend more money than their male counterparts on food with high nutritive value for their families such as fish and fishery products, condiments, vegetables, and fruits, etc.[8] All these examples show that policies designed to boost women's income earning potential have a direct impact on children's health.

The presence of a mother can also have a significant positive impact on children's education.[9,10] A strong indicator of this is the drop in child school attendance that can follow the mother's death as suggested by a study undertaken in Tanzania. The study showed that where an adult woman had died within the past 12 months, children spent half as much time in school as did children from households where no such death had occurred or where rather an adult male had died.[11]

Clearly therefore, substantial socioeconomic benefits are derived if a mother stays healthy, while significant costs are incurred from her sickness or premature death. These costs are by no means limited to the family concerned as illustrated in **Table 5.1** showing a causal link traceable, for example, from the death of a mother to broader societal detriment across a range of variables. However, it is in the home that the emotional and financial implications of sickness and premature deaths are felt most directly. This is particularly the case in the context of health systems based on out-of-pocket payment, the predominant financing model in sub-Saharan Africa.

In Nigeria, for example, 70% of women with breast cancer or cervical cancer report significant loss of revenue resulting from their illness, 62% report their inability to work, while 33% report that their illness disrupted a relative's work. Studies have also shown that with cancers, even when treatment is provided free of charge or covered by health insurance, the financial burden can absorb up to 50% of the family's annual income.[11] This subject has been examined extensively in Chapter 3 and will not be rediscussed here, suffice it to recall that 90% of global financial catastrophe occurs in the Region where the borrowing and selling of assets to finance health care are common coping strategies.[12] It is also worth remembering that user fees are a particular problem for women in the African Region because they are often dependent financially on men.

Table 5.1 Potential adverse effects of maternal morbidity and mortality on children, families, households and society

Potential effects	On children	On families and households	On society
Demographic	Death	Loss of deceased Dissolution of family/household Increased number of orphans	Loss of deceased Increased number of one-parent households
Health	Illness Injury Malnutrition Poor hygiene	Reduced allocation of labour to health-maintaining activities Poor health for surviving household members	Reduction in the allocation of labour to health-maintaining activities
Economic	Increased child labour	Reduced productivity of ill adult Lost output of deceased adult Reallocation of land and labour Medical costs of treatment Loss of savings Changes in consumption and investment Funeral costs, legal fee Transfers Changes in household management	Reduced productivity of ill adult Lost output of deceased adult Reallocation of land and labour Loss of savings Changes in consumption and investment Transfers Economic burden of one-parent family
Psychological	Depression Other psychological problems	Depression Other psychological problems Grief of loved ones	Grief Loss of community cohesion
Social	Social isolation Reduced education Reduced parental supervision and care	Social isolation Changes in care for children, the elderly, and the disabled	Changes in responsibility for care of children, elderly, and disabled Loss of community/societal leaders Changes in women's right, heath policy, other public policy

Source: Koblinsky M, *et al.*,[13] quoted by Gill K, *et al.*[1]

While it is relatively easy to assess the impact of a mother's illness or death on a household, the impact on the broader economy is unclear and hard to assess given the lack of research in this area and the paucity of available data.

A growing literature exists illustrating the link between overall health and economic growth.[14–16] Unfortunately the impact of poor maternal health on economic growth remains largely unexamined.

Women's health and economic growth

In general terms, improvement in women's health increases productivity in two ways: (i) directly, such as through a reduction of days lost to sickness or disability; and (ii) indirectly, through lessening the need for informal care by family members and/or friends who may also be part of the labour force. Improved women's health can also free resources that can be used for child health care, education and feeding, contributing to an increase in future productivity.[17]

There is a large body of evidence of the positive impact of good health on economic performance.[15,18,19] The evidence is focused particularly on health indicators such as adult survival rates and their strong positive correlation with GDP growth.[19] An empirical study using data from 53 countries over the period 1965–1990 revealed that a percentage increase in average adult survival rate corresponded to an increase in income growth of 0.23% annually.[20]

Research has also shown that health enhances labour productivity and has a positive, sizable and statistically significant effect on aggregate output.[21] Other studies[18,21] indicate that countries that devote substantial resources to health and education experience higher growth rates. While pregnancy is obviously not a sickness, giving birth exposes women to health risks and high fertility has an impact on health in diverse ways as well as a significant economic impact. Research has shown that high fertility and poor maternal health are correlated and have an adverse impact on productivity. Furthermore, studies by Blackburn and Cipriani have shown that high fertility and mortality rates are both negatively related to per capita income.[22]

“While pregnancy is obviously not a sickness, giving birth exposes women to health risks and high fertility has an impact on health in diverse ways as well as a significant economic impact.”

Research has tended to be on the health of populations in general, rather than on women’s health in particular. Meanwhile, empirical evidence on the relationship between health and economic output in African countries is lacking. However, because women are the dominant source of farm labour, the economic benefits of improving women’s health in the Region would appear to be significant. Moreover, several studies suggest that poverty is more prevalent among female-headed households; therefore initiatives targeting women’s health would have a huge impact on overall poverty reduction.

Table 5.2 provides an indication of the economic cost of maternal mortality and presents the estimates of the Commission on Women’s Health in the African Region regarding loss of productivity per capita due to maternal death in the WHO African Region in 2008 International Dollar values. What is immediately striking is the wide range of losses incurred, with Angola suffering a loss of I$ 25.41 per citizen as a result of maternal death, compared with the relatively low I$ 0.54 loss incurred by Zimbabwe. In terms of the estimated total productivity loss, Nigeria carries the greatest economic burden, having lost over I$ 1.5 billion due to maternal mortality. For the Region as a whole the economic loss was I$ 6.85 per capita which, multiplied by the total population of the Region, implies a total economic loss of just under I$ 5.4 billion.

At the global level estimates by USAID suggest that the economic cost of maternal and newborn mortality is over US$ 15 billion annually in terms of lost potential productivity, of which roughly half is attributed to women and half to newborns.[23]

In sub-Saharan Africa, other estimates for four countries based on 2001 data indicate that the cost of total productivity loss per year associated with poor maternal, newborn and infant health ranges from around US$ 8 million in Mauritania to US$ 85 million in Uganda (using different assumptions, and adding household and health centre costs to such estimates, the annual cost of productivity loss in Uganda is closer to US$ 102 million) and US$ 95 million in Ethiopia.[24,25] Meanwhile per capita annual productivity losses are estimated to range from US$ 1.5 in Ethiopia to over US$ 3 in Uganda and Mauritania, and almost US$ 5 in Senegal.[26] At the regional level, Kirigia *et al.*[27] estimate that US$ 49 224 per annum is lost due to maternal mortality, as each maternal death is associated with a loss of about US$ 0.36 per year.

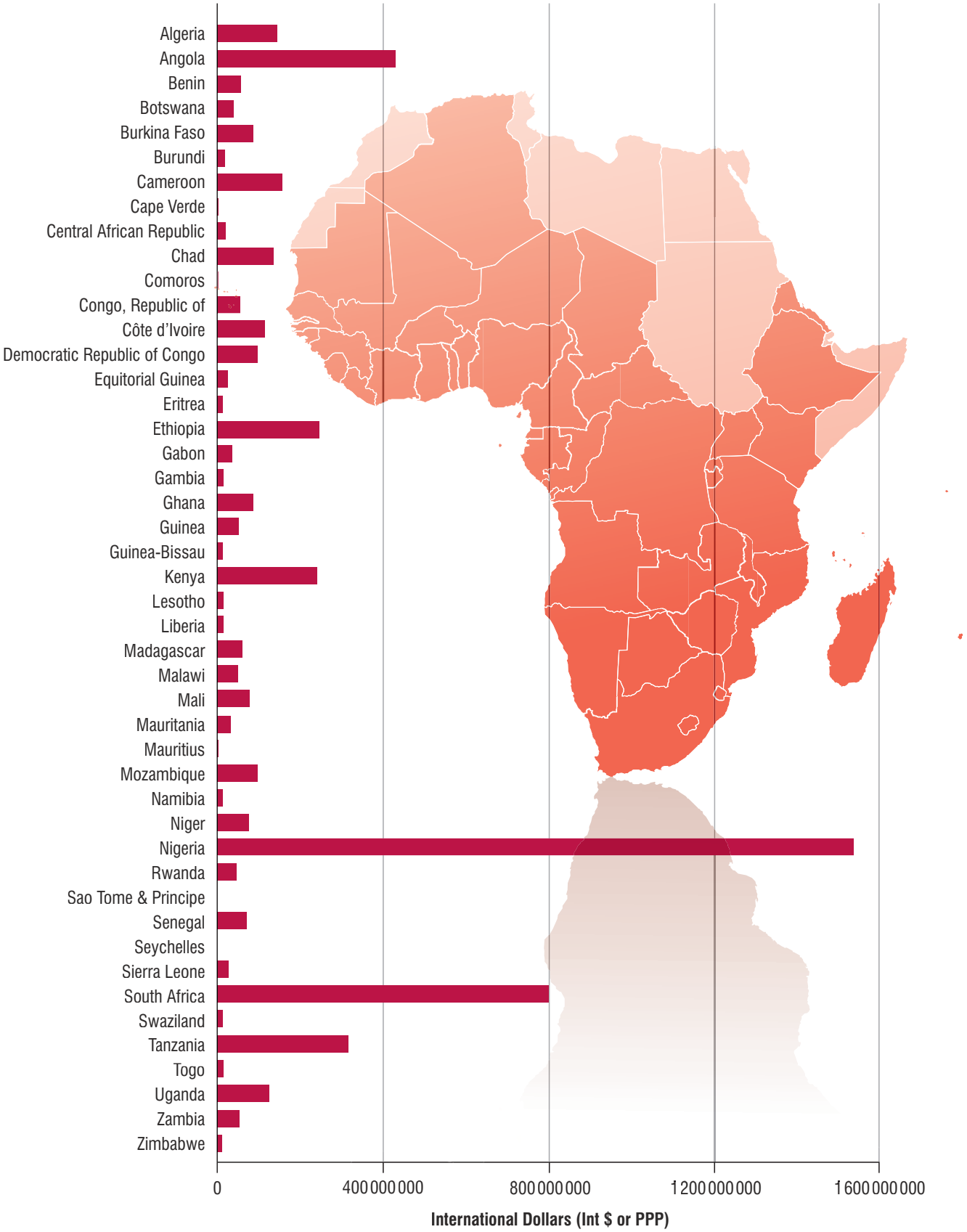
Table 5.2 Per capita productivity loss due to maternal deaths in the WHO African Region, International Dollars, 2008

Country	(A) Population in 2008	(B) Total productivity loss in International Dollars (PPP)	(C=B/A) Productivity loss per capita (Int$)
Algeria	34 800 000	138 114 369	3.97
Angola	16 808 000	427 031 289	25.41
Benin	8 107 000	52 763 225	6.51
Botswana	1 546 000	33 374 887	21.59
Burkina Faso	14 042 000	80 580 567	5.74
Burundi	7 949 000	16 276 373	2.05
Cameroon	19 383 000	154 233 972	7.96
Cape Verde	504 000	928 584	1.84
Central African Republic	4 355 000	13 542 844	3.11
Chad	9 730 000	130 473 086	13.41
Comoros	652 000	1 691 898	2.59
Congo, Republic of	3 650 000	50 875 450	13.94
Côte d'Ivoire	19 031 000	109 666 830	5.76
Democratic Republic of Congo	62 885 000	96 565 663	1.54
Equatorial Guinea	1 240 000	20 705 511	16.70
Eritrea	5 006 000	8 636 556	1.73
Ethiopia	79 179 000	239 658 186	3.03
Gabon	1 454 000	30 135 783	20.73
Gambia	1 630 000	6 940 738	4.26
Ghana	22 532 000	83 155 341	3.69
Guinea	10 279 000	47 533 534	4.62
Guinea-Bissau	1 717 000	4 997 113	2.91
Kenya	35 265 000	239 590 136	6.79
Lesotho	2 451 000	6 060 570	2.47
Liberia	3 942 000	9 235 673	2.34
Madagascar	20 215 000	59 859 205	2.96
Malawi	13 656 000	43 384 564	3.18
Mali	13 360 000	73 158 411	5.48
Mauritania	3 032 000	24 437 451	8.06
Mauritius	1 272 000	1 648 778	1.30
Mozambique	20 747 000	90 772 756	4.38
Namibia	2 045 000	12 092 537	5.91
Niger	13 765 000	74 108 291	5.38
Nigeria	147 810 000	1 541 708 626	10.43
Rwanda	9 591 000	41 235 267	4.30
Sao Tome & Principe	160 000	–	0.00
Senegal	12 519 000	67 141 257	5.36
Seychelles	82 000	–	0.00
Sierra Leone	5 887 000	23 925 759	4.06
South Africa	48 687 000	800 816 164	16.45
Swaziland	1 022 000	11 711 729	11.46
Tanzania	39 743 000	312 536 495	7.86
Togo	6 625 000	12 260 758	1.85
Uganda	32 042 000	119 274 121	3.72
Zambia	12 450 000	52 300 391	4.20
Zimbabwe	11 732 000	6 375 405	0.54
Totals	**784 579 000**	**5 371 516 143**	**6.85**

Source: Commission's calculations.

Notes: (i) Population estimates are from Source of population data: International Monetary Fund, World Economic Outlook Database, October 2008; (ii) Total productivity loss in International Dollars (PPP) and productivity loss per person in population (Int$) are estimates of the Commision on Women's Health in the African Region; (iii) Estimates for Sao Tome and Principe and Seychelles are missing because the maternal mortality statistics were missing in the WHO/UNICEF/UNFPA/World Bank latest estimates. Estimates of the indirect costs of maternal deaths for the same year also show the burden carried by Nigeria in **Figure 5.1**.

Figure 5.1 **Indirect cost of maternal deaths in WHO African Region in 2008**



Source: Commission's calculations.

Table 5.3 Cost of services, and pregnancy outcomes, according to use of family planning and maternal and newborn health services in sub-Saharan Africa, 2008

Cost and health outcome categories	Cost of current level of services	Cost of 100% of met needs for services
Services	**US$ million**	**US$ million**
Family planning services	290	2380
Maternal and newborn care	1460	8100
Total	**1750**	**10480**
Pregnancy outcomes	**Number in thousands**	**Number in thousands**
Intended births and miscarriages*	26950	26950
Unintended births and miscarriages	11730	2750
Induced abortions	5310	1240
Total	**43990**	**30940**
	Number of deaths	**Number of deaths**
Maternal	290000	90000
Newborn	1220000	670000
Total	**1510000**	**760000**

Source: Guttmacher Institute and UNFPA (United Nations Population Fund). New York: UNFPA; 2009.
*Number of current intended births and miscarriages are unaffected by the scaling up of family planning services.

The estimated costs of addressing maternal and newborn morbidity and mortality strongly suggest that the costs are significantly outweighed by the potential benefits. Here again, though research is lacking, it has been estimated that 30–50% of the Asian economic growth between 1965 and 1990 was attributable to favourable demographic and health changes that were largely a result of reductions in infant and child mortality and subsequently in fertility rates, as well as improvements in reproductive health.[28–32]

Focusing on sub-Saharan Africa, a study by Guttmacher Institute in collaboration with United Nations Population Fund (UNFPA) suggests that providing all pregnant women in the Region with the recommended standards of maternal and newborn care would cost US$ 8.1 billion but only if investments were concurrently made in modern family planning. Without that crucial investment in family planning the study estimated that the cost of providing care would be US$ 2.7 billion higher.[33] However, the considerable investment benefits would include a 77% drop in unintended pregnancies from 17 million to 4 million and a 77% decline in unsafe abortions (see **Table 5.3**). Family planning services would also be expected to save 750000 lives annually, 200000 among women and 550000 among newborns. This would represent a 69% decline in maternal mortality and a 45% decline in newborn deaths. Similarly there would be a two-thirds decline in the number of healthy years of life lost because of disability and premature death among women and their newborns, DALYs dropping from 61 million to 22 million. The benefits of extending effective family planning services to women include a saving in the cost of providing maternal and newborn care that would be equivalent to 130% of the cost of providing family planning services.

These benefits would have profound implications for the Region's socioeconomic development. By simply reducing the number of unplanned births among adolescents, for example, policy makers could expect more young women to stay in school and find employment later. This would also contribute to improvements

in gender equity, health status and economic output which would in turn lead to a reduction in poverty. Other studies have come to similar conclusions regarding the savings that could be made by simply investing in family planning services. The World Health Organization estimates that in a number of low-income settings including sub-Saharan Africa investing one US Dollar in family planning can save four US Dollars that would otherwise be spent later to address the complications resulting from unplanned pregnancies.[34] Specific interventions that can help countries achieve these positive results will be discussed in the next chapter.

Finally, it is worth noting that investment in maternal health not only improves maternal and newborn health outcomes, but has significant spill-over benefits for overall health service delivery and use.[1] To take just one example, where facilities are upgraded to provide essential obstetric care they also become capable of responding to other kinds of accidents and emergencies,[5,6] since the equipment used for maternity care, such as blood pressure gauges and IV kits, are also used for many other clinical interventions.[35]

Women's health and cycles of disempowerment

Thus far, this report has focused on the socioeconomic benefits of investing in maternal and newborn health. However, as stated at the outset, women in sub-Saharan Africa have much more to contribute to society than bearing and nurturing children, as important as these roles may be. A range of pressures including poor health often prevents them from realizing their potential, including their potential for wealth generation. Furthermore, "solutions" focusing solely on "public health" (e.g. the provision of comprehensive maternal health care) miss the fundamental interrelationships between health and other issues, the recognition of which is at the core of the multisectoral "rethinking" that this report seeks to encourage. Sickness, ignorance and poverty are part of the cycle of disempowerment of women in the Region (see **Figure 5.2**), as the components of this cycle combine in different ways and in different settings to harm women. As noted in Chapter 2 this cycle can begin to turn at an early age even if the girl child herself is healthy. If the mother becomes ill, her daughter, already burdened with household work, may have to take up more responsibilities, thus missing crucial opportunities for education.

Investing in women's health is an investment in development, hence an investment in the future. The investment will only be effective if there is concurrent investment in women's education and other initiatives designed to encourage their economic advancement. Women's socioeconomic empowerment feeds into better health, just as their health promotes socioeconomic empowerment (**Figure 5.3**).

Figure 5.2 The cycle of women's disempowerment

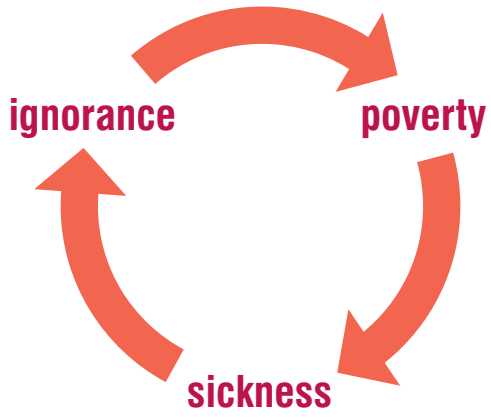
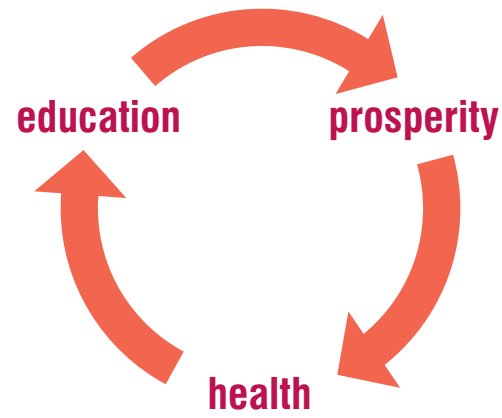


Figure 5.3 The cycle of women's empowerment



A discussion of women's empowerment in sub-Saharan Africa should begin with the recognition of what women already contribute to society especially in terms of their economic output. Despite the lifelong adversity they face, women already make a significant contribution to the Region's economy, contributing at least as much as men. Comparisons are complicated because much of what women do takes the form of unremunerated services, but some attempts have been made at comparison, notably by Campbell-White *et al.* in a study demonstrating that in some countries women actually produce more than men.[36] In Uganda, for example (**Table 5.4**), women's contribution to GDP is estimated to be slightly higher than men's overall contribution (50.6% compared with 49.4) and is significantly higher in agriculture, estimated at 75% compared with 25%. The same study notes that women's share of output is relatively low in the industrial sector (15%) and quite substantial in the service sector (32%).

Table 5.4 Breakdown of productivity in Uganda by sector and gender (in percentages)

			Gender intensity of production	
Sector	**Share of GDP**	**Share of exports**	**Women**	**Men**
Agriculture	49.0	99.0	75.0	25.0
Industry	14.4	1.0	15.0	85.0
Services	36.0	0.0	32.0	68.0
Total	**100.0**	**100.0**		
Contribution to GDP			50.6	49.4

Source: Campbell-White A, *et al. Reproductive Health: The Missing Millennium Development Goal. Poverty, Health and Development in a Changing World.* Washington, DC: The World Bank; 2006.

The importance of women's contribution to the agricultural sector is well documented. It is estimated that women's input in farm labour accounts for almost 70% of the total work done by women in the Region. Women also produce an estimated 60–80% of the food[37] in the Region. Because women are the dominant source of labour for agriculture, which is the mainstay of economies in the Region as a whole, investing in their health (e.g. through better primary health care) will generate significant economic gains. Again, if this issue is considered solely from one standpoint, there is a risk of missing the big picture which, as already stated, comprises a number of discrete but interconnected elements. Improvement in women's health contributes to increased productivity which is, to a large extent, influenced by prosperity.

Crucially, if the woman in the field cannot benefit from her own work, her prospects of achieving better health are limited as are the prospects of better health and education for her children. Sadly this is the situation faced by many women in the Region. For example, despite the tremendous importance of women's work to the agricultural sector, women own just 1% of farmlands.[38] Moreover, they receive just

7% of the agricultural extension services (education designed to improve land use provided by governments and/or NGOs), and less than 10% of the credit made available for smallholder agriculture.

Limited access to credit, land and extension services hampers women's contribution in their households, particularly in the area of cash crop production.[39,40] Where women are freed from such constraints they have increased crop yields by up to 22%.[39] A study undertaken in Burkina Faso estimates that shifting existing resources between the farmland of women and those of men within the same household could increase output by 10–20%, while in Zambia, if women had the same overall degree of capital investment in agricultural assets, including land, as their male counterparts, output would increase by up to 15%.[39] Women are similarly excluded from the benefits of their labour when they go to market. The proceeds from the sale of farm products – the bulk of which are obtained from the labour of women – are often controlled by men.[41,42]

Women's associations in rural and urban areas, such as rotating savings and credit associations (ROSCAS) in Eastern Africa, and the *tontine*, *mbotaay*, *nat* and *tuur* in West Africa, have helped create social networks capable of mobilizing investment resources for women in rural localities, but much more can be done. The role of African women in the marketing of essential commodities in some settings is well documented.[43] Examples include market women in Yoruba communities in Nigeria, the "Mammies" in Ghana or the "Nana Benz" in Togo.

Similar examples can be found throughout Africa where women entrepreneurs are contributing to wealth creation in their communities. Although their market activities are informal, and usually concentrated in crafts and the sale of goods and personal services, they represent the germ of entrepreneurial activity that has the potential to penetrate other sectors. Unfortunately, Africa trails other developing regions in promoting women's entrepreneurship and African women face considerable challenges in accessing business credit and basic social services such as health care and education and this stifles their entrepreneurial activities.[43]

"...granting women property rights enhances their participation in civic activities, a crucial aspect of women's empowerment."

Another effect of giving women a greater stake in the economy, e.g., by granting them property rights or enhancing their access to credit, is that it raises their status within the household and the community and strengthens their negotiating positions in household decisions, notably decisions related to their health needs. It has also been shown that granting women property rights enhances their participation in civic activities, a crucial aspect of women's empowerment.[44,45] Women are significantly under-represented in politics in Africa, as most countries in the Region have fewer than 10% female members of parliament. This deficit begins at the grassroots level because women do not feel they have a voice.

Fortunately the situation is improving in some countries, especially in Rwanda where women account for more than half of the membership of parliament. Women are also quite active in politics in Burundi, Mozambique and Tanzania. The picture is similarly bleak with regard to women in cabinet positions or senior appointments in the civil service. Women's participation in the highest political structures of government is clearly crucial to mainstreaming women's health issues. It has already been important in supporting the enactment of laws that fight gender-based discrimination and harmful cultural practices such as female genital mutilation.[43]

The link between low levels of education and exposure to health risks has already been discussed in terms of research on HIV/AIDS infection rates in Zambia (see Chapter 2) and the postponement of sexual debut in Kenya.[46] This issue is a crucial aspect of women's empowerment, particularly insofar as it relates to women's entry into formal work. According to a recent study by Jorge Saba Arbache *et al.*[47] on gender dynamics and its impact on work-related indicators such as employment, unemployment, sector of activity and pay gap, African women are about half as likely as men to obtain formal employment, the main underlying reasons being lack of education among women and the constraints imposed by domestic obligations. The proportion of women in formal sector employment in the Region is estimated at 25.2% and where women find salaried work, it tends to be in lower cadre positions. Women are also less well paid than men for equivalent work, some estimates suggesting women's remuneration to average out to 50% of that of men.

Clearly one of the most direct ways to reduce the gender gap in the African labour market is to make sure that women are given the same opportunities in education as their male peers.

Once again this is an issue requiring a multisectoral approach that recognizes, at the very least, the need for attitudinal change at the household and community levels (e.g. making boys participate in household tasks rather than putting the burden of domestic work solely on young girls), and for building schools designed to accommodate both sexes. Policy makers should also think about using conditional cash transfers to encourage families to enrol girls in school, an approach that has worked so well in a number of low-income settings.[48] Evidently, educating young women with a view to increasing their opportunities for employment will have only a limited impact if those opportunities do not exist – a point made in the Saba Arbache study noting that countries having the highest job rate for men also have the least gender inequality.[47]

Despite women's important contribution to the Region's economy, women's disempowerment, expressed differently in different settings *but always with poor women's health as a key component*, has substantially undermined development on the continent.[36] The development of sub-Saharan Africa is closely linked to the health of its female population. The fact that women's health is a core consideration in virtually all the Millennium Development Goals (**Table 5.5**) is indicative that this view is shared by the global community as well.

It is important to note, even at the risk of repetition, that women's health cannot be separated from the broader issue of women's empowerment which in turn has implications for development. It is no coincidence that 19 of the 20 countries at the bottom of the United Nations Gender Development Index are in the African Region[49] where women also carry an inordinate share of the global burden of disease and death. There is, therefore, an urgent need for change and, as already stated, one of the key agents of that change is African women themselves. To that end, women need the support and commitment of policy makers to enable them to break the cycle of poverty, illness and ignorance that prevents them from enjoying the health that is their right, and leaves untapped their immense physical and intellectual potential.

"...women need the support and commitment of policy makers to enable them to break the cycle of poverty, illness and ignorance that prevents them from enjoying the health that is their right, and leaves untapped their immense physical and intellectual potential."

Table 5.5 Women's health and MDGs

Number	Title of MDG	Relationship of women's health to MDG
1	Eradication of extreme poverty and hunger	Women carry the largest burden of poverty in Africa and it is a key determinant of their health. But it is important to realize that sickness feeds poverty too and no poverty reduction policy can achieve its intended goals in Africa without addressing the issue of women's health
2	Achievement of universal primary education	Education is key to the empowerment of women and the basis of women's contribution to socioeconomic development
3	Promotion of gender equity and empowerment of women	Equity in access and use of health services is essential to promotion of gender equality and empowerment of women
4	Reduction of child mortality	Maternal health affects children's health to such a degree that in many ways it is meaningless to discuss one without the other
5	Improvement in maternal health	Improving maternal health is the immediate goal of investing in women's health
6	Combating HIV/AIDS, malaria and other diseases	Women are the group most affected by the issue in sub-Saharan Africa
7	Ensuring environmental sustainability	As the primary users and managers of natural resources, women are directly concerned with sustainable development issues
8	Developing a global partnership for development	Development is also about helping the most vulnerable or least-privileged people to meet their needs in a sustainable manner. Since women make up a larger group of the population, women's health and gender inequality issues are crucial to the development of such global partnership

Source: Compiled from Millennium Development Goals National Reports, UN Millennium Project, United Nations, New York.

Key considerations and points for action

a) The important role that women play in socioeconomic development must be acknowledged.
b) It should be recognized that the economic benefits of addressing maternal and newborn morbidity and mortality far outweigh the costs.
c) Limited property rights, poor access to credit and agricultural extension services hamper women's contribution to the African economies, particularly in the area of cash crop production – and these issues should be actively addressed.
d) Africa lags behind in promoting women's entrepreneurship. The considerable challenges that African women face in accessing business credit and basic social services should be understood and acknowledged.
e) Women's empowerment, which has implications for social and economic development, cannot be separated from issues related to women's health – and should be actively encouraged.

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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 interventions[1] 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 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]

"The waiving of school fees for girls has been used with some success in a number of countries in sub-Saharan Africa..."

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 girls[21] (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]

"...attitudinal resistance to contraception remains significant, while access to contraceptives, though improving, is still extremely limited."

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.

"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."

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.

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]

"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."

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

"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."

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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Chapter 7:
Conclusions and recommendations

Conclusions

The approach to improving the health status of women in Africa proposed in this report is based on two premises: (i) that women's health, apart from being desirable in itself as a basic human right, is a fulcrum for socioeconomic development; (ii) that interventions designed to improve women's health should be multisectoral in order to succeed. For policy makers, therefore, the challenge is not only to design, implement and fund health systems that are more responsive to women's needs, but also to ensure that the socioeconomic circumstances that trap women in ignorance, economic poverty, social disempowerment and disease are changed.

This process must begin with countering gender discrimination in the home, which finds expression, in the early years, in unequal task assignment, intimidation and physical violence. The process must ensure that girls benefit from the same educational opportunities as boys; that they are not subjected to harmful traditional practices; and that they have access to the higher education that opens doors to specialized training later in life and provides opportunities for positions of responsibility. By enabling women to have a voice through the establishment of social networks committed to their concerns and by encouraging their participation in politics at grassroots and executive levels of power, policy makers can rally themselves and others to their own cause and achieve the much-needed momentum in reforms to dismantle gender-based discrimination and other barriers to women's empowerment.

The benefits associated with investing in women's health in the African Region are considerable – not just for women themselves, but also for their families and communities, and for society at large. The health interventions required to realize these benefits are available, affordable and cost-effective. However, the implementation of these interventions faces major challenges, starting with inadequate political commitment at the highest levels of government, and the lack of funding required to support viable health care systems. Governments, development partners and regional organizations including the African Union should intensify women's empowerment by investing in interventions that promote women's health, education and human rights on a scale large enough to make a difference.

Policy makers seeking to improve the health and socioeconomic status of African women, have no greater ally than women themselves. As this report has sought to demonstrate, women already make an enormous contribution to the continent, particularly by virtue of their labour in the home and in the field. Undoubtedly, they can achieve much more, notably in the health sector which, to date, as this report has shown, has failed to meet even their most basic needs. Only when the truth is known about the vital role that women can play in social and economic development will the Region begin to realize its full potential and achieve the political stability, economic prosperity and health that is the birth right of its large and growing population.

“Governments, development partners and regional organizations including the African Union should intensify women's empowerment by investing in interventions that promote women's health, education and human rights on a scale large enough to make a difference.”

Recommendations

This report has identified six clusters of interventions that, with the appropriate level of investment, can improve the lives of women in the African Region. However, for the investment to bear fruit it must be backed by political commitment and leadership, and the resources and support of many players including governments, development partners, communities and women themselves.

1. Good governance and leadership to improve, promote, support and invest in women's health

Actions to address this recommendation:

Governments at Local and National Level

- Prioritize women's health issues in national development and political agendas, and ensure that these are supported by appropriate budget resources.
- Establish and/or support national bodies or institutions tasked with promoting and monitoring progress made in women's health and development.
- Promote good leadership through recognizing and rewarding local and national achievers in the areas of women's health and development.

International, Regional and Subregional Organizations

- Introduce measures to require accountability in countries that fail to meet their women's health related commitments, such as Millennium Development Goals (MDG), Maputo Plan of Action, Committee on the Elimination of Discrimination against Women (CEDAW), African Charter, Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA), etc.
- Encourage regional/multinational approaches for addressing common women's health challenges, such as girl child trafficking, female genital mutilation (FGM) and problems related to geographical/environmental factors.
- Advocate for the essential resources required to support the implementation of cost-effective health interventions in member countries.
- Ensure sociopolitical stability by being more proactive in wars and conflict within the subregion and developing robust regional protocols to protect and reduce the burden of wars and conflicts on women and girls.

Developmental Partners

- Mobilize resources required to fund the implementation of key cost-effective health interventions.
- Partner with governments to design mechanisms and protocols for improving accountability and management at all levels of resources for health care systems and women's health interventions.
- Work together with governments and other partners to coordinate their activities and programmes to support stated national agenda for women health.

2. *Policy and legislative initiatives to translate good governance and leadership into concrete action*

Actions to address this recommendation:

Governments at Local and National Level

African governments are urged to formulate policies and enact legislation designed to bridge the gender gap and to protect women and girls in the following areas: maternal health, education and employment, and harmful sociocultural practices (such as FGM, domestic violence and human trafficking).

All countries in the African Region are encouraged to:

- Review all legislation and policies relating to women's health with the aim of improving such legislation to promote and/or protect their health by year 2015.
- Introduce policies (such as scholarship schemes and waiver of school fees) to promote girls' education to secondary school level, with the objective of increasing the proportion of girls completing secondary education by 30% annually.
- Remove all restrictive policies and laws that limit women's access to financial resources, property and health care services (e.g. spousal consent for family planning, comprehensive abortion care, spousal consent for loan acquisition and property).
- Advocate, budget for and promote at national and local level social education programmes that increase awareness of the negative health impacts of discrimination against girls and women.

Civil Society and Communities

- Advocate for policy makers to introduce health policies to promote and protect women's health.
- Sensitize and educate women and community members about national and local policies and legislation that promote and protect women's health.

International, Regional and Subregional Organizations

- Harmonize health policies among different organizations to maximize synergy in addressing the health problems of women throughout their life course.
- Implement measures to review the performance of member countries with respect to women's rights in accordance with agreed global or regional protocols.

Developmental Partners

- Assist member countries to implement and monitor policies designed to improve women's health in accordance with agreed regional and international commitments.
- Support experience sharing in relevant policy and legislation revision and implementation.

3. *Multisectoral interventions needed to improve women's health*

To improve women's health and enhance their social status, there is a need to shift from interventions rooted within the health sector to multisectoral approaches. Moreover, investment in women's health should be seen as a critical ingredient for overall socioeconomic development rather than as an outlay restricted to the fighting of disease.

Actions to address this recommendation:

Governments at Local and National Level

- Develop multisectoral national and/or local strategic plans for improving women's health which emphasize the linkages, roles, responsibilities and measurable targets for all sectors in achieving the agreed national objectives.
- Recognize the particular importance of the environment, food and agriculture, water and sanitation sectors to women's health; these sectors should be encouraged to implement appropriate technologies that minimize health hazards faced by women.
- Include in national budgets, identifiable budget resources in relevant sectors, such as economic planning, justice, finance, agriculture, environment, social welfare and education for improving women's health.
- Mandate institutions or ministries for women and gender affairs, where they exist, to coordinate multisectoral interventions for women's health.

Civil Society and Communities

- Multisectoral groups such as religious, traditional, professional, and male and female social groups to undertake active roles in improving women's health. They should partner the health sector to enhance women's awareness of key health issues, mobilize resources and support the successful implementation of proven health care interventions.

International, Regional and Subregional Organizations

- Promote intersectoral sharing of experiences and best practices at regional/international fora.
- Develop regional frameworks that define the roles and responsibilities of all the different sectors in women's health and development.

Developmental Partners

- Advocate for and promote the inclusion of other sectors in the planning, implementation and evaluation of their supported country programmes relating to women's health.

4. Empowering girls and women to be effective agents of their own interests

Actions to address this recommendation:

Governments at Local and National Level

- Ensure that there is at least 30% female representation in governance at all levels by introducing affirmative policies and legislation which encourage women's participation in local and national governance.
- Ensure that the needs and opinions of women are taken fully into account in all national policy designs and programmes by developing protocols that take gender into consideration.
- Provide opportunities for disadvantaged and less educated women to empower themselves by developing and implementing programmes that increase their access to microfinance and also to non-formal education, as was done in the Biruh Tesfa programme in Ethiopia.

Civil Societies and Communities

- Advocate for women and girls, particularly from marginalized and/or disadvantaged backgrounds, such as the disabled and abused women (e.g. the NUWODU programme in Uganda).
- Support and promote women's health (e.g. the Badienou Gokh initiative in Senegal).
- Engage communities, women and men in efforts to reduce social discrimination against women in leadership positions.

International, Regional and Subregional Organizations

- Advocate and promote gender balance in all their organizational activities.
- Partner with and support regional civil society women's organizations that advocate for and promote women's health, such as Forum of African Women Educationalists (FAWE) and Federation of International Women Lawyers (FIDA).

Developmental Partners

- Prioritize support for the implementation of national and local programmes that empower women in regard to their health and development, such as girl child educational programmes and economic empowerment programmes.
- Support women's leadership development training programmes.

5. *Improving the responsiveness of health care systems to address the health needs of women*

Actions to address this recommendation:

Governments at Local and National Level

- Enhance gender and sociocultural acceptance of women's health care services by introducing policies that ensure women's needs and opinions are taken into account in health care delivery at all levels.
- Implement all recommended cost-effective health care interventions for the various life stages of women.
- Urgently redesign the health care system to ensure that by 2020, all women of reproductive age, will have access to basic and emergency obstetric care whenever the need arises using criteria recommended by WHO.
- Improve women's access to reproductive health care services, in particular, by removing financial barriers through mutual health insurance schemes or through fee exemption policies.
- Bring health services closer to where women live through a variety of programmes including community outreach, community based health planning and services (CHPS) and through investing in strengthened health care systems generally.
- Address human resource shortages that cripple health care services – particularly for women in rural and disadvantaged communities – by instituting policies to correct maldistribution of care providers, train more staff, train mid-level staff in life-saving midwifery skills, provide incentives to retain staff and enhance public–private partnerships.
- Promote the use of information technology to improve women's access to care and also to enhance quality of health care services for women.
- Develop/strengthen effective national and local monitoring and evaluation systems for women's health care and services using recommended indicators.
- Develop quality of care indicators for women's health services and incorporate into facility accreditation criteria.
- Recognize and reward achievers or institutions providing high quality women's health services.

Civil Societies and Communities

- Mobilize resources to support improvement in health care services for women and girls.
- Engage the health care system as partners in promoting high quality, gender and culturally sensitive health care services for women.
- Educate and support women's utilization of existing health facilities.

Professional Organizations Involved in Women's Health Care

- Develop, promote and enforce professional ethics and guidelines to protect the rights of women.
- Partner with government to develop protocols and standards for reproductive health services.

International, Regional and Subregional Organizations

- Monitor progress made by member countries in achieving set targets for women's health services using agreed indicators and criteria.
- WHO to support a multicenter study on the use of non-physician clinicians to address women's health needs.

Developmental Partners

- Support governments in the implementation of cost-effective health care interventions for women's health particularly in member states with a high burden of morbidity and mortality amongst girls and women.
- Partner with government to source funding for health system infrastructure development particularly in the establishment of basic and emergency obstetric care facilities in deprived and underserved communities.

6. *Data collection for monitoring progress made towards achieving targets for girl's and women's health*

Actions to address this recommendation:

Governments at Local and National Level

- Review and revise vital registration systems and health information systems to strengthen the availability of sex and age disaggregated data for monitoring and evaluation of women's health interventions throughout the life course.
- Strengthen, encourage and fund national and local research institutions to conduct relevant qualitative and quantitative research to provide accurate data for the identification of women's health problems, and policy and programme development.
- Partner with international, regional, local and community organizations to mobilize resources for women's health research and data collection.
- Coordinate the multisectoral approach to women's health by promoting data collation across all relevant sectors in order to provide more comprehensive assessment of women's health for policy development and implementation.
- Ensure that strategic plans for improving women's health include effective mechanisms for collecting data for programme monitoring and evaluation.

Civil Society and Communities

- Sensitize women, men and communities on the importance of participating in vital statistic registrations, such as births and deaths.
- Encourage establishment of simple, community-based, vital statistic registers in all communities where formal services do not exist or are inaccessible. Religious organizations and traditional leaders can provide the setting for such registers.

Research Institutions

- Partner with communities, governments, local, regional and international research groups and agencies to conduct high quality quantitative and qualitative research into health problems affecting women.

International, Regional and Subregional Organizations

- Promote regional collation of women's health data as an integral part of regional policy development, programme development and resource mobilization
- By 2013 define and reach consensus on core indicators for monitoring progress in women's health improvements across all sectors in member countries.

Developmental Partners

- Support the strengthening of research and of vital statistic institutions that focus on women's health.

Monitoring Progress

In light of the above stated Recommendations, selected indicators identified for monitoring progress in the African Region include:

- Number/proportion of countries with developed and costed national multisectoral frameworks/mechanisms for improving women's health.
- Number/proportion of countries with specific budget resources for improving women's health.
- Number/proportion of countries with legislation in place to protect women against harmful practices and discrimination.
- Number/proportion of countries achieving the 30% target increase in secondary school enrolment for girls.
- Proportion of women in member countries earning below poverty level.
- Proportion of women appointed to office in member countries at national and local government levels including parliamentarians.
- Number of research publications on women's health from institutions in member countries.
- Number/proportion of countries with fee-free or insurance cover for maternal and newborn care.
- Annual rate of decrease in maternal mortality ratio in member countries.
- Proportion of unmet needs in family planning in member countries.

Appendix:
The methodology used to prepare this report

Summary

The methodology used to prepare this report is interdisciplinary, bringing together researchers from the social sciences, economics, and public health as well as from clinical and biomedical research, plus experts with specific experience in intervention design and evaluation, human rights and women's rights, parliamentarians and representatives from the African Union. The process was greatly enhanced by the coordination activities performed by the Secretariat of the African Region of WHO and by feedback from internal and external reviewers. Details of the methodology are set out below, but in summary consisted of the following activities:

- Working group and subgroup sessions to achieve a consensus on objectives, methods of data collection, analysis and findings validation;
- Review of articles published in peer-reviewed publications and scientific journals relevant to clinical and biomedical research, public health, social sciences and economics;
- Use of information gathered from WHO and UN agencies, in the form of both printed documents and website data;
- Extensive use of internet searches and relevant website-based information (Google Search, Medline, Cochrane Library, ScienceDirect, PubMed, POPLINE, Social Science Citation Index, etc.);
- Secondary analysis of data gathered from the WHO database on the Global Burden of Disease (GBD);
- Collection and analysis of qualitative data;
- Review of evidence and preliminary findings provided by peers and the African Region of WHO internal and external reviewers.

Methodology

A commission of 16 members, comprising political and civic leaders, parliamentarians, representatives of the African Union and a multidisciplinary group of experts drawn from the fields of epidemiology, biomedical sciences, sociology and economics, met seven times. The first meeting, held in Pretoria, defined the terms of reference of the Commission and assigned specific responsibilities to the experts of the Commission. The second meeting, in Kigali, discussed the preliminary findings of the experts and agreed on the general process and methodology. The work in the third meeting, held in Monrovia, consisted of small group activities and plenary sessions to discuss the first draft, and to evaluate, cross-examine and validate the initial findings. At this meeting the experts were joined by the other commissioners and internal and external reviewers. The official launch of the activities of the Commission by its Honorary President, H.E. Mrs. Ellen Johnson Sirleaf, the President of the Republic of Liberia, also took place during this meeting. The last four meetings of the Commission, which took place at the African Region of WHO headquarters in Brazzaville, consisted of intensive interdisciplinary discussions on the sources, relevance and weight of the findings as well as the consolidation of the drafts of the chapter reports. Internal and external reviewers participated in this meeting and their comments and input were integrated into the draft report.

The literature reviews drew on published and unpublished manuscripts, contained in electronic and printed media. High priority was given to articles published in peer-reviewed journals, mainly in the fields of anthropology, epidemiology, sociology, economics, demography and public health. Besides peer-reviewed publications, databases maintained on websites of international and multilateral organizations, such as the World Health Organization, African Development Bank, United Nation's Economic Commission for Africa, United Nation's Children Fund and the World Bank were used to obtain the required information. Internet searches were conducted using lists of terms relevant to each chapter or section of the report. Reviews were usually limited to the most recent papers (published within the past 10 years). However, in some cases, where recent publications were hard to find, earlier works (more than 10 years old) were included among the research materials reviewed. The 10 year time frame was not strictly applied in searches involving anthropological studies, because older records can yield useful information on cultural concepts transmitted to current populations from distant pasts, and which continue to have a significant effect on women's health.

For each of the major research domains considered for this study (the conceptual framework, situation analysis, determinants of women's health, socioeconomic benefits of investing in women's health, interventions to improve women's health) lists of key words were generated and constantly updated to guide identification of sources and collection of relevant data. Inventories of the contents of the evidences and of the designs and methods associated with them were made.

Electronic search of the literature on the socioeconomic benefit of investing in women's health revolved mainly around the words "Benefit of investing in women's health". This theme led to the search for other related phrases such as "effect of investing in women's health", "health status/conditions of African women", "African child/adolescents' health", "economic benefits/advantages of good health of African women" and the like. Literature searches for individual sections and subsections were guided by shorter phrases and themes. For example, the search for the sections and subsections related to benefits of investing in women's health such as benefits for the women themselves and/or other family members included concepts/terms such as "maternal health", "maternal mortality", "maternal morbidity", "gender inequality", "health equity", "millennium development goals effect on women" and related terms.
To capture fully the relationships between economic opportunities and African women's health, further search terms were added such as "education", "job opportunity", "income", "savings", "well-being", "assets", "economic opportunity", "occupation" and "microcredit". In relation to the sociocultural benefits of investing in women's health searches comprised key terms which reflected sociological/anthropological discourses such as "African family", "differential social roles", "gender (in)equality", "equity to health", "decision-making in the households", etc. In relation to the link between women's health and development outcomes, terms such as "disability-adjusted life years (DALYs)", "burden of disease", "productivity", "economic growth", "household finances", "family" and "individual effects" were searched.

Additional analysis of the burden of disease was performed using databases from the Global Burden of Disease (GBD). These datasets contain causes of death and DALYs as a result of premature death and morbidity. Data on women were selected and health status comparisons made between the WHO African Region and other WHO Regions (the Region of Americas, Eastern Mediterranean Region, European Region, South East Asia Region and Western Pacific Region). This analysis demonstrated the low health status of African women relative to the health status of women in other WHO Regions. The evidence generated on international health inequality here should spur cross-regional exchange of experiences on health-improving interventions that can be used to enhance women's health in Africa.

In addition to the literature review and to the secondary analysis of health data, the study used findings from qualitative research. The aim of the qualitative research was to echo the opinion and voices of African women on their own life experiences in dealing with health problems in relation to social,

economic, cultural and political issues. As with any qualitative research, the issue was not to measure phenomena from representative samples, but to collect concepts, elements of discourses and cultural referents that would help to understand insiders' perspectives.

For this qualitative component, 32 key informants (from Cote d'Ivoire, Burkina Faso, Ghana, Guinea Bissau, Democratic Republic of Congo, Kenya, Rwanda, Senegal and South Africa) were interviewed on local perceptions regarding pregnancy, childbirth, maternal mortality, family planning, gender based violence and women's experiences regarding access to care and in using health facilities. Questions were asked through face to face interviews, telephone interviews and questionnaires sent by e-mail. Key informants were recruited through two African networks of social science researchers: the Council for the Development of Social Science Research in Africa (CODESRIA) and the Social Aspect of HIV-AIDS Research Alliance (SAHARA). Basic ethnographic summary and thematic analysis were performed on the qualitative database.

Some of the qualitative findings presented in this report were derived from databases of unpublished studies on female sexuality, pregnancy, delivery, stigma related to diseases affecting mostly women and health seeking behaviours of women. Analysis of these databases was conducted to explore, detail and aggregate cultural health issues documented in chapters on the situation of women in Africa and the factors affecting their health. The databases were collected from individual interviews and focus group discussions and from life stories of women in Senegal, Guinea, Burkina Faso and Rwanda. The data were coded and processed using *Ethnograph* and *Anthropack* software. The main concept underlying the qualitative analysis was to obtain insights into cultural factors affecting women's health, their gender roles and socioeconomic responsibilities.

Finally, individual additional methods were also used, it was possible for researchers to conduct analyses and present the findings to peer review and to WHO internal and external reviewers. This reviewers' evaluation also served as an engine for cross-fertilization of findings emerging from different disciplines (clinical research, public health, gender analysis, sociology, anthropology, economy and operational research).

The methodology used for the Recommendations followed different steps:

- At the end of each chapter, authors inserted a box consisting of the "Key considerations and points for action";
- At the end of the validation process for the findings and preliminary results, authors met and developed a matrix and tables for the main identified problems and for the concepts of recommendations and suggestions of actions to be carried out by various target audiences;
- The concepts of recommendations were then developed into the text of the Report and collectively analysed by the contributors, WHO secretariat and reviewers.

Appendix:
Photography

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“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.”

World Health Organization
REGIONAL OFFICE FOR Africa