

Summary
edition



Addressing the Challenge of Women's Health in Africa

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



World Health
Organization

REGIONAL OFFICE FOR Africa

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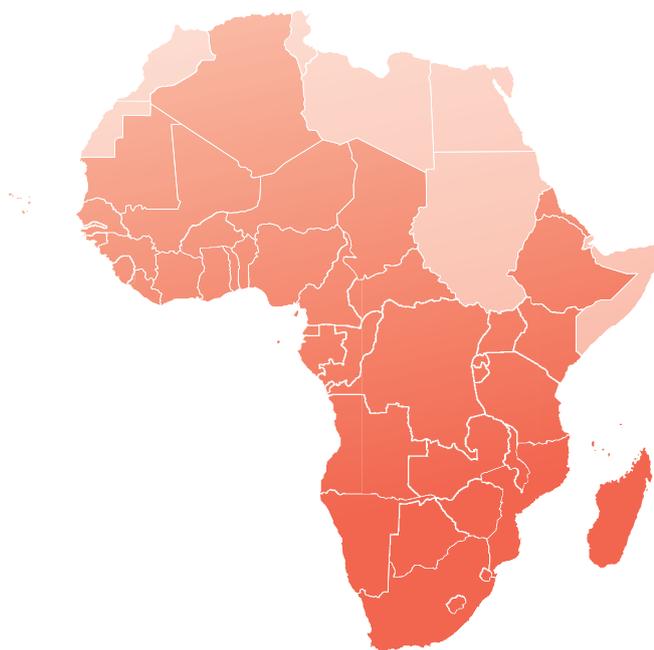
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H.E. Mrs. Ellen Johnson Sirleaf
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“ I am hereby calling on all governments to reinforce their commitments and dedication to accelerating the reduction of maternal and newborn mortality as a fundamental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

An extract from her Foreword to the Report



Dr. Luis G. Sambo
Regional Director for Africa, WHO

“ The Report shows that the African Region promotes women’s empowerment and entrepreneurship. However, in respect to maternal health, the situation in the Africa 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 improving women’s health, in terms of labour productivity and national income. The Report therefore calls for profound rethinking of approaches to improving women’s health in the African Region. ”

An extract from his Foreword to the Report



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.

Overview

The report of the World Health Organization's expert Commission 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.

Key findings of the report

African women bear an unacceptably huge burden of disease and death

Women in Africa account for more than half of deaths of women worldwide due to communicable diseases, maternal and perinatal conditions and nutritional deficiencies. They bear an even heavier burden of HIV/AIDS with the related morbidity and mortality accounting for 89% of disability-adjusted life years (DALYs) among women worldwide. The burden of disease and death in the African Region is worst in regard to maternal mortality.

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. 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.

Out-of-pocket payment for health care punishes the poor and penalizes women in particular. There is overwhelming evidence that out-of-pocket 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. The report shows that even when the fees charged are low they discourage utilization. Out-of-pocket 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 out-of-pocket payment is discontinued, utilization rates rise. However, out-of-pocket payment should not be discontinued without careful planning because the replacement of out-of-pocket payment with financing systems based on prepayment and pooling of resources presents considerable organizational and governance challenges.

A multisectoral approach is imperative to improve women's health

Ill health is both a symptom and a cause of women's disempowerment – one of the drivers 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. There is ample evidence, for example, 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. Women themselves have an important part to play, therefore, 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.

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.

Educating women promotes socioeconomic empowerment. However, the empowerment will be incomplete unless women are also allowed to participate fully in the job market and to 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.

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 in the Region and tend to increase in crisis situations such as natural disasters and armed conflicts. Violence against women becomes particularly pernicious in respect to 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-female genital mutilation campaigns, as well as interaction with communities in addressing the cultural reasons for perpetuation of this practice.

There are immense socioeconomic benefits from improving women's health

As the report shows, a major 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.

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 and there is therefore a need for age and sex disaggregated data to monitor women's health status across age categories.

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 focus urgently on 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.

Policy makers seeking to improve the health and socioeconomic status of African women have no better ally than the women themselves. Although African women are already making an enormous contribution to social and economic activities of the continent, they can achieve much more. Only when there is a true understanding of the important role that African women can play in the Region's development will the Region begin to realize its full potential in terms of political stability, economic prosperity and better health outcomes for all.



Section 1

Rethinking women's health

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, WHO

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. 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.¹

Rethinking policy

For policy makers to create the enabling conditions for women at all levels of society to benefit from better health care they need to 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 institute modern methods of childbearing in health facilities that are convenient to women and protect their 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.²

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.

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.

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. 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 2001.³ 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.

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 payment for health care. 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.

The alternative to direct out-of-pocket 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.³

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.

The Region has weak and dysfunctional health systems that are plagued by lack of funds, a human resource crisis and weak and inadequate infrastructure.

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.

African women must be encouraged to engage in the planning and organization of their own health care services. The optimal system for delivery of maternal health services in the African Region is described in Section 3.

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. According to the Nigerian anthropologist Oyéronké Oyéwùmi, age is the main organizing principle of identities and social relationships in many African societies.

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. One example of this can be seen in women's exclusion by law from ownership of land or property, which increases their social, physical and financial vulnerability.

Gender discrimination is also often linked to some traditional practices that can result in direct physical harm. An example is female genital mutilation. An estimated 92 million girls and women above the age of 10 years in Africa live with the consequences of female genital mutilation and each year some three million more are mutilated.^{4,5} Women are also exposed to health risks through early marriages, issues around the practice of wife inheritance, and child slavery.

Rethinking social attitudes towards women must 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".

Rethinking women's right to health

It is important to remember that health is a basic human right, and that women have the same claim to that right as men.

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 revealing that HIV/AIDS in Zambia spread faster among uneducated girls compared with educated ones.

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.

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 their low 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.

Rethinking the connections between women's health and socioeconomic development

Health is both a cause and a consequence of socioeconomic development. 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.

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

Key considerations and points for action

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

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



Section 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 under-size 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.⁶

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%),³ 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,⁷ and each episode exposes the child to the risk of dehydration and death.

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 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%. Even in the absence of antiretroviral interventions exclusive breastfeeding carries a lower risk of transmission than mixed feeding.

Diarrhoea is closely followed by malaria as a cause of premature death in girls aged 0–4; 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.

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 is a significant risk in sub-Saharan Africa. In 2009 mother-to-child-transmission occurred in an estimated 370 000 live births. 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.⁶

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 of HIV.

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.

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.

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.

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 population using improved sanitation facilities is increasing too slowly – from 30% in 1990 to 34% in 2008.

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 already noted there is evidence of correlation between the education and health status of girls. 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.

↳ Societies limiting girls' access to education pay a huge price... ↵



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, which involves partial or total removal of the female external genitalia by cutting, burning or scraping,⁸ 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 14.⁴

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.

Another factor that can affect girls in this age group is violence and unfortunately violence against adolescent girls 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. This violence becomes more acute in crisis situations such as natural disasters or armed conflicts when girl children and adolescents are most vulnerable.

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. 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.

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.

Key considerations and points for action

- Addressing the many health challenges faced by young women in sub-Saharan Africa in their early years requires a multisectoral approach.
- 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.
- Education, associated with better health outcomes, has a number of other beneficial effects.
- 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.
- The onset of sexual activity is associated with morbidity and mortality especially from HIV infection and maternal mortality.

↳ ...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. ↵

Section 3

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

It is estimated that women in Africa produce up to 80% of the food needs of the continent. 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. In addition, of course, the workload of women is greatest when fulfilling the role of childbearing and nurturing.

High fertility rate

Sub-Saharan Africa has the highest fertility rate worldwide, estimated at 5.2. In some countries fertility rates may be as high as 6.0 and beyond.⁹ A high fertility rate is associated with low contraceptive prevalence. 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.



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 scourge of HIV

In sub-Saharan Africa, women account for 60% of people living with the HIV virus. HIV/AIDS prevalence in the Region is estimated at 3.2% in the 15–24 year age group, i.e. more than five times the global prevalence rate for the same age bracket. 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.

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.

Male-on-female violence or the threat of violence also plays a major role in driving the epidemic. 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.¹⁰ 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.

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.

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...

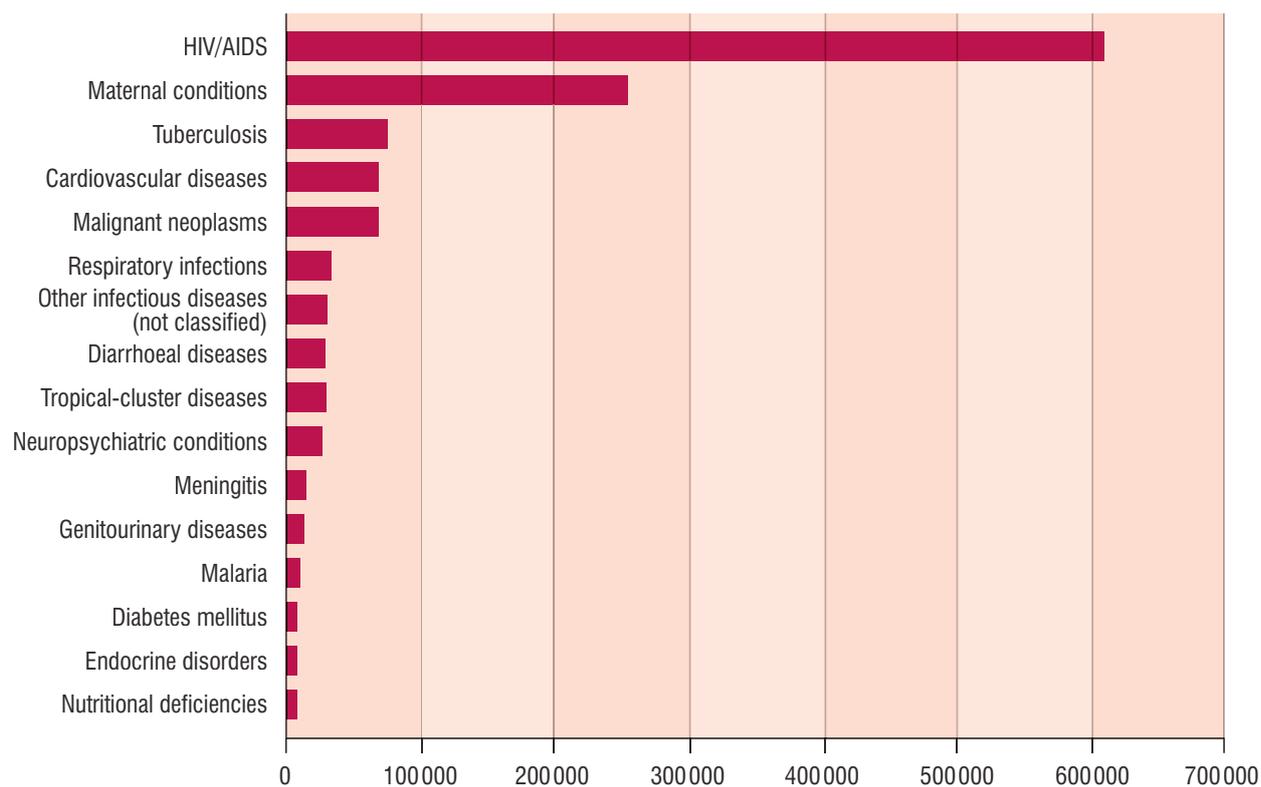
The high unmet sexual and reproductive health needs especially of young women, a population that is severely affected by both HIV and violence, underscores the urgent need to take a multisectoral approach to what is truly a multisectoral problem.

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 3.1**). Particularly in the 15-to-29 age bracket (**Figure 3.2**), 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.

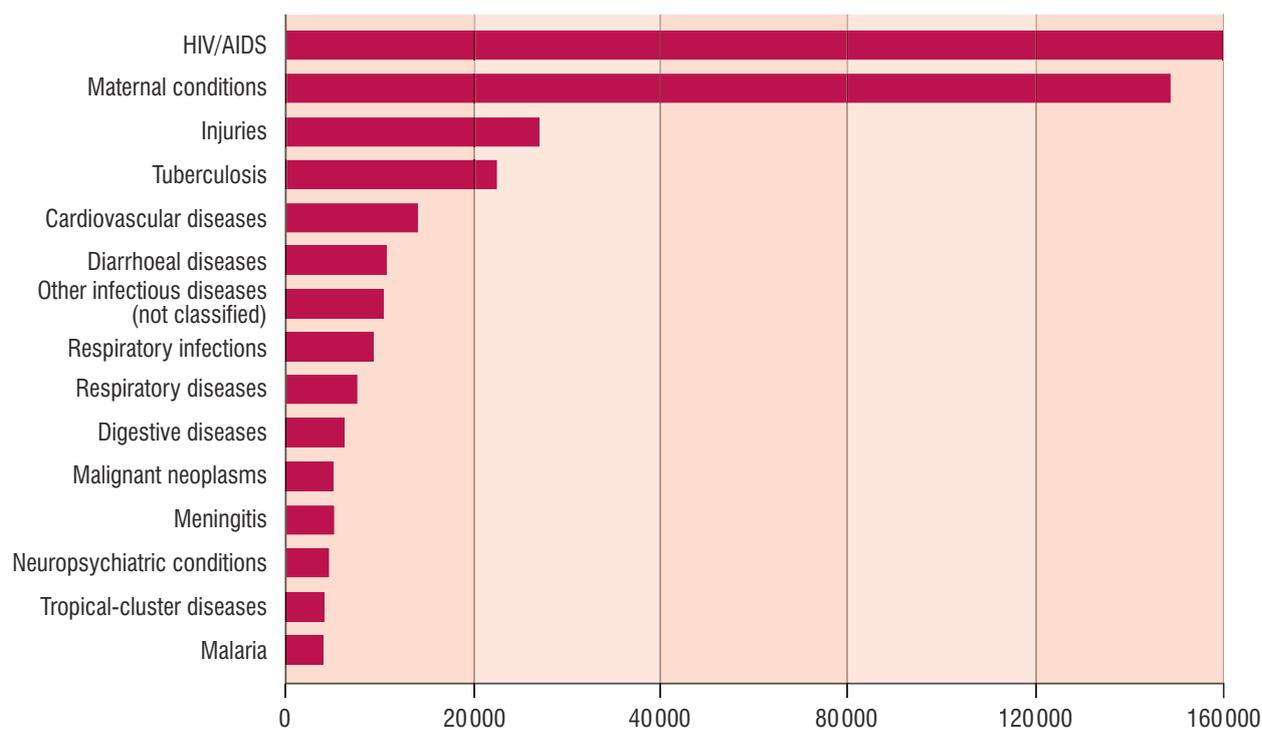
Skilled attendance at birth is known to be crucial for maternal and newborn survival; however, the majority of African women do not have access to skilled attendance at birth. The same is true of postpartum care which is needed to detect and treat infection and other conditions including postpartum depression. Postpartum care is also crucial for providing advice on family planning and other issues such as breastfeeding.

Figure 3.1 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 3.2 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.

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,¹¹ but of the countries worldwide suffering a critical shortage of health workers 36 are in the African Region. Where health workers have been trained, their retention is problematic due to poor working conditions especially low salaries.

The shortage of skilled care is 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.

Unacceptably 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.¹² 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 tragic because 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 of the world.¹³

In the African Region women have a 1 in 42 lifetime risk of dying prematurely in childbirth compared with the 1 in 2900 lifetime risk of women in Europe.

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 lifetime risk of dying prematurely from childbearing compared with the 1 in 2900 lifetime 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 30 women who suffer short- or long-term disabilities. It is estimated that around a quarter of maternal deaths could be prevented by emergency obstetric care.

The importance of keeping promises to African mothers

African countries have 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.*



However, despite the impressive roll call of conventions and initiatives the good intentions have often failed to result in change.

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.

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 – to date, only seven countries are meeting their Abuja Declaration target.

The optimal system design for the delivery of maternal health services in the African Region comprises two levels providing basic and comprehensive obstetric care.

There are, however, 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.¹⁴

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.

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.

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.

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.

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.

Cervical cancer

Sub-Saharan Africa has the highest incidence of cervical cancer in the world. 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. 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.

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.

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.

Conclusion

Women of childbearing age in the African Region are confronted by a range of complex 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.

Section 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 noncommunicable diseases (NCDs) start to weigh quite heavily, notably diseases of the heart, cancers and chronic respiratory diseases.

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.

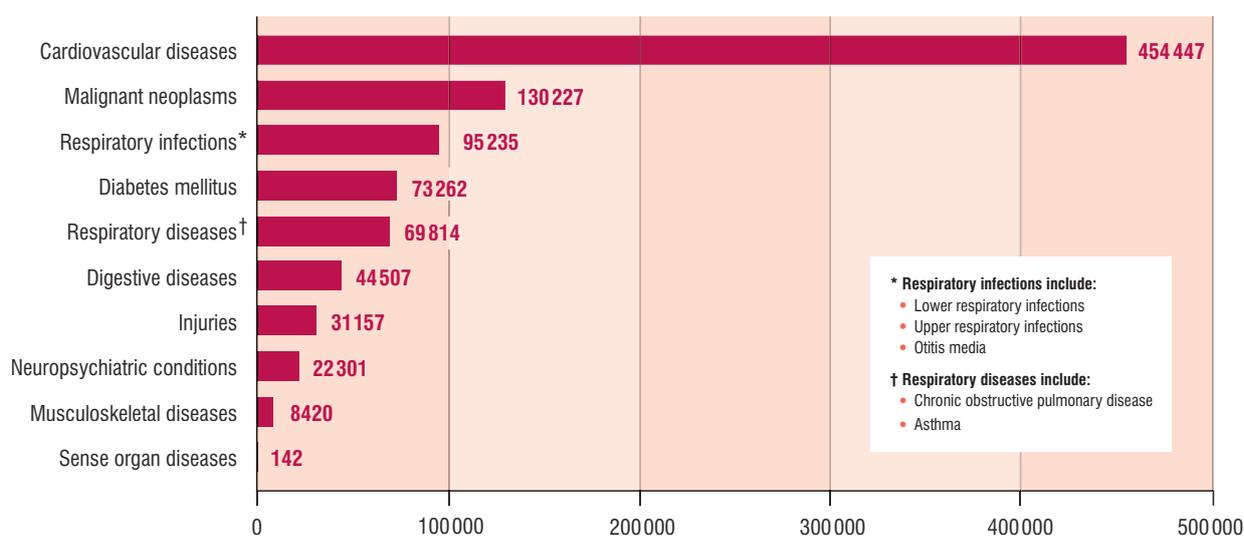
According to WHO, if nothing is done to address the issue of NCDs, they will account for at least 50% of mortality in the African Region by 2020.

NCDs are high among women above 60 years

Urban population growth is also associated with diabetes and cardiovascular diseases¹⁵ 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 4.1).

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. 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. NCD prevalence rates are generally not recorded by health systems in the Region, but selected studies suggest that they are high and increasing.

Figure 4.1 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.

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 2020.¹⁴

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.

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.

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. 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.

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.

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.

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

In reality, therefore, an increasing number of elderly African women will probably spend their last years in institutions.¹⁶ Policy makers must, in consequence, 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.

Section 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.



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. Where the mother thrives the children are better fed and better educated. Where the mother becomes sick or even dies the children suffer.

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. 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.

Clearly substantial socioeconomic benefits are derived if a mother stays healthy, while significant costs are incurred from her sickness or premature death.

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.

There is a large body of evidence of the positive impact of good health on economic performance. Research has also shown that health enhances labour productivity and has a positive, sizeable and statistically significant effect on aggregate output.

While empirical evidence on the relationship between health and economic output in African countries is lacking, 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.

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 is 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.¹⁷

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.¹⁸



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. Family planning services would also be expected to save 750 000 lives annually, 200 000 among women and 550 000 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. This would also contribute to improvements in gender equity, health status and economic output which would in turn lead to a reduction in poverty.

Of course, 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.

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.

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 food¹⁹ 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.

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.²⁰ 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.

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

A significant 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. 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.

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. 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 is indicative that this view is shared by the global community as well.

There is, therefore, an urgent need for change and, 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.

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 trails other developing regions 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.

Section 6

Interventions to improve women's health

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 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.

In order to address the budgetary challenges facing women's health care programmes, governments should be encouraged to reassess national budget priorities. 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. Moreover, the provision of, at least, safe motherhood care packages is well within the budgetary reach of many African governments.

Strong advocacy is needed

By presenting leaders with the evidence of the benefits that supporting women's health investments²¹ can bring to their societies and economies, 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. 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.

Supporting women's health and development throughout the life course

Apart from immunization, the interventions^{22,23} 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).

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.

Promoting healthy motherhood

The socioeconomic benefits of healthy motherhood have been discussed in some detail. 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 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. 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.

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

It is when women enter their reproductive years 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.²⁴ 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.²⁵

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.

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.

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.

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.

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.



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.

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.

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. The availability of skilled staff and adequate supply of medicines are among the key factors associated with quality care, but improved education and training and sensitivity to cultural considerations are also important factors.

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, available evidence suggests that user fees and direct payment have led to an overall decline in the utilization of health services.

Political leadership is essential to bringing about an effective transition to prepayment and pooling.

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.

Empowerment of women

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 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.

Another 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.

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.

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.

Section 7

Recommendations

There are 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 undertake to play 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:

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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.



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