Background Paper on Harmonizing Approaches to Women’s Health in Africa

Dialogue with African Ambassadors to the United States
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<td>AFRO</td>
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<td>ANC</td>
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<tr>
<td>Acronym</td>
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</tr>
<tr>
<td>UNFPA</td>
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<tr>
<td>UNESCO</td>
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Under the auspices of the World Bank, a discussion on women’s health issues in Africa was undertaken with the Ambassadors of African countries in Washington, DC. The dialogue was the first step in the World Bank’s initiative to harmonize approaches of governments, development partners, and donors on women’s health in Africa. The key objectives of this initiative were to:

- Establish ongoing partnerships with African Ambassadors to identify current programs and activities in the region;
- Create a supportive constituency to promote women’s health in Africa;
- Enhance ownership of the women’s health initiative among African Ambassadors; and
- Provide a forum for African Ambassadors to advise the World Bank for supporting African governments on improving women’s health in the region.

The participation of African Ambassadors was an important milestone in progress towards achieving improvements in women’s health in the region. The participation of the Ambassadors in enabling support for such an initiative is vital. As their countries’ representatives, the Ambassadors have an important role in influencing policies and decision-making. They are in a position to engage their governments and donors to leverage support for women’s health initiatives in the region. They provide an additional lens through which countries can identify and select priorities for current and future investments. Individually and collectively, they can provide the much-needed support for elevating the agenda for improving women’s health in the region.

The World Bank and governments of African countries are committed to priorities outlined in the Millennium Development Goals (MDGs) and Poverty Reduction Strategy Programs. Improvement in women’s health is an important priority specified in these goals. Collaboration among stakeholders is integral to achieving these goals. During the last three decades, a greater impact on health and development might have been accomplished through stronger alliances and collaboration among stakeholders. A resounding theme in the MDGs is the establishment of partnerships among stakeholders for working towards the achievement of goals. Thus, the partnership of the Ambassadors and the World Bank will serve as a catalyst for accelerating the women’s health agenda in Africa and will contribute to progress towards meeting these goals.
The World Bank is in a unique position to forge alliances with constituents who are influential and can play an important role in advising governments on the issues at hand. The partnerships formed can accrue significant benefits for those involved. In particular, it is expected that the outcomes of such a partnership will:

- Add value to the understanding of women’s health, its multi-dimensionality, and its relationship with all aspects of development;
- Provide an additional mechanism for identifying opportunities and constraints and proposing new models to policy makers and program managers;
- Encourage diligence in monitoring the progress towards international goals and priorities by governments and donors; and
- Provide models where traditional and nontraditional groups can work together to promote women’s health.

The World Bank seeks to establish partnerships with all stakeholders to facilitate information sharing on the major issues pertaining to women’s health. Information on women’s health both from the human rights and the development perspectives will be gathered. These will include experiences of the struggles won and lost, issues pertaining to regional disparities in women’s health, and those related to gender-based vulnerabilities in health.

The report provides a synopsis of the major challenges and opportunities associated with women’s health as a means of generating further dialogue on these issues. Information from multiple sources has been collated to provide a comprehensive picture for allocating resources for improving women’s health. The report highlights the gender sensitive approach to women’s health, which is line with the global objectives for social justice, human rights, equity, peace, good governance, and democratization.

Prioritizing women’s health and allocating adequate resources to it is an investment that can bring about long-term benefits in a society. Improvements in health services cannot alone lead to gains in women’s health. Investments in health systems have to be accompanied by social and behavioral change. Only when all these priorities are addressed simultaneously, can women become healthy and productive members of society and contribute towards the health of their children and families. This dialogue with African Ambassadors for prioritizing women’s health is a step in this direction that the World Bank is privileged to initiate.

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Human Development Department  
Africa Region
This report was prepared by Belkis Giorgis, Consultant, and Khama O. Rogo, Lead Health Sector Specialist (AFTH3). The authors benefited from guidance and comments from Mark Blackden. Financial assistance from Dutch Trust Fund is gratefully acknowledged. Editorial support was provided by Mona Sharan, Hareya Fassil, and Nami Kurimoto. Thanks are also due to Elsie L. Maka for overseeing the publication process.
A dialogue on harmonizing approaches to women’s health in Africa was initiated by the World Bank. The participants included staff from the World Bank and African Ambassadors in Washington DC. This report documents the key issues discussed at that meeting and strives to place these issues within the cultural, political, and economic situation in the region.

A conceptual framework for women’s health in the region is discussed to gain a broad-based understanding of the issues discussed at the meeting. The life cycle approach to women’s health, the basic tenets, and principles of the International Conference on Population and Development, and the Millennium Development Goals provide key themes for the report.

Global initiatives for safe motherhood and prevention of HIV/AIDS, malaria, and tuberculosis present opportunities for addressing major health problems affecting millions of women in Africa. The report identifies the major causes of women’s ill health as well as underlying reasons for the disproportionate burden of disease and disability among women in Africa. It also analyzes relationships between gender equity, health, and development.

Issues related to HIV/AIDS, civil strife, refugees, migration, and urbanization impact upon women’s health. These problems are leading to a transformation of the cultural, social, and political environment in the region. There is a greater need now for sustained vigilance in monitoring progress towards women’s health.

To initiate dialogue and provide a comprehensive discussion on the issue of women’s health in Africa, this report seeks to:

- Provide an overview of the linkages among gender, health, and development;
- Present women’s health problems by the life cycle approach;
- Provide information on specific health issues in the region, and their impacts on women and children; and
- Make recommendations to stakeholders for improving women’s health in Africa.

Women’s equality and empowerment are critical to the achievement of the MDGs. Current discussions on the process of socio-economic planning and policy dialogue between governments and donors are centered on the MDGs. The goals also provide a strategic opportunity for engaging in issues surrounding women’s health. It is expected that the report will be a useful tool for initiating these dialogues and will provide the impetus for developing policies and programs to address women’s health in Africa.
CHAPTER I

Women’s Health in Africa

Investments in women’s health are necessary to bring about improvements in all aspects of human development. Good health is essential for making people productive. Healthy individuals are able to produce, earn, and invest more, thereby spurring economic development. In addition to their biological role as mothers, as primary care providers, women contribute significantly to the health status of families. As such, their health and wellbeing is not only critically important to that of their families, but also to the socioeconomic development of societies and nations. Promoting women’s health and development can thus, lead to far-reaching gains.

Experience shows that modest investments in women’s health can lead to significant gains both in the short and in the longer term. In the short term, it can lead to better health outcomes among women and children. In the longer term, investments in women’s health will impact upon the larger agenda of social justice by promoting gender equity, democratization, and good governance.

**Human development**

“Human development is about much more than the rise or fall of national incomes. It is about creating an environment in which people can develop their full potential and lead productive, creative lives in accord with their needs and interests. People are the real wealth of nations. Development is thus about expanding the choices people have to lead lives that they value. In addition, it is thus about much more than economic growth, which is only a means—if a very important one—of enlarging people’s choices.” (UNDP/HDR, 2006)

At the core of the definition of human development, it would be appropriate to state that, “women are the wealth of nations;” even though their contributions cannot always be readily quantified. Indeed, as articulated by the UN Secretary General in 2003:

“There is no effective development strategy in which women do not play a central role. When women are fully involved, the benefits can be seen immediately: families are healthier and better fed, their income and reinvestment go up. In addition, what is true of families is true of communities and in the long run, of whole countries.” (Annan, K., 2003)

Women make significant contributions to food production and preparation, fuel wood and
water collection, childbearing and rearing, and attending to the needs of their families. Providing financial, material, and technical resources to women can expand their potential to contribute to social and economic development.

Although pledges and commitments to improve women’s health have been made at various national and international forums, the required resources have not been allocated. Action falls short of grandiose plans and strategies. Moreover, the proportion of investments in women’s health is negligible compared to that in other sectors. Typically, women’s health or gender equity issues get subsumed within larger programs for family health or other multi-sectoral initiatives.

Women tend to be underrepresented in positions of power where decisions are made. Their advocates within civil society have meager resources for mobilizing their efforts. As such, their contributions tend to be limited to describing women’s problems, including those that are health-related. Beyond these efforts, there is little else activists are able to do to bring about change. Efforts are needed for creating an environment where policy makers can make women’s health a topmost priority.

The World Bank estimates that just US $3 per person, per year, would provide basic family planning, maternal, and neonatal health care to women in developing countries. A basic reproductive and child health package includes prenatal, delivery, and postnatal care, as well as postpartum family planning and sexually transmitted disease (STD) prevention services (GHC, 2006). Even these modest investments are not forthcoming.

**Literature on women’s health in Africa**

The literature on women’s health in Africa is abundant and it has been disseminated through various channels. The availability of information and communication technology has made this literature easily accessible to policy makers, researchers, and program managers. Yet the information needed to guide policy is elusive.

Quantitative data on mortality and morbidity rates for women do not convey the whole picture. The numbers lack the capacity to portray the daily realities of women’s lives, which contribute to negative health outcomes. While data provides the analytical and empirical base, it is not sufficient, by itself, to guide policy for women’s health. Information that can be used to formulate policies has to be readily available in forms that can be easily understood and applied by policy makers.

Information on women’s health from various sources is widely available through the internet, published books, articles, and the media. Broadly, the information sources can be classified under two categories: (a) those pertaining to biological aspects of women’s health, such as fertility, morbidity, and mortality; and (b) those pertaining to gender-specific health issues. The following are the main topics covered:

- Gender equity and empowerment: women’s role, status, and rights issues, including those related to education, employment, and reproductive health;
- Traditional harmful practices: female genital cutting, gender-based violence, including in the context of conflict, refugees, and displaced persons;
- Emerging trends: globalization, urbanization, adolescent reproductive health, HIV/AIDS, and refugee health; and
- Global initiatives related to women’s health: MDGs, the Safe Motherhood Initiative, and the Global Fund for AIDS, Tuberculosis, and Malaria.

Sharing best practices through the media and information technology makes up-to-date information available to all stakeholders.

Typically, information on women’s health posted on the internet is focused on specific issues and provides an inordinate amount of information on a particular topic. A case in
point is the information on FGC, a serious health problem faced by African women. A simple Google search on FGC will spew out numerous websites that contain superfluous information. Many organizations and groups working on women’s health issues disseminate their information on the internet. Chat forums organized by listserves on different development topics provide opportunities for a free-flowing exchange of information on various women’s health issues. Although information on the internet is widely available, it is difficult to establish how useful it is, particularly to individuals in the developing world who have limited access to it. Furthermore, most policy makers and program managers lack the time and capacity to contribute to this massive exchange of information on the internet.
CHAPTER II

Conceptual Framework for Women’s Health

Women in Africa play critical roles both within families and communities, and thus, embody the potential for determining how the region will fare in the coming decades. Their biological roles as mothers and primary agents of socialization superimposed on their roles as caretakers and health providers makes this group central to the development of the region.

Providing conceptual clarity and developing an interpretative framework is the first step in discussing women’s health issues. The discourse on women’s health tends to be focused on disease and disability. Instead, a more comprehensive picture of women’s health can be gained from understanding the issues that affect their lives, and consequently their health status. An analysis of women’s biological vulnerabilities and the major sociocultural, economic, and political factors that impinge on women’s health is necessary for such an understanding.

**Gender equity and health**

Gender-based inequities affect women’s health. Gender differentials arise from socially constructed roles ascribed to men and women on the basis of their sex. These roles are area- and time-specific, as gender roles are defined by the social and economic context and tend to vary over time. The word ‘sex’ is used to refer to explanations for observed differences between women and men (UN, 1996).

In her essay “Gender Equity in Health: Debates and Dilemmas,” Lesley Doyal (2000) argues that there are significant differences in the way in which gender equity is perceived and presented. The definition of gender equity itself, as well as judgments of its desirability, is generally open to question. After reviewing prevailing ideological debates on this topic, the author concludes that the pursuit of gender equity in health is a legitimate goal of public policy, and that the health of women (and maybe men) could be improved as a result. Women control less than 10% of global resources and only 1% of the world’s property, earning less than men for comparable work, which demonstrates the global inequities between men and women. Moreover, domestic and international mobilization patterns widen these disparities since existing inequalities constrain women’s ability to build on opportunities, to respond to policy
Reproduction continues to be the predominant focus of women’s health issues, whereas although its separation from their productive activities is artificial. Women working in the fields with children on their backs, breastfeeding while selling food at the market, pounding yam in front of their huts, all symbolize that production and reproduction are inextricably linked. Neither pregnancy and lactation, nor childbearing deters women from attending to their daily chores.

Figure 1
Health and Nutritional Problems Affecting Women During The Life Cycle

Source: Adapted from “A New Agenda for Women’s Health and Nutrition” (World Bank, 1994a)

initiatives or to make gains, in terms of land rights, credit, and technology. [1]

The life cycle approach to women’s health

The life cycle approach to women’s health captures the different health conditions of women as they move from infancy to old age. The life cycle chart (Figure 1) summarizes the health and nutritional problems affecting women during their life cycle.

Many women’s living conditions are influenced by different factors such as work inside and outside home, child care and care for the elderly, reproductive health influences, and chronic ailments (NIH, 2004). For example, a major problem affecting women during adolescence is malnutrition. Adolescents grow faster and need protein, iron, and other micronutrients to support the growth and meet the body’s increased demand for iron during menstruation.

The life cycle conceptual framework describes the biological vulnerabilities of women and the influence of social, economic, and cultural factors on their health. This framework recognizes that women experience different health conditions at different stages of development ranging from infancy, childhood, adolescence, menarche, reproductive life, the menopausal transition, post-menopausal years, and old age. Strategies and interventions for addressing the health needs of women through different life stages can be developed by using this framework.

Data on the leading causes of death for women worldwide show that malaria and maternal conditions constitute a considerable proportion of causes of death among women (Table 1). Malaria also contributes to negative health outcomes during pregnancy. Efforts to reduce maternal mortality must simultaneously address the leading causes of death among women. Maternal deaths are just the tip of the iceberg. For every woman that dies, at least 30 more women suffer from serious illness or debilitating injuries.

Table 1
Leading Causes of Death Among Women

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>Number of women</th>
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<tr>
<td>HIV/AIDS</td>
<td>1.3 million</td>
</tr>
<tr>
<td>Malaria</td>
<td>592,000</td>
</tr>
<tr>
<td>Maternal conditions</td>
<td>509,000</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>500,000</td>
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</table>

II

If women are not the originating points for investments in health, then all other interventions in poverty reduction will fail. The rationale for investing in women’s health has to move beyond the focus on providing women medical benefits to taking account of the broader family and societal benefits that accrue if women are in good health. Interventions must address ways to help women fulfill both their biological and productive roles, as the two are interdependent.

Maternal deaths carry a very high cost. When a mother dies, the whole family suffers, particularly dependent children who are left behind without a major breadwinner and the primary source of emotional and psychological support. Her family loses her love, her nurturing, and her productivity inside and outside the home (FCI, 2000). Empirical data show that women put in 12 to 15 hours of daily labor to meet the household’s needs, including food, water, and fuel as well as caring for children. A mother’s death means the loss of the primary wage earner and therefore, the livelihood of the whole family. Communities are denied her paid and unpaid labor, and countries have to forego her contributions to economic and social development. Any social and economic investment that has been made in her life is lost. A woman’s death is thus more than a personal tragedy. It is an enormous cost to her personal tragedy. It is an enormous cost to her family, her community, and her nation.

Millennium Development Goals

Over the past decade, UN conferences have provided a platform for formulating the development agenda on different issues. The Millennium Declaration is one such blueprint for development. The Millennium Development Goals aim to significantly reduce the percentage of people living in poverty and improve overall standards of living. The eight goals are visionary, ambitious, and provide benchmarks to measure progress towards development.

Although all the goals outlined by the MDGs are relevant for women, Goals 3, 4, and 5 are particularly gender-specific and lie at the core of women’s health and development. To bring about positive change through poverty reduction—the cornerstone of the MDGs—women must be made an important target because their poverty is more severe and carries the worst consequences.

Gender inequity and women’s subordination represent major barriers to the achievement of
MILLENNIUM DEVELOPMENT GOALS

Goal 1
Eradicate extreme poverty and hunger: By 2015, halve the proportion of people living on less than a dollar a day and those who suffer from hunger.

Goal 2
Achieve universal primary education: By 2015, ensure that all boys and girls complete primary school.

Goal 3
Promote gender equality and empower women: Eliminate gender disparities at all levels by 2015.

Goal 4
Reduce child mortality: By 2015, reduce mortality rate among children under five by two-thirds.

Goal 5
Improve maternal health: By 2015, reduce maternal mortality ratio by three-quarters.

Goal 6
Combat HIV/AIDS, malaria, and other diseases: By 2015, halt and begin to reverse the spread of HIV/AIDS, incidence of malaria and other major diseases.

Goal 7
Ensure environmental sustainability. Integrate the principles of sustainable development into country politics and programs and reverse the loss of environmental resources: By 2015, reduce by half the number of people without access to safe drinking water. By 2020, achieve significant improvements in the lives of at least 100 million slum dwellers.

Goal 8
Develop a global partnership for development: Develop further an open trading and financial system that includes a commitment to good governance, development, and poverty reduction nationally and internationally. Address the special needs of the least developed countries and those that are landlocked. Deal comprehensively with developing countries debt problems.

devolution objectives. The Millennium Development Goals can provide guidance to both donor agencies and governments and make them aware of these barriers. According to Noeleen Heyzer, Executive Director, UNIFEM:

“Gender equality and women’s empowerment is the goal through which women’s perspectives must be incorporated into all other goals, including that of halving the number of people living on less than $1 a day. If this goal is to be reached it is critical that the feminization of poverty, increasingly recognized by government as well as international documents, receives systematic attention—especially in this era of globalization.” (Heyzer, 2002)

Women’s health as a human right

If the women’s health agenda is placed within the broader development and human rights framework, it is more likely to be addressed. Such an approach can reframe the development dialogue as it relates to women’s health. Women’s health, as a rights issue, can become a part of an activist agenda. Activists can also demand action on women’s key concerns and mobilize civil society in both the North and South, by highlighting labor rights and employment needs and pushing for a global reordering of the world’s resources (Barton and Pendergast, 2004).

A rights approach to women’s health should guarantee safe pregnancy and delivery as one of its primary objectives. It can also ensure that development action supports internationally agreed standards for human rights. In 1996, the President of the World Bank said:

“Safe motherhood is a human right...if the system lets women die, then the system has failed. Our task and the task of many like us are to ensure that in the next decade safe motherhood is not regarded as a fringe issue but as a central one.” [3]

If safe motherhood is a right, the evidence shows that the system has failed in Africa. The data show that 13 countries of the world represent 67% of all maternal deaths worldwide. Seven of the 13 countries are in Africa and the data for six of the countries, where maternal mortality is the highest, is presented in the table on the previous page (Table 2).

Reproductive health and rights are major goals for women since pregnancy increases women’s biological vulnerabilities and makes their subordinate status within families and communities more pronounced. Among women of reproductive age (15-44 years) in developing countries, reproductive ill-health accounts for 36% of the total disease burden compared with 12% for men. This 36% was made up by pregnancy-related death and disabilities, sexually transmitted diseases, and HIV/AIDS. (WHO, 1997)

At the 1994 International Conference for Population and Development (ICPD) in Cairo, reproductive health was defined as follows:

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Table 2
Top Countries by Number of Maternal Deaths

<table>
<thead>
<tr>
<th>Country</th>
<th>Number of maternal deaths</th>
<th>Maternal deaths per 100,000 live births</th>
<th>Lifetime risk of maternal deaths</th>
<th>Skilled attendance at delivery</th>
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<tbody>
<tr>
<td>Nigeria</td>
<td>37,000</td>
<td>800</td>
<td>1 in 18</td>
<td>42%</td>
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<tr>
<td>DRC</td>
<td>24,000</td>
<td>990</td>
<td>1 in 13</td>
<td>61%</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>24,000</td>
<td>850</td>
<td>1 in 14</td>
<td>6%</td>
</tr>
<tr>
<td>Tanzania</td>
<td>21,000</td>
<td>1500</td>
<td>1 in 10</td>
<td>23%</td>
</tr>
<tr>
<td>Angola</td>
<td>11,000</td>
<td>1700</td>
<td>1 in 7</td>
<td>44%</td>
</tr>
<tr>
<td>Kenya</td>
<td>11,000</td>
<td>1000</td>
<td>1 in 19</td>
<td>56%</td>
</tr>
</tbody>
</table>

Source: Data adapted from Interim Report of MDG Goal #4 [4]

---


[4] The data which is prepared from a table of 13 countries, accounts for 67% of all maternal deaths worldwide (257/529,000). Of the 13 countries, seven are in Africa.
“Reproductive health is a state of complete physical mental and social well being and not merely the absence of disease and infirmity in all matters relating to the reproductive system and its functions and processes. Reproductive health therefore implies that people are able to have a satisfying life and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in the last statement are the rights of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right to access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.” (UN, 1994)

The ICPD document also defines the broad range of services required to achieve reproductive health. Reproductive health services are defined as “the constellation of methods, the techniques and services that contribute to reproductive health and wellbeing through preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations and not merely counseling and care related to reproduction and STDs (ibid).”

In May 2004, the 57th World Health Assembly adopted the World Health Organization’s first strategy on reproductive health. The aim of the strategy is to accelerate progress towards meeting the Millennium Development Goals and the reproductive health goals identified by the ICPD. The strategy identifies five priority areas for improving reproductive and sexual health:

- Improving antenatal, delivery, postpartum, and newborn care;
- Providing high quality services for family planning, including infertility services;
- Eliminating unsafe abortion;
- Combating STIs including HIV, RTIs, cervical cancer, and gynecological morbidities; and
- Promoting sexual health.
Regional Priorities for Women’s Health

In Africa, certain health conditions need to be addressed on a priority basis in order to bring about overall gains in women’s health. This section provides an overview of the health conditions that contribute significantly to poor health among women in Africa. Issues that affect women’s health, such as the condition of health services and women’s education, are also reviewed.

Maternal mortality

Some of the highest maternal mortality rates are found in sub-Saharan Africa (see Table 3; Figures 2 and 3). Africa accounts for 20% of the world’s births but 40% of the world’s maternal deaths. Recent findings by WHO, UNICEF, and the UNFPA show that a woman living in sub-Saharan Africa has a one in 16 chance of dying in pregnancy or childbirth. This compares with a one in 2,800 risk for a woman from a developed region. In Sierra Leone and Afghanistan, one in six women will die from complications related to pregnancy and childbirth.

Women who die during their childbearing years usually leave at least two children behind. Some one million children are left motherless each year because of maternal deaths. These children are three to ten times more likely to die within two years than children who live with both parents (CS, 2006).

The Millennium Development Project Interim Report on maternal and infant mortality indicates that virtually all of the health conditions identified in the MDGs correlate with income poverty. However, it also cautions that the solution to good health is not simply poverty reduction.

Maternal deaths are a symptom of the daily realities of women in Africa. Poor reproductive health outcomes result from cumulative effects of malnutrition in childhood, lack of adequate housing and sanitation, poor educational opportunities, and lack of access to health care. Early marriage and childbearing as well as a high number of and closely spaced pregnancies also put women at higher risk of maternal mortality. All of these factors occur within the context of gender inequality, which further undermines women’s ability to gain access to resources and safeguard their health.

Major causes of maternal mortality and morbidity

Up to 15% of pregnant women in all population groups (equivalent to 20 million women
Table 3
Maternal Mortality Indicators, by Region

<table>
<thead>
<tr>
<th>Region</th>
<th>Maternal mortality ratio (maternal deaths per 100,000 live births)</th>
<th>Number of maternal deaths</th>
<th>Lifetime risk of maternal mortality 1 death in:</th>
</tr>
</thead>
<tbody>
<tr>
<td>World total</td>
<td>400</td>
<td>529,000</td>
<td>74</td>
</tr>
<tr>
<td>Developed regions</td>
<td>20</td>
<td>2,500</td>
<td>2,800</td>
</tr>
<tr>
<td>Europe</td>
<td>24</td>
<td>1,700</td>
<td>2,400</td>
</tr>
<tr>
<td>Developing regions</td>
<td>440</td>
<td>527,000</td>
<td>61</td>
</tr>
<tr>
<td>Africa</td>
<td>830</td>
<td>251,000</td>
<td>20</td>
</tr>
<tr>
<td>Northern Africa</td>
<td>130</td>
<td>4,600</td>
<td>210</td>
</tr>
<tr>
<td>Sub-Sahara Africa</td>
<td>920</td>
<td>247,000</td>
<td>16</td>
</tr>
<tr>
<td>Asia</td>
<td>330</td>
<td>253,000</td>
<td>94</td>
</tr>
<tr>
<td>Eastern Asia</td>
<td>55</td>
<td>11,000</td>
<td>840</td>
</tr>
<tr>
<td>South-Central Asia</td>
<td>520</td>
<td>207,000</td>
<td>46</td>
</tr>
<tr>
<td>South-Eastern Asia</td>
<td>210</td>
<td>25,000</td>
<td>140</td>
</tr>
<tr>
<td>Western Asia</td>
<td>190</td>
<td>9,800</td>
<td>120</td>
</tr>
<tr>
<td>Latin America &amp; the Caribbean</td>
<td>190</td>
<td>22,000</td>
<td>160</td>
</tr>
<tr>
<td>Oceania</td>
<td>240</td>
<td>530</td>
<td>83</td>
</tr>
</tbody>
</table>


Figure 2
Maternal Mortality, by Region

1995 Estimates
Pregnancy and childbirth-related deaths per 100,000 live births

each year) experience potentially fatal complications. About 70% of all maternal deaths are directly caused by the following five complications:

**Hemorrhage** (25%): is the most common cause of maternal death. It should be treated within two hours for a woman’s life to be saved. Treatments at a medical facility include the use of drugs requiring intravenous application or injections, blood transfusions, and other clinical measures. The drug called misoprostol effectively prevents and treats hemorrhage after home births where hospital drugs are not accessible. This is a usual setting where most childbirths happen in Africa and other low-resource regions of the world. (Prata et al., 2005).

**Infection or sepsis** (15%): normally occurs due to poorly performed abortions and use of non-sterile procedures during delivery. It can also result from prolonged labor when a woman’s membranes have ruptured and she has not delivered within 24 hours. The infection has to be treated with antibiotics.

**Unsafe abortion** (13%): unwanted pregnancies are usually terminated with abortions performed with unclean instruments in unsanitary conditions. This is more likely to happen in settings where abortion is illegal. Hemorrhage or infections resulting from unsafe abortions can lead to death unless properly treated.

**Eclampsia** (12%): high blood pressure can lead to eclampsia (convulsions) during pregnancy, which, if not treated in the early stages, can result in death. Eclampsia can be prevented if it is detected during prenatal screening.

**Obstructed labor** (8%): requires treatment at a hospital or health facility where the skills and resources for performing caesarean sections are available.
Illegal abortion

Worldwide, more than one-fifth of all pregnancies—nearly 46 million—are terminated each year. An estimated 36 million procedures take place in the developing world and 10 million in the developed world. Twenty million of these abortions are illegal and thus carried out under unsafe conditions. Women's decisions to terminate a pregnancy tend not to be affected by the legality of abortion in their country. Many women are willing to risk unsafe abortions in order to terminate a pregnancy. In the poorest countries, women face a much higher risk of death from unsafe abortion.

Illegal and unsafe abortions contribute significantly to maternal mortality and morbidity in Africa. Abortion is illegal in the majority of African countries and restricted in a few. In Africa, one in every 150 abortions leads to death, compared to one in every 85,000 procedures in the developed world (PAI, 2001).

A 1998 country profile by Zambia's Central Statistics Office (CSO) found that some 80% of women admitted to health care facilities with complications from induced abortions were younger than 19 years. Many deaths occur outside of these institutions and go unreported. Ironically, Zambia has one of the most liberal abortion laws in Southern Africa, but most women and health care providers are unaware of the legality and availability of abortion services.

Pregnancy and delivery associated morbidity

Numerous studies have documented the incidence of pregnancy-related complications. However, women's health outcomes after childbirth have not been well-documented. One main reason for this is that postpartum care for the mother and the newborn is usually not available or utilized. Much of the available data are derived from women's self-reported symptoms, which experts consider unspecific and not clinically valid.

Due to work-related responsibilities, women often do not get the time to rest and recuperate after childbirth. Fatigue, malnutrition, and heavy workloads have a deleterious effect on their postpartum health. Women also tend to give lower priority to their own health as compared to that of other family members. Case studies from a number of countries reveal this to be an enormous problem that is shrouded in a "culture of silence and endurance" (Murray and Lopez, 1998).

Medical literature shows that if a woman experiences prolonged labor, inappropriate care, or unclean practices during delivery, it may lead to infections, which can affect her ability to have children in the future. Genital prolapse can also lead to chronic backache, urinary problems, pain during sexual intercourse, and complications in future pregnancies. Among the worst complications of birth is obstetric fistula, which not only has devastating consequences for women's health, but also has negative social and economic implications.

Obstetric fistula

According to the UNFPA, obstetric fistula, the most devastating of all pregnancy-related disabilities, affects an estimated 50,000 to 100,000 women around the world every year. This is a serious issue particularly in sub-Saharan Africa. The World Health Organization estimates that at least 8,000 Ethiopian women develop new fistulas every year.

Some of the underlying causes of fistula include, early age of childbearing, poverty, malnutrition, and lack of education. Women with obstetric fistulae suffer from crippling injuries because the condition is exacerbated by long and strenuous labor.

Obstetric fistula is a preventable and treatable condition. The condition occurs when a woman experiences prolonged and obstructed labor and does not have access to emergency obstetric facilities where a caesarean section could be
performed. Obstructed labor may occur because of a small pelvis, an abnormal fetal position, or size. An abnormal opening between the vagina and the bladder or rectum results from extreme pressure and tissue damage during prolonged or obstructed labor. If a caesarean section delivery is not available, the baby is usually stillborn and a fistula forms, resulting in the uncontrollable passage of urine and feces into the vagina (Ashford, 2002).

Fistulae can be surgically repaired but only where trained surgeons and good post-operative care are available. Only two centers in Africa specialize in fistula care: one in Addis Ababa, Ethiopia, and the other in Jos, Nigeria. The operation costs about US$150, a fee beyond the means of most women who are affected.

**Women’s nutrition**

Malnutrition presents a range of threats to women’s health. It weakens women’s ability to survive childbirth, makes them more susceptible to infections, and leaves them with fewer reserves to recover from illnesses. Women tend to be at greater risk of suffering from food shortages. Disparities in allocation of household foods are known to disadvantage women and girls disproportionately (UN, 1995).

Adequate nutrition is important for women not only because it helps them become productive members of society, but also because it affects the health and development of the next generation. There is also a growing concern that maternal malnutrition may contribute to the growing burden of cardiovascular and other non-communicable diseases among adults in less developed countries. Maternal malnutrition’s

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5 Adapted from ACC/SCN (Administrative Committee on Coordination /Sub-Committee on Nutrition) appointed Commission on the Nutrition Challenges of the 21st Century: *Ending Malnutrition by 2020: An Agenda for Change in the Millennium* (February, 2000).
toll on the survival of mothers and children counteracts countries’ efforts towards achieving essential global development goals (Ransom and Elder, 2003). Table 4 outlines how improving women’s nutrition can help efforts towards achieving the Millennium Development Goals.

HIV-infected mothers who are malnourished may be more likely to transmit the virus to their infants and to experience a more rapid transition from HIV to full-blown AIDS. Malnutrition undermines women's productivity, their capacity to generate income, and to care for their families. Figure 4 shows how poor nutrition among women can lead to a range of health problems throughout the life cycle.

<table>
<thead>
<tr>
<th>Table 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Better Nutrition Helps Achieve Millennium Development Goals</strong></td>
</tr>
<tr>
<td><strong>Millennium Development Goal</strong></td>
</tr>
<tr>
<td><strong>How Improving Women and Adolescent Girls’ Nutrition Helps</strong></td>
</tr>
<tr>
<td><strong>Goal #1: Eradicate extreme poverty and hunger.</strong></td>
</tr>
<tr>
<td>Halve, between 1990 and 2015, the proportion of people who suffer from</td>
</tr>
<tr>
<td>hunger.</td>
</tr>
<tr>
<td>Well-nourished women are better able to provide for themselves, their</td>
</tr>
<tr>
<td>children, and their families.</td>
</tr>
<tr>
<td>Well-nourished mothers are more likely to have infants with healthy</td>
</tr>
<tr>
<td>birth weight; such children are less likely to suffer from malnutrition.</td>
</tr>
<tr>
<td><strong>Goal #4: Reduce child mortality.</strong></td>
</tr>
<tr>
<td>Reduce by two-thirds, between 1990 and 2015, the under-5 mortality rate.</td>
</tr>
<tr>
<td>Well-nourished mothers are less likely to bear low birth-weight babies</td>
</tr>
<tr>
<td>who tend to be at risk of dying in infancy.</td>
</tr>
<tr>
<td>Well-nourished mothers are more likely to have healthy babies who can</td>
</tr>
<tr>
<td>survive childhood illnesses.</td>
</tr>
<tr>
<td><strong>Goal #5: Improve maternal health.</strong></td>
</tr>
<tr>
<td>Reduce by three-quarters, between 1990 and 2015, the maternal mortality</td>
</tr>
<tr>
<td>ratio.</td>
</tr>
<tr>
<td>Women with adequate stores of iron and other micronutrients are less</td>
</tr>
<tr>
<td>likely to suffer fatal infections and are more likely to survive</td>
</tr>
<tr>
<td>bleeding during and after childbirth.</td>
</tr>
<tr>
<td>Well-nourished adolescent mothers are less likely to experience</td>
</tr>
<tr>
<td>obstructed labor than their undernourished peers.</td>
</tr>
</tbody>
</table>

**Lack of access to appropriate and good quality services**

Health care utilization among women in Africa remains poor because of several reasons. Health care utilization patterns are primarily affected by the limited availability of health resources. Moreover, the limited resources that do exist are also often underutilized. Among factors affecting the underutilization of health services is women’s perceptions of the services available. Women are less likely to seek care if they have poor perceptions regarding the quality of the services offered or if they have not been treated well by service providers. In some instances, women are denied...
access to care because of cultural restrictions or because the decision to seek care rests with other family members.

Lack of access to health services, including emergency obstetric care, contributes to high maternal mortality in a significant way. The “three delays” that women experience in receiving emergency obstetric care include (GHC, 2006):

- Delays in recognizing that complications are serious enough to require help;
- Delays in getting to a treatment center equipped for obstetric emergencies due to transportation problems or distance to the treatment center; and
- Delays encountered in starting treatment at a care facility due to lack of available trained health care personnel, life-saving drugs, and/or equipment.

The five major medical causes of direct obstetric deaths, which account for nearly two-thirds of all maternal deaths, are preventable, if the treatment is provided on time. Relatively simple and inexpensive medical technology for preventing almost all deaths from common obstetric complications have been available for nearly half-a-century.

Despite this, large numbers of women in developing countries continue to die, due to causes related to pregnancy and childbirth, and in some countries the rates of maternal mortality are on the increase. For example, in Zambia, maternal mortality increased from 649 per 100,000 live births to 729 per 100,000 live births from 1996 to 2001/2002 (ZDHS, 2003, p.245). The increasing rate is, in part, a reflection of the inability of the health system to provide emergency obstetric services. It is also an indication of women’s preference for delivering at home, often because of the reluctance to travel long distances and incur costs associated with hospital delivery (Geloo, 2003).

It is clear from the above that improving women’s access to good quality sexual and reproductive health services is vital. Such services can contribute to economic growth and equity in several ways. They allow young adults to stay healthy and productive and can also help prevent stigmatizing medical conditions. They enable parents to have smaller families and devote greater time and financial resources to each child, thereby reducing public expenditures on education, health care, and other social services. Access to appropriate health care services can also enable young women to delay childbearing until they have achieved their education and training goals. Improved reproductive health contributes towards improving women’s social position and increasing their community and political participation.

**Education and its impact on women’s health**

Female education is critical for improving women’s health. Studies show that educated women are more likely to know when and where to seek health care, comply with treatment and medication, and return for follow up care. The MDGs also emphasize female education, with the target being to eliminate gender disparity in primary and secondary education by 2015.

About 70 countries are at risk of failing to meet this objective (see Table 5). In sub-Saharan Africa, 31 countries have gender gaps in education. The literacy rate for women is 51%, while that of men is almost 70% (Figure 5).

Of all regions, female literacy in sub-Saharan Africa has experienced the lowest average annual growth in total years of schooling between 1960 and 1990. This constitutes an annual increase of 0.04 years, raising the average years of schooling of the adult female population by a mere 1.2 years. Gender inequality in education and employment is estimated to have reduced per capita growth in the 1960-92 period by 0.8 percentage points per year (UNESCO, 2003).

The declining rates in primary school enrollment in Africa are particularly alarming (Fig-
Kenya, Tanzania, and Zambia show a significant drop in primary school enrollment. This trend may be the result of HIV/AIDS and increased poverty. The AIDS epidemic is compromising opportunities for children to attend primary school. The impact of HIV/AIDS on education represents a vicious cycle affecting rates of enrollment, quality of education, and long-term development outcomes (Figure 7).

Mother’s education also affects children’s nutritional status (Figure 8). As indicated

![Figure 5](image_url)  
**Adult Literacy by Region**

**Table 5**  
**Prospects of Achieving Gender Parity in Primary and Secondary Education**

<table>
<thead>
<tr>
<th>Region/Group</th>
<th>Parity by 2005: No. of countries</th>
<th>Parity by 2015: No. of countries</th>
<th>At Risk of No Parity by 2015: No. of countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arab States</td>
<td>5</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Central Asia</td>
<td>3</td>
<td>—</td>
<td>2</td>
</tr>
<tr>
<td>Central/E. Europe</td>
<td>13</td>
<td>—</td>
<td>4</td>
</tr>
<tr>
<td>E. Asia/Pacific</td>
<td>5</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Caribbean</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>N. America/W. Europe</td>
<td>14</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>sub-Saharan Africa</td>
<td>4</td>
<td>9</td>
<td>16</td>
</tr>
<tr>
<td>S./W. Asia</td>
<td>2</td>
<td>—</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>52</td>
<td>22</td>
<td>54</td>
</tr>
</tbody>
</table>

*Source: UNESCO Education for all Monitoring Report (UNESCO, 2003).*
Figure 6
Declining Primary School Enrollment in Africa

Net Enrollment Ratio
Primary-school-age children enrolled as a percentage of primary-school-age children

Source: ORC Macro, Demographic and Health Surveys.

Figure 7
HIV/AIDS and Education

by data from Mali, 40% of children whose mothers have no education are stunted or nutritionally compromised, compared to only 14% of children whose mothers have had secondary education. Educated women also have healthier and fewer children than women who are not educated. Schooling tends to improve a mother’s knowledge of and use of health services with each additional year of schooling; it is also estimated to decrease under-five mortality by up to 10%. Women with schooling are also more likely to send their own children, especially girls, to school (World Bank, 1993).

**Figure 8**
Child Malnutrition, by Mother’s Education

*Children whose height is abnormally low for their age; clinically malnourished.
Source: ORC Macro, Demographic and Health Surveys.*
Africa has the highest fertility compared to other regions. On average, women in Africa have 5.3 children. With a population growth rate of 2.5%, there will be one billion people living in Africa by 2025.\(^6\) This will pose a tremendous strain on the meager resources of the region. Figure 9 shows that the total fertility rate in Africa has declined from 6.8 to 4.9 from the 1965–70 to 2000-05 period. Three decades of family planning programs and initiatives have contributed to only a modest decrease in fertility.

\(^6\) Only three countries in sub-Saharan Africa are estimated to have a negative population growth during 2001 to 2050. These include Botswana, South Africa, and Zimbabwe. The possible impact of the availability of ARTs is not known (PRB, 2001).

**Figure 9**
**Trends in Childbearing, by Region**

*Average number of children per woman*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>World</td>
<td>4.9</td>
<td>2.7</td>
</tr>
<tr>
<td>Africa</td>
<td>6.8</td>
<td>2.7</td>
</tr>
<tr>
<td>Asia</td>
<td>5.7</td>
<td>2.5</td>
</tr>
<tr>
<td>Latin America/Caribbean</td>
<td>5.6</td>
<td>2.4</td>
</tr>
<tr>
<td>More Developed Countries</td>
<td>2.4</td>
<td>1.6</td>
</tr>
</tbody>
</table>

The demographic transition in Africa is taking place at a much slower rate than in other regions. Several factors contribute to this phenomenon. The heavy toll of the HIV/AIDS epidemic is one such factor. Promoting fertility reduction is a challenge in settings that are grappling with the epidemic. The current trends of high fertility are expected to continue in the region.

The age of marriage in Africa contributes to the high fertility rates. Figure 10 shows that the median age of marriage for African women in selected countries is low, ranging from 16 in Niger to 19 in Benin and Zambia.

**Family planning**

The concept of family size limitation is alien to the norms and beliefs of many African societies. A small proportion of African women of childbearing age use contraceptives. In all sub-Saharan countries, except South Africa, the average number of children desired by women is 5.7. In some countries, such as Chad and Niger, it is as high as 8.5. In no country of the region is the average number of children desired less than 4. Figure 12 shows that in comparison to other countries, contraceptive use in Africa is the lowest and, correspondingly, the total fertility rate is the highest. The three most populous countries in the region, Nigeria with a population of 130 million, Ethiopia with 68 million, and Democratic Republic of the Congo with 54 million, have the lowest rates of contraceptive use. By contrast, in developed countries contraceptive use is high and, consequently, fertility is lower.

As shown in Figure 11, only 19% of women between the ages of 15 to 49 use some form of family planning and the remaining use no method. Among family planning users, a large number prefer traditional methods, i.e., the withdrawal and rhythm methods, which may not be as effective as modern contraceptive methods.

There are several barriers to contraceptive use in the region. These include lack of accessible family planning services, shortages of equipment, commodities, and personnel.
**Figure 11**
Contraceptive Use and Method Mix Among Married Women

*Family Planning Methods, Sub-Saharan Africa*
Married Women 15 to 49 Using Family Planning, Late 1990s

Note: Total exceeds 100 percent due to rounding.
*Source:* Data from DHS from 17 countries, calculated by Shea Rutstein, MACRO International.

**Figure 12**
Family Planning and Childbearing

*Percent of women 15 to 49 using family planning, mid/late 1990s*

- MDR*: 1.5
- LAC**: 2.7
- Asia: 2.6
- Africa: 5.2

barriers include: limited choice and availability of methods; lack of knowledge about the safety and effectiveness of contraceptives; poor client-provider interactions; financial constraints; lack of spousal or community support; misinformation and rumors; contraceptive side effects; and insufficient follow-up to promote method switching or to ensure proper use and dosage (UNFPA, 2004).

Cultural and religious beliefs in Africa provide support for high fertility. Women tend to adhere to cultural beliefs and are, therefore, more likely to prefer having a large number of children. This is particularly true of poor and uneducated women. Poor women are also less likely to have access to family planning services. The richest women are five times more likely to have access to and use contraception than the poorest women in the region (ibid: p.41).

There is also a stigma associated with infertility and low fertility. Undesirable fertility outcomes among women have led to divorce, loss of status and, in some cases, ostracism of women. In societies where a woman’s worth is measured by her ability to have children, there are limited means of acquiring social status other than childbearing.

Fertility also tends to be high when infant mortality is high. A comparison of fertility and infant mortality rates from different regions shows that in Africa, where infant mortality is the highest, fertility is also the highest.

A reason for high fertility in the region is that women continue to have children in the older age groups. Women in sub-Saharan Africa have more children in the older age groups than women in any other region of the world. Women over age 40 contribute an average of 0.5 children to the total fertility rate in the region.

Family planning programs in the region have been inadequate. In general, programs fail to take into account the effect of gender inequalities on women’s health. Sensitivity towards women’s rights, needs, dignity, and privacy is neglected in

Figure 13
Infant Mortality and Childbearing, by Region

Infant Mortality Rate and Total Fertility Rate

the provision of care. Family planning providers lack skills for providing gender-sensitive services and typically, the health center infrastructure does not allow women adequate privacy when seeking care.

The central focus of family planning programs has been on supplying contraceptives to women. There has been little emphasis on promoting informed choice and providing a comprehensive range of good quality services. Typically, such programs provide a limited range of services. Prenatal care, emergency, and essential obstetric care are typically not available (Evers and Juarez, 2002: p.24). Other women’s health concerns, such as malnutrition are not addressed through these programs. Moreover, insufficient attention has been given to the involvement of men in family planning.

Adopting family planning methods for birth spacing can lower the risk of infant mortality. The International Planned Parenthood Foundation estimates that 20% of infant deaths could be averted if all births were spaced by at least two years. The relative risk of child mortality has been shown to increase with short birth intervals (Figure 14).

### Benefits of Family Planning

Family planning allows women to space and limit childbirths, which in turn, leads to several beneficial effects for individuals, families, and communities, including:

- Improved maternal and infant health, expanded opportunities for women’s education, employment and social participation, as well as reduced health risks and abortion;
- Reduced competition and dilution of resources within the family, alleviation of household poverty, and more possibilities for shared decision-making; and
- Accelerated demographic transition and improved opportunities to use “the demographic bonus” to speed up economic development (UNFPA, 2004).
Adolescent reproductive health

Africa has the highest childbearing among teens globally. The age of marriage in Africa continues to be the lowest in the world (see Table 6 and Figure 15). The median age of first intercourse is not much different from the age at first marriage. While the age of marriage is increasing, the age of first sexual intercourse is not. In 13 countries of the region, 10 to 25% of unmarried adolescents were pregnant or had had a child[7] (Zlidar, V.M. et.al. 2003)

7 These countries are those where data has been collected since 1990.

---

**Table 6**

<table>
<thead>
<tr>
<th>Country</th>
<th>Median age of married women (25–49 years)</th>
<th>Median age of women at first marriage (25–49 years)</th>
<th>Percentage of teenagers who have begun childbearing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uganda, 2000-01</td>
<td>16.6</td>
<td>17.8</td>
<td>31.4</td>
</tr>
<tr>
<td>Kenya, 1998</td>
<td>16.5</td>
<td>19.2</td>
<td>20.9</td>
</tr>
<tr>
<td>Zambia, 2001-01</td>
<td>16.8</td>
<td>17.8</td>
<td>31.6</td>
</tr>
<tr>
<td>Tanzania, 1999</td>
<td>16.6</td>
<td>18.1</td>
<td>24.5</td>
</tr>
<tr>
<td>South Africa, 1998</td>
<td>18.4</td>
<td>24.2</td>
<td>16.0</td>
</tr>
<tr>
<td>Rwanda, 2000</td>
<td>20.1</td>
<td>20.7</td>
<td>6.8</td>
</tr>
<tr>
<td>Mozambique, 1997</td>
<td>15.9</td>
<td>17.1</td>
<td>40.0</td>
</tr>
</tbody>
</table>

*Source: Population Reference Bureau (PRB, 2004)*

**Figure 15**

Age at Marriage in sub-Saharan Africa

Median Age at First Marriage, Women 20 to 24 at Time of Survey

*Source: DHS STATcompiler, accessed online at ?????????????????, on July 22, 2004.*
Education has a significant effect on childbearing among teens (see Figure 16). Among teenage girls who had no education, a higher percentage was pregnant with their first child or had become mothers, in comparison with girls who had at least secondary school education. Childbearing during teen years is particularly risky because adolescents are more likely to suffer from the consequences of unintended pregnancies. Since adolescents are less likely to afford the costs of skilled providers, they often resort to unsafe abortions, which can pose serious health risks.

As indicated by data from 1998 to 2001, unwanted pregnancy among teens is very high in Africa (Figures 17 and 18). Almost 48% of adolescents in both Kenya and Ghana report that their pregnancies were unintended. Zimbabwe and Côte d’Ivoire also have very high rates of unintended births among adolescents; 41 and 35% respectively. In East Africa, Tanzania has the lowest rate of unintended births among teens, at 19%. In West Africa, the lowest figure recorded (11%) was in Niger.

**Infant and child mortality**

Worldwide, child mortality decreased over the past 25 years, but the pace of this decline slowed in the 1990s and, in some countries, the mortality rate increased during that period (Figure 19). At the current rate of progress, only a few countries are likely to achieve the MDG target for infant and child mortality reduction.

In low-income countries, one in 11 children dies before his or her fifth birthday, compared with one in 143 in high-income countries. The MDG progress report shows that there is a 20-fold increase in disparities in child mortality between the rich and the poor (Table 7).

Africa has the highest under-five mortality rate. The major causes of child deaths are as-
Figure 17
Unintended Births to East African Teens
Births to 15-to-19-Year-Olds Who Said Births Were Unintended
Percent

Source: ORC Macro, Demographic and Health Surveys.

Figure 18
Unintended Births to West African Teens
Births to 15-to-19-Year-Olds Who Said Births Were Unintended
Percent

Source: ORC Macro, Demographic and Health Surveys.
### Table 7
**Under-Five Mortality**

<table>
<thead>
<tr>
<th>Region</th>
<th>Under-Five Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>High income countries</td>
<td>6 per 1,000 live births</td>
</tr>
<tr>
<td>Developing World</td>
<td>88 per 1,000 live births</td>
</tr>
<tr>
<td>Poorest Countries</td>
<td>120 per 1,000 live births</td>
</tr>
</tbody>
</table>

*Source: Millennium Project: Interim Report, April 2004*

### Table 8
**Proportion of Under-Five deaths by Cause of Mortality**

<table>
<thead>
<tr>
<th>Disease and Condition</th>
<th>Proportion of under 5 deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal</td>
<td>33%</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>22%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>21%</td>
</tr>
<tr>
<td>Malaria</td>
<td>9%</td>
</tr>
<tr>
<td>Measles</td>
<td>1%</td>
</tr>
<tr>
<td>AIDS</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>9%</td>
</tr>
</tbody>
</table>

*Source: World Health Organization*
associated with poor nutrition and lack of basic amenities such as health care (Table 8). Neonatal deaths are often associated with maternal health conditions such as physical immaturity, poor nutrition, lack of prenatal, delivery, and postnatal care. Diarrhea, among the leading causes of child mortality, is associated with lack of sanitation and unsafe water supplies.

A vast majority of the estimated 8 million prenatal deaths (late miscarriages, stillbirths, and deaths in the first week of life) in developing countries are associated with maternal health problems or poor management of labor and delivery. For example, obstructed and prolonged labor asphyxiates an estimated 3% of newborns, resulting in the death of nearly 25% of these infants and brain damage in another 25%.

In addition, women suffering from poor nutrition and infections during pregnancy are more likely to have low birth-weight infants (weighing less than 2,500 grams). Low birth-weight infants are 20 to 30 times more likely to die in the first week of life than infants of normal weight. Those who survive are more likely to suffer disabilities such as cerebral palsy, seizures, and severe learning disorders.

Most of the infant and child deaths in Africa can be prevented. About 3,000 African children die from malaria each day; this is equivalent to one every 30 seconds (BBC NEWS, 2003).[8] Insecticide-treated bed nets protect fewer than 3% of children at risk of the disease in Africa. Most children contract malaria before they have acquired adequate clinical immunity. Ninety percent of all malaria deaths in Africa occur in young children. Repeated malaria infections make young children more susceptible to other common childhood illnesses, such as diarrhea and respiratory infections, and thus contribute indirectly to mortality.
Today, sub-Saharan Africa remains by far the region worst affected by the AIDS epidemic (see Table 10 and Figure 20). The region has just over 10% of the world’s population, but is home to two-thirds of all people living with HIV. According to the UNAIDS, an estimated 40 million people in the world are living with HIV. In 2003, an estimated 4.6 million people were newly infected with the disease and 2.8 million died of AIDS. More than 95% of the newly infected live in low- and middle-income countries; sub-Saharan Africa accounted for 3 million of these new infections and 2.1 million AIDS deaths (UNAIDS/WHO, 2005).

In sub-Saharan Africa, the HIV/AIDS epidemic is a significant social and economic problem. Recent research also points to the linkages

**Figure 20**
People Living with HIV/AIDS, by Region

between poverty, inequality, in particular gender inequality, and the AIDS epidemic.

The countries with the highest HIV/AIDS prevalence countries are in Africa (Table 9). Swaziland has the highest prevalence, at 38.8%. These figures demonstrate the disproportionate impact of the epidemic on the region.

As compared to other regions, life expectancy in the Africa region is the lowest. The toll of the HIV/AIDS epidemic has lowered the life expectancy in Africa and this trend is expected to continue in the years to come. The epidemic is generalized (1% HIV prevalence or above among 15–49 year-olds) in nearly every country in the region. Seven Southern African countries (Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe) have adult prevalence rates above 20%.

### HIV/AIDS and women’s health

Women and girls represent the majority of those infected with HIV worldwide (Figure 21). In sub-Saharan Africa, two-thirds of those infected are women. African women are considerably more likely—at least 1.2 times—to be infected with HIV than men. Among young people aged 15–24 years, this ratio is the highest; young women are 2.5 times more likely to be infected than young men (UN. 2004). However, women are not only more likely to get HIV/AIDS but they also get sicker at a lower viral load as compared to men.

The risk of contracting the HIV infection during unprotected sex is two to four times more for women than for men. These vulnerabilities are compounded by women’s inability to negotiate safe sex or refuse coercive sex. Women bear the brunt of the disease, not only as victims but also as caretakers of those affected. HIV/AIDS policies and programs must take account of these social realities when developing strategic interventions for reaching women.

### Orphans and HIV/AIDS

Today, there are about 34 million orphans in sub-Saharan Africa. The region accounts for the highest proportion of HIV/AIDS orphans worldwide (Figure 23). More than one million children under the age of 15 in sub-Saharan Africa have lost at least one parent to HIV/AIDS; more than half those orphaned by HIV/AIDS are between the ages of 10 and 15. The proportion of Africa’s orphans whose parents died from HIV/AIDS has grown from 3.5% in 1990 to 32% in 2001, which is expected to increase (Figure 24).

The orphan crisis in sub-Saharan Africa is expected to worsen dramatically in the coming years. By 2010, it is estimated that approximately 20 million children in sub-Saharan Africa will have lost at least one parent to HIV/AIDS.

Children are also at risk of contracting the infection. Nearly 10 million of the infected

---

**Table 9**

Top 15 HIV/AIDS Prevalence Countries in Africa (End 2003)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Country</th>
<th>HIV/AIDS Prevalence Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Swaziland</td>
<td>38.8</td>
</tr>
<tr>
<td>2</td>
<td>Botswana</td>
<td>37.3</td>
</tr>
<tr>
<td>3</td>
<td>Lesotho</td>
<td>28.9</td>
</tr>
<tr>
<td>4</td>
<td>Zimbabwe</td>
<td>24.6</td>
</tr>
<tr>
<td>5</td>
<td>South Africa</td>
<td>21.5</td>
</tr>
<tr>
<td>6</td>
<td>Namibia</td>
<td>21.3</td>
</tr>
<tr>
<td>7</td>
<td>Zambia</td>
<td>16.5</td>
</tr>
<tr>
<td>8</td>
<td>Malawi</td>
<td>14.2</td>
</tr>
<tr>
<td>9</td>
<td>Central African Rep.</td>
<td>13.5</td>
</tr>
<tr>
<td>10</td>
<td>Mozambique</td>
<td>12.2</td>
</tr>
<tr>
<td>11</td>
<td>Tanzania</td>
<td>8.8</td>
</tr>
<tr>
<td>12</td>
<td>Gabon</td>
<td>8.1</td>
</tr>
<tr>
<td>13</td>
<td>Côte d’Ivoire</td>
<td>7.0</td>
</tr>
<tr>
<td>14</td>
<td>Cameroon</td>
<td>6.9</td>
</tr>
<tr>
<td>15</td>
<td>Kenya</td>
<td>6.7</td>
</tr>
</tbody>
</table>

*Source: Population Reference Bureau (2004)*
### Table 10

<table>
<thead>
<tr>
<th>Region</th>
<th>Adults and children living with HIV/AIDS</th>
<th>Adults and children newly infected with HIV</th>
<th>Adult prevalence (%)</th>
<th>Percent of adults living with HIV who are women (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-Saharan Africa</td>
<td>23.0–27.9 million</td>
<td>2.7–3.7 million</td>
<td>6.7–8.1</td>
<td>57</td>
</tr>
<tr>
<td>North Africa and Middle East</td>
<td>200,000–1.4 million</td>
<td>31,000–200,000</td>
<td>0.1–0.7</td>
<td>50</td>
</tr>
<tr>
<td>South and South East Asia</td>
<td>4.0–9.7 million</td>
<td>410,000–2.0 million</td>
<td>0.4–0.9</td>
<td>25</td>
</tr>
<tr>
<td>East Asia</td>
<td>350,000–1.1 million</td>
<td>33,000–300,000</td>
<td>0.04–0.1</td>
<td>17</td>
</tr>
<tr>
<td>Oceania</td>
<td>38,000–99,000</td>
<td>2,600–27,000</td>
<td>0.2–0.6</td>
<td>44</td>
</tr>
<tr>
<td>Latin America</td>
<td>1.2–2.1 million</td>
<td>120,000–310,000</td>
<td>0.4–0.8</td>
<td>32</td>
</tr>
<tr>
<td>Caribbean</td>
<td>200,000–510,000</td>
<td>17,000–68,000</td>
<td>1.1–2.7</td>
<td>50</td>
</tr>
<tr>
<td>Eastern Europe and Central Asia</td>
<td>740,000–1.8 million</td>
<td>120,000–680,000</td>
<td>0.1–1.0</td>
<td>26</td>
</tr>
<tr>
<td>Western and Central Europe</td>
<td>550,000–870,000</td>
<td>13,000–37,000</td>
<td>0.2–0.4</td>
<td>27</td>
</tr>
<tr>
<td>North America</td>
<td>570,000–1.8 million</td>
<td>15,000–120,000</td>
<td>0.3–1.1</td>
<td>25</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>34.0–41.9 million</strong></td>
<td><strong>4.0–6.0 million</strong></td>
<td><strong>1.0–1.2</strong></td>
<td><strong>47</strong></td>
</tr>
</tbody>
</table>

*Source: AIDS epidemic update (UNAIDS/WHO, 2005).*

### Table 11
**Sub-Saharan Africa HIV and AIDS estimates (2003)**

<table>
<thead>
<tr>
<th>Category</th>
<th>Estimate (2003)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults (15–49 years) living with HIV</td>
<td>23,100,000</td>
</tr>
<tr>
<td></td>
<td>(Range: 21,400,000–25,700,000)</td>
</tr>
<tr>
<td>Women (15–49 years) living with HIV</td>
<td>13,100,000</td>
</tr>
<tr>
<td></td>
<td>(Range: 12,200,000–14,600,000)</td>
</tr>
<tr>
<td>AIDS deaths in adults and children</td>
<td>2,200,000</td>
</tr>
<tr>
<td></td>
<td>(Range: 2,000,000–2,500,000)</td>
</tr>
</tbody>
</table>

Figure 21
HIV/AIDS Demographics, Africa

Composition of the Infected Population, 2001
Sub-Saharan Africa


Figure 22
HIV/AIDS Demographics, Africa: Proportion of Cases by Gender

HIV/AIDS and Women’s Health

were between the ages of 15 to 24; almost 3 million of them were children under the age of 15 (UNICEF, 2002).

HIV/AIDS and the labor force

A significant proportion of the population in Africa is engaged in subsistence farming; women constitute a majority of these farmers. Women are major contributors to agriculture and economic productivity in the region. Thus, death and disability among African women due to HIV/AIDS results in significant losses in the labor force (Figure 25) and, consequently, a decline in agricultural productivity and increased poverty in the region.

HIV/AIDS Prevention and Care

The ‘HIV/AIDS prevention and care continuum’ model (Figure 26) demonstrates how men and women are affected at each stage of the disease’s progression. Because women are more likely to contract HIV/AIDS as well as to provide the care and support to families, the current disparities among men and women may become even more pronounced as the epidemic progresses.

HIV/AIDS programs must also address family planning and safe motherhood since these are critical avenues for HIV interventions. The momentum gained in the area of women’s reproductive health could have provided the impetus for HIV/AIDS prevention and care, thereby leading to a comprehensive agenda for addressing the health needs of women. This, however, has not happened.

Notwithstanding the clinical, biomedical, behavioral, economic, and even global security implications of the epidemic have influenced policies and programs. (meaning unclear) Indeed, the HIV/AIDS agenda has been fueled by media hype and led by lobbies backed by international finance. AIDS prevention projects and awareness campaigns have become a booming industry. HIV/AIDS work has become a cash cow that everybody wants to milk for the profit
it can fetch along with the respectability, if not the prominence, that is assured with its association. The AIDS prevention lobby has cultivated every influential sector within countries as well as funding agencies abroad. NGOs are flourishing and, as the numbers of those affected by the disease increase, so do the coffers of those in the HIV/AIDS business.

Figure 24
Number and Proportion of Orphans up to Age 14 in Sub-Saharan Africa, 1990–2010


Figure 25
Impact of AIDS on Agriculture in Africa

Agricultural Labor Force Lost to HIV/AIDS, 1985–2020 (Projected)

Percent

Figure 26
HIV/AIDS Prevention and Care Continuum

<table>
<thead>
<tr>
<th>HIV Infection</th>
<th>Onset of AIDS</th>
<th>Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninfected</td>
<td>Living</td>
<td>Living with AIDS</td>
</tr>
</tbody>
</table>

**Prevention:** behavior change, STI management, universal precautions

**Postexposure prophylaxis**

**Voluntary counseling and testing**

- Provide psychosocial support to patients and families
- Support orphans and vulnerable children
- Prevent and treat opportunistic infections
- Prevent mother-to-child transmission
  
  - Provide home-based care
  - Administer antiretroviral therapy
  - Provide palliative care

*Source:* Family Health International.
Women in Africa are afflicted by a range of infectious diseases and conditions encompassing those beyond reproductive health and HIV/AIDS. The following is an overview of the impact of the major infectious diseases on women’s health in the region.

**Tuberculosis**

Tuberculosis (TB) infection is transmitted via air, through coughing, sneezing, or even talking. The symptoms include fever, weight loss, and violent coughing, which disperses the bacteria in the environment and infects other individuals. Women tend to suffer disproportionately from the fallout of the TB epidemic. Women are less likely to seek treatment for themselves because their children’s and their husbands’ health concerns tend to be their priority. Women also tend to prioritize income generation activities over health concerns.

Tuberculosis cases in Africa, already in the millions (Figure 27), are expected to double over the next decade as HIV continues to spread across the continent. In many sub-Saharan African countries, especially in Central and East Africa, the incidence of TB has increased with the spread of HIV (Table 12). In several of these countries, one in three people with HIV die from TB and infect hundreds of HIV-negative persons with TB bacteria. In most sub-Saharan African countries, the magnitude of the threat of TB has not been acknowledged at the policy level.

Of the estimated 25 million Africans now living with HIV, about 8 million also harbor the bacillus that causes TB. Each year, 5 to 10% of these co-infected people develop active TB and up to half develop the disease at some point in their lives. Without treatment, people infected with TB typically die within months. In some regions in Africa 75% of HIV/AIDS patients are infected by TB; in countries such as Ethiopia, Kenya, Mozambique, Uganda, and Zimbabwe, fewer than 40% are receiving proper TB treatment. In Nigeria less than 10% are receiving treatment (WHO/UNAIDS, 2004).

Combining TB treatment with HIV testing and treatment could save up to 500,000 HIV-positive Africans every year. National TB programs in Africa are currently treating less than half of all HIV-positive people with active TB, despite the fact that the cost of TB drugs is as low as US$ 10 per patient. Indeed, few patients are currently being offered an HIV test or ARV treatments. (ibid.)
Table 12
HIV and TB

<table>
<thead>
<tr>
<th>TB in Africa</th>
<th>Relationship between HIV and TB</th>
<th>Treatment of TB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa has a TB incidence of 272 per 100,000. The rate for European countries is 27 per 100,000.</td>
<td>TB cases are increasing 10% per year in Africa because of HIV.</td>
<td>Untreated, a single person with contagious TB can infect between 10-15 people a year.</td>
</tr>
<tr>
<td>Nearly 1.6 million TB cases per year occur in sub-Saharan Africa.</td>
<td>There were nearly two million new TB cases in Africa in 1999.</td>
<td>A simple strategy called DOTS, which costs as little as US $10–15 per patient, cures most people with TB.</td>
</tr>
<tr>
<td>The number of TB cases in Africa will reach 3.3 million by 2005 and surpass 4 million shortly thereafter.</td>
<td>Two-thirds of those above also infected with HIV.</td>
<td>DOTS has successfully treated two million people with infectious TB.</td>
</tr>
</tbody>
</table>
| Ninety-five percent of the eight million new TB cases every year occur in developing countries. | Up to 50% of people living with HIV can expect to develop TB. |                                                                [
A priority in the region is the development of a sustainable TB control project and especially one that emphasizes treatment compliance among patients. Patient compliance is integral to the success of TB treatment. Compliance among women especially needs to be improved. The stigma attached to TB often results in women being divorced by their husbands and isolated from society. Health policies are needed to create community programs with the involvement of different community groups to address this issue in a culturally acceptable manner (Amazigo, year).

Innovative strategies will have to be adopted to achieve this objective. Such strategies can include, training non-health personnel to provide treatment, utilizing community-based service provision approaches, and training women as peer educators to reach patients in their communities. Local women’s groups can also aid in identifying potential TB patients and facilitate improved compliance among patients who are already receiving treatment.

**Malaria**

Malaria is a parasitic infection that presents a serious threat to pregnant women and young children in sub-Saharan Africa. In Africa, about 30 million women living in malaria endemic areas become pregnant each year. For these pregnant women, malaria is a threat both to themselves as well as to their babies. Overall, there are about 200,000 newborn deaths each year as a result of malaria in pregnancy. (WHO, 2003a)

*Plasmodium falciparum*, the type of malaria most prevalent in Africa, is known to cause maternal anemia and impaired fetal growth, both of which contribute to low birth weight in newborns. Malaria can also cause spontaneous abortion, stillbirth, premature birth, and intrauterine growth retardation. Maternal death may result either directly from severe malaria or indirectly from malaria-related severe anemia. A woman’s immunity to malaria may be compromised by HIV infection; both the prevalence and the intensity of malaria infection during pregnancy are higher among HIV-positive women.

In areas of high and moderate (stable) malaria transmission, most adult women have developed sufficient immunity so that, even during pregnancy, the infection does not usually result in fever or other clinical symptoms. In these areas, the principal impact of malaria infection is malaria-related anemia in the mother and the presence of parasites in the placenta. The resulting impairment of fetal nutrition contributes to low birth weight and is a leading cause of poorer infant survival and development. In areas of Africa with stable malaria transmission, *Plasmodium falciparum* infection during pregnancy is estimated to cause an estimated 75,000 to 200,000 infant deaths each year.

Malaria cases are on the increase, with roughly quadruple the number of cases in the 1990s compared to the 1970s, and two to three times the number of deaths recorded in hospitals. In large part, this is due to high levels of resistance to the drugs chloroquine and sulphadoxine-pyrimethamine. By 1999, resistance rates ranged from 28 to 97% in Tanzania, 66 to 87% in Kenya, and 10 to 80% in Uganda. Poor and pregnant women and their babies are particularly at risk. Malaria costs Africa an estimated $12 billion/year in lost gross domestic product (WHO/UNICEF, 2003; Philips-Howard *et al.*, 2003).

Timely antenatal clinic attendance is essential for delivering the prevention package to pregnant women. Some 40% of pregnant African women present for the first time to antenatal clinics in the second trimester of pregnancy and about 25% come for the first time in the third trimester.

About two thirds of pregnant women in sub-Saharan Africa attend antenatal clinics at least once during pregnancy to prevent and treat malaria. The aim is to deliver this package—especially intermittent preventive treatment—to pregnant women as part of their routine antenatal care, using and strengthening the existing antenatal care infrastructure. This strategy is now
an integral part of WHO’s “Making Pregnancy Safer” initiative, which aims to strengthen antenatal services and provide preventive measures, treatment, care and counseling to improve all aspects of health in pregnant women and their newborns.

Insecticide-treated nets (ITNs) are the most effective method for the prevention of malaria in sub-Saharan Africa (Philips-Howard et al., 2003). ITNs have been shown to decrease severe malaria by 45%, reduce premature births by 42% and cut all-cause child mortality by 17%–63%. In order to meet the theoretical need among the most at-risk populations, WHO estimates annual need for over 32,000,000 ITNs (AED, 2006).

In some countries, the price of a treated bed-net is as much as 8% of per capita GNP. Subsidies and other forms of support to help women buy and use malaria nets are underway in a few countries. For example, the government in Tanzania eliminated taxes on mosquito nets and anti-malaria chemicals in keeping with a pledge which was made in 2000 along with 15 other African countries at a meeting on malaria in Abuja, Nigeria. Waiving the taxes has lowered the costs of nets and encouraged investment in related industries. Nevertheless, a recent National Institute for Medical Research (NIMR) study found that even after the waiver not even 2% of Tanzanians slept under nets. The country has received at least US $19.8 million from the UN Global Fund to support the country’s National Insecticide-Treated Nets Implementation Plan (NatNets). To reduce further the cost to pregnant women and women with children below age five, the government launched a pilot system in 2003. Under this scheme, women are given vouchers to buy bed nets from designated shops at a cost between 500 shillings (50 US cents) and 700 shillings (70 US cents) depending on size. So far, the scheme, which is funded by the UN Children’s Fund at a cost of $11 million, is only available in two of Tanzania’s districts, Kibaha and Kilosa, where more people die from malaria than anywhere else in the country. The scheme could eventually be available throughout the country if the government can raise the necessary funds. The target is to have 60% of pregnant women and children below age five using insecticide-treated nets by 2007 (IRIN, 2004).

Trachoma

Trachoma is an eye infectious disease, which is the world’s leading cause of preventable blindness. According to the WHO, 6 million are blind due to trachoma, and more than 150 million people are in need of treatment. Repeated infections scar the upper eyelid eventually turning it inward. It is common in rural communities where access to clean water and health care is limited and overcrowded living quarters are common (WHO, 2001).

Proper hygiene, including face washing and keeping surroundings clean, can prevent the infection. The availability of clean water and its distribution patterns among the family members are important determinants of disease prevention. Women’s appreciation of the importance, as well as the ways of preventing infection also plays an important role.

Trachoma is primarily a disease affecting women. The rate of trachoma and the risk of blindness are three to four times higher in women than men. However, surgery to correct advanced stages of trachoma is more likely to be carried out on men than women. Eye surgery

9 The reduction in taxes by the five countries is in response to the Abuja Declaration of April 25, 2000, signed by representatives of 38 African states. In a move that promises to protect millions of people from the danger of malaria, five African countries have recently reduced or abolished taxes on insecticide-treated bed nets (ITNs) to make them more affordable to their populations. They include: Ivory Coast, Nigeria, Tanzania, Uganda and Zambia (IRIN, 2004).
rates are 1.2 to 1.7 times higher for men than for women, despite the fact that women account for 63% of all cases for potential surgery.\footnote{The Vision 2020 Initiative (WHO/IAPB, 1999) and the work of Dr. Paul Courtright and Dr. Ken Basset of the Kilimanjaro Center for Community Ophthalmology and the British Columbia Center for Epidemiological and International Ophthalmology. Additional information also obtained from International Trachoma Initiative: Strategy to combat trachoma in the following countries, Ghana, Mali, Morocco, Tanzania and Vietnam as the first countries. By 2001, Ethiopia, Nepal Niger and Sudan were included in the program.}

Gender disparities in receiving surgical treatment from trachoma result from a variety of socioeconomic and cultural factors. Men tend to be more likely to afford the cost of surgery as compared to women. Women also tend not to seek treatment because they underplay their own discomfort and disease symptoms.

### Other tropical diseases

Other tropical diseases affecting women in Africa include schistosomiasis, intestinal helminthes, and filariasis. Parasitic worms transmitted by exposure to infested water and food cause schistosomiasis and intestinal helminthes, which infect 200 to 250 million people around the world. Filariasis, which afflicts about 120 million people worldwide, results from long, thread-like worms that are transmitted by mosquitoes, mites, or flies.

The effect of these diseases during pregnancy depends on the severity of the infection and the stage of the pregnancy. These diseases can result in anemia or malnutrition, both of which can have serious consequences for a pregnant woman and her fetus. They are also associated with other reproductive health concerns such as reduced fertility, contraceptive use complications, or other harm to a pregnant mother or her fetus (Otieno-Nyunya, 1999; PRB/ACCP, 2004).

Tetanus is another illness that affects both mothers and newborns. Infants are at increased risk of contracting the disease when their umbilical cords are cut with unclean instruments or treated with unhygienic traditional concoctions that can cause infections.

### Cervical cancer

Eighty-three percent of the world’s new cases and 85% of all cervical cancer deaths occur in developing countries and sub-Saharan Africa is one of the regions where it is most prevalent. Cervical cancer results from the abnormal growth and division of cells at the opening of the uterus or womb—the area known as the cervix. The human papillomavirus (HPV), a sexually transmitted infection (STI) is considered to be the underlying cause of this cancer. The virus is often without symptoms and there is no known cure for HPV. While the infection remains stable or becomes undetectable in most cases, HPV can lead to precancerous conditions that progress to cancer over time. Cervical cancer can be precipitated by conditions, such as HIV/AIDS, which compromise the immune system.

A significant majority of women who contract HPV are young and the cancer most likely develops in women who are 35 or older. Prevention of HPV infection would sharply reduce cervical cancer rates and efforts to develop a vaccine have generated tremendous hope in this regard. In the meantime, however, the Pap smear test, which can be easily done, can detect the growth of abnormal cells and treatment for this has been highly successful in developed countries where cervical cancer rates have been reduced dramatically.

The lack of comprehensive reproductive health services hinders cervical cancer awareness raising and prevention efforts. As a result, many women die because of this condition. Including cervical cancer screening into an integrated package of women’s health services is essential.
While as many as 450 million people suffer from mental or behavioral disorders, 40–70% of the patients do not receive treatment even in developed countries with well-organized health care systems. The treatment gap is more startling in developing countries, being close to 90%. The WHO warns that mental health problems are a major challenge to global development as they affect society as a whole (WHO, 2003b).

Mental disorders are firmly rooted in the social environment of individuals, with several social factors associated with their onset, course and outcome. Significant life events act as stressors that can predispose individuals to mental disorders. The effect of stressors is not just limited to mental disorders but is associated with a number of physical conditions, such as myocardial infarction.

Certain population groups, such as refugees, internally displaced persons (IDPs), and survivors of disasters, are exposed to extreme stressors. These groups make up over 40 million people worldwide, the majority of whom are located in sub-Saharan Africa. Women and children in particular, tend to be at greatest risk for mental health problems, comprising approximately 80% of those at risk.

The availability of clinical care and treatment, access to medication and rehabilitation of mental health patients all remain limited. There is thus, a critical need for policies and interventions aimed at addressing this burden of mental health disorders.

**Women and mental disorders**

Sociocultural, economic, legal, infrastructure and environmental factors affect women’s mental health in each country or community setting. Women experience tremendous mental health burdens due to a variety of factors, including: gender discrimination, physical and sexual violence, racism, lack of access to appropriate physical and mental health care, nutrition and education, high rates of non-literacy, the burden of being the family caretaker, and limited opportunities for power and decision-making.\(^{11}\)

Medical evidence points to gender-specific vulnerabilities in mental health problems. Unipolar

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\(^{11}\) The World Health Organization (WHO) has concluded that women living in poor social and environmental conditions are prime candidates for mental disorders (Sandrasagra, 2000).
and bipolar depression occurs approximately twice as often in women than in men. Women are over-represented in insecure job conditions and unpaid labor; they also tend to be predisposed to chronic stress with regard to their personal and family situations (Sandrasagra, 2000).

The multiple roles that women play put them at greater risk for mental problems. Juggling multiple tasks such as household, child-care, food production, etc. increases the risk of mental and behavioral disorders. Twice as many women as men suffer from depression. Certain groups such as migrant and poor women are at greater risk.

Women experience not only mental health problems disproportionately, but are also responsible for taking care of those who have mental health disorders. Mental health issues have been exacerbated by the HIV/AIDS pandemic in Africa. In many cases, very young and very old women have had to assume responsibilities for their surviving family members. Stress resulting from these added responsibilities placed upon them can lead to psychological disorders.

Many women who take care of the sick tend to neglect their own health. They are also more likely to blame themselves for contracting the disease and feel responsible for leaving children behind after death or transmitting the infection to them. The stigma and discrimination against people with HIV/AIDS also contributes to the psychological distress associated with the disease.

**Gender-based violence**

Certain fundamental values are essential to international relations in the twenty first century, including freedom, equality, and tolerance. Men and women have the right to live their lives and raise their children in dignity, free from the fear of violence, oppression or injustice. Furthermore, no individual and no nation must be denied the opportunity to benefit from development. The equal rights and opportunities of women must be assured. Finally, human beings must respect each other in all their diversity of belief, culture, and language. Differences within and between societies should neither be feared nor repressed. Rather, such diversity should be cherished as a precious asset of humanity. A culture of peace and dialogue among all civilizations should be actively promoted. [13]

Violence against women and girls includes physical, sexual, psychological, and economic abuse. It is often known as ‘gender-based violence’ because it evolves, in part, from women’s subordinate status in society. Figure 28 which presents an ecological model of factors associated with partner abuse, demonstrates the ways through which violence is perpetrated on women and the levels at which these are reinforced and made acceptable. Despite its importance, the role of the state is not specified in this model. The state can enforce legislations or punitive measures that can decrease violence against women.

Violence against women is associated with a variety of negative physical and mental health outcomes such as fractures and internal organs injury, unwanted pregnancy, gynecological problems, depression, low self-esteem, post traumatic stress disorder, etc. The violence sometimes leads to fatal outcomes, including suicide, homicide, maternal mortality, and HIV/AIDS. (UNICEF, 2000).

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12 **Sexual violence** has been defined by the international Criminal Tribunal for Rwanda as “any act of sexual nature committed on a person under circumstances, which are coercive.” According to the ICTR, sexual violence includes rape as well as acts, which may not involve penetration or even physical contact, such as forced nudity. (Prosecutor v. Akayesu, ICTR, 1999).

13 Violence against women refers to “any act of gender based violence that results in or is likely to result in physical sexual and psychological harm or suggesting to women, including threats of such acts, coercion or arbitrary deprivation of livery, whether occurring in the public or in the prove life (Declaration on the Elimination of Violence Against Women: Article I, UN, 1993).”

Figure 28
Ecological Model of Factors Associated with Partner Abuse

- Norms granting men control over female behavior
- Acceptance of violence as a way to resolve conflict
- Notion of masculinity linked to dominance, honor, or aggression
- Rigid gender roles
- Poverty, low socioeconomic status, unemployment
- Associating with delinquent peers
- Isolation of women and family
- Marital conflict
- Male control of wealth and decision-making in the family
- Being male
- Witnessing marital violence as a child
- Absent or rejecting father
- Being abused as a child
- Alcohol use

Source: Adapted from Heise 1998 (210).

Figure 29
Experience of Spousal Violence by Women

Recent data show the significant levels of violence women experience in their own homes at the hands of their partners or husbands (Figure 29). It should be noted, that such violence experienced by women in the home often tends not to be reported or prosecuted.

**Conflict, lack of democracy and governance**

The conflicts in Africa have been particularly brutal, causing tremendous loss of life and displacement of people. The conflicts have lasted many years and have been characterized by brutal violence including rape, severing of limbs, genocide, and mass migration. Countries in the region that have endured war and conflict for several years include Angola, DRC, Eritrea, Ethiopia, Liberia, Mozambique, Rwanda, Sierra Leone, and Sudan.

There has been an unprecedented number of conflict-related deaths in Africa in the past years. In 1990, the highest number of war-related deaths worldwide was in sub-Saharan Africa (52.9 per 100,000). (Reza, A. et al., 2001). Women and girls constitute the largest share of the refugee and displaced populations. Conflict, civil war, and lack of good governance place women at a particular risk of direct and indirect gender-based violence. The following data illustrate the enormity of this crisis:

- In DRC, 2.5 million deaths were attributable to the conflict and one in eight households experienced at least one violent death; women and children accounted for 40% of these deaths.
- One hospital in Brazzaville reported treating 1,600 raped women over a six-month period.
- Up to 80% of the displaced women in Liberia have had an induced abortion by age 15, including girls as young as 11 years.
- Over 50% of women in Sierra Leone suffered some type of sexual abuse during the period of conflict.
- Over 500,000 refugees died fleeing from Rwanda after the genocide.
- Over one million people were killed during the Rwandan genocide within a period of 100 days.
- Survivors of the Rwandan genocide who have been raped show a dramatic increase in the rate of HIV/AIDS.
- In Sierra Leone, rebels chopped arms, legs of civilian men, women, and children, crippling them for life.[14]

Armed conflicts have always caused ill health and disease throughout history. In Africa too, conflicts in the past years have had a devastating impact on the health of the region’s people. The following are some of the ways in which conflict has affected health:

- The diversion of resources into conflict has led to a breakdown of health services.
- The displacement of populations has left many without food, water, shelter or health care (UNIFEM, 2002).
- There has been an increase in malnutrition and famine because of disruptions in food production.
- The use of food as a weapon in some conflicts has also caused serious problems of malnutrition, including anemia, which has been exacerbated by disease and lack of adequate sanitation.
- Gender-based violence has resulted in the rise of STIs and unwanted pregnancies.
- The burden on women for caring for the sick, traumatized, injured, or maimed has increased.[15]

14 The brutality of these actions can be demonstrated by the account of the people in these areas where rebels sometimes asked those who were to be the victims of this assault if they want “short sleeves or long sleeves”.

15 Data collected from the UNIFEM report (UNIFEM, 2002) and other sources (newspapers, articles and personal information from refugees and displaced population)
• Infectious disease epidemics resulting from these crises last long after the conflict is over. Some of the diseases that commonly emerge after wars are measles, tuberculosis, pneumonia, and cholera.
• Injuries and wounds caused by land mines are a remnant health crisis following conflicts and wars.

War compounds the risks for all other health conditions, especially for women and girls. UNIFEM recommends the following efforts for addressing women’s health in areas of conflict:

• Recognition of the special health needs of women such as injuries, including amputations;
• Special attention to the provision of adequate food supplies for displaced and war affected populations in order to protect them and to prevent sexual abuse and exploitation;
• Protection against HIV/AIDS and provision of reproductive health services; and
• Immediate provision of emergency contraceptives and STI treatment for rape survivors (ibid: p. 137).

Adverse social and economic conditions occurring during periods of instability tend to increase violence against women. These include:

• Economic instability: increased unemployment, reduced public expenditure, and increased poverty, resulting from economic instability are conditions associated with violence against women, prostitution, trafficking of women, male alcoholism, and domestic violence.
• Labor trends: large numbers of women make up the informal sector, which in turn puts them at risk of harassment, gender discrimination, and violence.
• Introduction of cash crops: women have to travel longer distances for water, fuel, and farm work, which exposes them to risk of sexual assault.

• Civil unrest and violence: increases risk of violence against women including rape, and rise in fundamentalism constrains women’s autonomy. Sexual exploitation and rape is also used as a weapon of war.
• Changing family dynamics: changed roles of women due to migration of males for long periods and changed family dynamics among refugees and IDP camps create antagonism and familial and community violence (Mclean and Sicchia, 2004).

Unstable situations have also led to marital dissolutions, an increase in transaction sex, risk of infections, and unwanted pregnancies. The evidence shows that over 90% of areas that experienced civil wars had fertility rates of 3.01 or higher. Moreover, states with high fertility rates are twice as likely to experience internal conflict as countries with low fertility rates (while controlling for other possible causes of internal conflict) (Caprioli, 2003).

The greatest number of deaths of women is among those aged 15-29; some 25,000 women in this group died directly of conflict in 2000. The highest mortality rates of conflict and war are among men aged 15-44. However, when direct fatalities are estimated by age and sex, children, women, and adolescents account for a significant proportion of deaths (UNIFEM, 2002).

The adverse impact of war on adolescents, resulting from trauma and lack of support and services have been documented. When social structures breakdown, young people frequently engage in high risk drug use or sexual behavior. The presence of peacekeeping forces and humanitarian workers, who are usually male, increases the demand for commercial sex, leading to sexual abuse and exploitation of adolescents.

Higher levels of gender inequality increase the likelihood of domestic conflict (Caprioli, 2003). Over 90% of instances of civil war occurred in non-democratic states. Gender inequality is a manifestation of structural and cultural violence. Inherent norms of discrimination and violence
appear to be symptoms of heightened levels of societal violence.

Seventy-two percent of areas that experience civil wars have a per capita income less than or equal to US$1,000. Half a million people fled their homes because of violence during the first nine months of 2001 in Central Africa and in the Horn of Africa (USCR, 2001). In 2000 alone, UNIFEM reported that conflict directly resulted in an estimated 310,000 deaths, with more than half occurring in Africa.
Cultural factors not only define women’s roles and status in African society, but also impact upon their health. Both traditions and institutions tend to reinforce and maintain the status quo in gender inequality. Some of the ways in which women are disadvantaged include being denied access to credit, productive inputs, education, training, information, and medical care. Laws and regulatory practices also prevent women from maximizing their potential. Imbalances in resource allocations resulting from such discrimination carry high development costs.

**Customary and traditional law**

The subordination of women is maintained through social, cultural, and psychological mechanisms that are reinforced through religious, cultural, and traditional practices. Customary laws handed down from generations have created sanctions that reproduce and maintain gender inequality. Pre-colonial sub-Saharan Africa was characterized by dynamic societies whose customs evolved with changing economic, social, and political circumstances. Customary law dictating marriage, custody, inheritance patterns, and delegation of roles and responsibilities emerged during this period. These have historically influenced women’s lives in African societies. As such:

“The differences between women and men are socially constructed and changeable over time, and have wide variations within and between cultures. Gender is a socioeconomic and political variable with which to analyze roles, responsibilities, constraints and opportunities of people, it considers both men and women in their power relations. Through the cultural stamp of gender, individuals absorb and reproduce what is permitted and prohibited, thus, shaping their perceptions and sense of responsibilities with respect to all the social facets of life.” (Cohen and Burger, 2000)

Despite constitutional provisions to guarantee gender equality in many countries, women are discriminated against covertly and overtly. Moreover, the application of civil law is not uniform and many women are caught between customary and civil law. The basic tenets of both customary and civil law continue to deny rights and privileges to women while giving them additional responsibilities and burdens.

At the household level, women are denied the right to make decisions regarding the allocation
of resources in the family because they do not have control over income and property. The responsibility for bearing and nurturing children is predominately that of women, yet the primary decision-makers remain men. Women are also underrepresented at the policy level and therefore their voices are not heard. If women are not given control over resources, they will remain unable to adopt non-traditional roles.

Women reproduce gender inequalities because they are socialized in a patriarchal system. (to be revised) Changing gender inequalities would require the participation of both men and women. African countries do not yet have adequately strong civil society networks to advocate for such change. Education can provide opportunities for addressing gender inequalities in Africa. Through education, the next generations of men and women can be provided with information and skills to question and challenge gender inequalities.

### Women in decision-making

Women comprise 13% of national legislators and 14% of government ministries worldwide. Among policy-making areas, economics and finance have the lowest number of women represented across all countries. Women tend to be better represented within ministries of social welfare and health. Women also remain under-represented within international institutions that make policy, commit resources, and determine development priorities. The gender breakdown of the Board of Governors and the Board of Directors at the World Bank and the IMF illustrates this disparity (see Table 13).

At the Fourth World Conference on Women in Beijing, a goal was set to achieve one-third representation of women in national parliaments. Currently, only 11 countries in Africa have achieved this goal. In Nigeria, for example, women represent only 3.2% of the seats in national parliament. In sub-Saharan Africa, elections were held in 23 countries during 2000-2002. Out of these countries, women’s representation showed an increase in 14 countries. (Mutume, G. 2004). In four countries, there was no change in the proportion of women representatives and in another four, the proportion actually decreased. Mozambique and Uganda were two countries where the representation of women increased. In Burundi, women’s representation jumped from six to almost 20%, and in Rwanda, women’s representation rose from 17 to 25%.

### Women’s productive roles

From the small-scale farmers along the Niger River in Sahelian Africa, to the famous market

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**Table 13**

Gender Breakdown of Board of Governors and Board of Directors of the World Bank and the IMF[^16]

<table>
<thead>
<tr>
<th>Institution</th>
<th>Male</th>
<th>Female</th>
<th>% Male</th>
<th>% Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>World Bank Board of Governors</td>
<td>171</td>
<td>10</td>
<td>94.5</td>
<td>5.5</td>
</tr>
<tr>
<td>IMF Board of Directors</td>
<td>24</td>
<td>0</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>World Bank Board of Directors</td>
<td>22</td>
<td>2</td>
<td>91.7</td>
<td>8.3</td>
</tr>
</tbody>
</table>

[^16]: Table constructed from data provided by the Gender and Peace Building Program. Boards are appointed by national government. At the IMF women comprise of 63% of alternatives to the Board of Governors and 4.2% of alternatives to the Board of Directors. At the World Bank, women comprise of 9% of alternatives to the Board of Governors and 16.7% of the alternatives to the Board of Directors.
women of Ghana, from the fishmongers along Lake Victoria to the Congolese cloth traders, and the thousands of chocolate-colored women who now ply their trade across the Indian Ocean to Dubai, Hong Kong, and Bangkok—the fingerprints of the African woman are in every successful and meaningful economic endeavor in Africa today. In spite of all this, the African woman essentially remains the mother, the caretaker of the sick, and the revered wife, even as she struggles to succeed in her economic pursuits.\(^{17}\)

The scope and range of activities that women undertake ensures their survival and that of their families. In addition to their economic activities, women are active within their communities and are a source of support to their societies. Women’s community roles include their involvement in faith-based organizations, credit schemes, and revolving funds. Women struggle to overcome poverty and subordination to contribute to these efforts.

It is well documented that women in the region work longer hours than men. Figure 30 compares the number of hours of labor contributed by men and women in Cameroon. In Uganda, women work more than twice as long, which is 50 hours a week compared to men’s 23 hours. (UNFPA, 1999). Much of women’s productive work is unrecorded and not included in the System of National Accounts (SNA).\(^{18}\) The division of labor between men and women contributes to gender-related differentials in health.

Table 14 provides data from various countries in Africa which demonstrate women’s range of activities and the time they devote to each on a regular basis. In addition to these routine activities, women have to accommodate disruptions, such as caring for sick children. Seasonal patterns of disease also impact upon women’s abilities to fulfill these responsibilities. Some diseases occur during seasons when the demand for labor is the highest. At times, women are not

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17 Mamphela Ramphele (Managing Director, WB), Dialogue with African Ambassadors Meeting, April 12, The World Bank.

18 In Kenya, for example, it is estimated that nearly 60% of female activities are not captured by the SNA, compared to only 24% of male activities.
are able to excuse themselves from work to recover fully from childbirth or other debilitating conditions. Women’s health and welfare are seriously compromised in these situations.

Children, too, contribute to household chores in a significant way. Even when both boys and girls are engaged in the household, girls carry a disproportionate burden of work, which includes fetching water (Table 15)\(^{19}\) and caring for younger siblings. This limits their abilities to attend school, as noted in Table 14.

\(^{19}\) Inadequate water and sanitation has been flagged as a barrier to female education in Africa, with an estimated 1 in 10 not attending school during menstruation or dropping out at puberty due to the absence of clean and private sanitation facilities.
tend school. Data compiled by the International Food Policy Research Institute (IFPRI) indicate that African women perform the following tasks (Quisumbing et al., 1995): 

- 90% of the work of processing food crops and providing household water and fuel wood;
- 80% of the work of food storage and transport from farm to village;
- 90% of the work of hoeing and weeding; and
- 60% of the work of harvesting and marketing.[20]

**Access to water**

Despite the fact that global consumption of water is doubling at more than twice the rate of human population growth, access to clean water sources for Africa has not changed significantly during the last decade. The Millennium Development Goal # 7 seeks to “halve the proportion of people who are unable to reach or to afford safe drinking water” (World Bank, 2004). With water sources dwindling and the global consumption of water expected to double in the next 20 years, attaining this goal is a major challenge.

In addition to its impact on subsistence agriculture, access to water affects a household’s drinking, cooking and bathing activities and, hence, the overall health of the family. Women are the world’s primary water collectors and domestic workers. They are responsible for finding alternative water sources if clean water is not readily available. This responsibility increases their burden of work by adding several hours of labor every day.

Head loading is associated with a plethora of negative health outcomes including chronic pain, fatigue, stunted growth and loss of time and energy. Women living in urban slums have insufficient and contaminated water available to them. In addition, they have to stand in line for hours to wait for their turn at communal water sources.

**Harmful traditional practices**

Female genital mutilation, also known as female genital cutting (FGC), is a traditional practice which involves the removal of all or part of the female genitalia. FGC is practiced on 2 million girls and women every year, primarily in sub-Saharan Africa (GHC, 2006). It is estimated that 130 million women worldwide have undergone FGC. The procedure is prevalent in about 28 African countries and among a few minority groups in Asia.[22] Figure 31 shows the preva-

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20 It should be noted that there are marked sub-regional variations in men and women’s share of work; in much of the Sahel, men predominate in agriculture, including in the food sector.

21 Adapted data from UNIFEM (2004).

22 Types of female genital cutting (FGC):
- Type I: excision of the prepuce, with or without excision of part or all of the clitoris.
- Type II: excision of the clitoris with partial or total excision of the labia minora.
- Type III: excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulations).
- Type IV: pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue.
- Scraping of tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purpose of tightening or narrowing it; and any other procedure that falls under the definition given above (WHO, 2000).

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Table 15

<table>
<thead>
<tr>
<th>Number of hours traveled per day</th>
<th>8 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance to water sources</td>
<td>10 to 15 kilometers</td>
</tr>
<tr>
<td>Volume of Water to be transported</td>
<td>15 to 20 liters in each trip</td>
</tr>
</tbody>
</table>
lence of FGC among rural and urban women in several African countries during 1999-2000. The reasons why FGC is practiced include:

- **Psychosexual reasons**: the belief that reduction or elimination of the sensitive tissue of the outer genitalia, particularly the clitoris, attenuates sexual desire in females, maintains their chastity and virginity before marriage and fidelity during marriage. It is believed to increase male sexual pleasure as well.
- **Sociological reasons**: adherence to cultural heritage, initiation of girls into womanhood, social integration and the maintenance of social cohesion;
- **Hygiene and aesthetic reasons**: the external female genitalia are considered dirty and unsightly and are removed to promote hygiene and provide aesthetic appeal;
- **Health reasons**: the belief that it enhances fertility and increases likelihood of child survival;
- **Religious reasons**: some Muslim communities practice FGC in the belief that it is demanded by the Islamic faith. The practice, however, predates Islam.

The prevalence of FGC in Africa varies from about 5% in DRC and Uganda to 98% in Somalia. It is estimated that 15% of all circumcised women have undergone the most severe form of FGC infibulations which involves the stitching and narrowing of the vaginal opening. Approximately 80 to 90% of all FGC in Djibouti, Somalia and Sudan are of this type.

FGC has long been a controversial issue and the topic has received wide-ranging publicity. Advocating against FGC as an act of violence against women can lead to the criminalization of the practice. However, the cultural context within which it takes place also needs to be addressed. Other underlying causes of FGC include poverty and subordination of women. FGC is also seen as a practice that compromises women’s rights.

The reproductive health and rights agenda can include FGC prevention efforts. This would provide mechanisms for involving men, women, religious leaders, health providers, and policy makers in this mission. Disseminating information regarding harmful consequences of FGC and delegitimizing it would be important steps in this regard.

This issue has gained international recognition after being highlighted by social activists. Several governments in Africa have consequently taken steps to eliminate the practice of FGC in their countries. These steps include laws criminalizing FGC, education, and outreach programs, and the use of civil remedies and administrative regulations to prevent the practice.\[23\]

### Religious factors affecting women’s health

Religion dictates norms and behaviors that impact upon women’s lives and health in many ways. Although it can be interpreted in ways that can support women’s empowerment and autonomy, religion tends to support patriarchal systems and prevents women from exercising their rights. In sub-Saharan Africa, the majority of the population is either Christian or Muslim and a minority subscribe to traditional beliefs.

Women who adhere to the Muslim faith in sub-Saharan Africa reclaim their rights not through the rejection of Islam, but through relevant knowledge of the Quran and the Hadith to defend their positions. Islamic fundamentalism presents a challenge for women rights. AIDS, poverty, gender-based violence, and lack of ac-

\[23\] Thirteen countries—Benin, Burkina Faso, Central African Republic, Chad, Côte d’Ivoire, Djibouti, Ghana, Guinea, Kenya, Niger, Senegal, Tanzania, and Togo—have enacted laws criminalizing FC/FGM. The penalties range from a minimum of six months to a maximum of life in prison. Several countries also impose monetary fines. In Egypt, the Ministry of Health issued a decree declaring FC/FGM unlawful and punishable under the Penal Code.
countability can fuel fundamentalist sentiments. These can lead to distorted interpretations of religion for oppressing women’s autonomy, particularly as it relates to matters of sexuality, reproductive health and equality.

**Figure 31**

Female Genital Cutting by Residence

Prevalence Among Women 15 to 49 Living in Urban, Rural Areas

Percent

Health Services for Women

In Africa, women’s relationship with health services is variable, as sometimes they are the providers of health services, and at other times, they are consumers. In both roles, women face unique challenges.

**Women as caregivers**

Women are the primary caregivers of their family on health-related matters. They care for the young, the sick, the elderly, and the disabled. Often women have to take care of their family members when they are sick themselves. Women carry a heavy burden of disease and disability, particularly between the ages of 15-49 years. During these years, they also play the most active role as caregivers. Since women contribute in a major way to household responsibilities, earnings, and expenses, their disability can have profound consequences for their families and the broader community (Reed *et al*., 2000: pp.6, 17).

When health systems are weak or not available, women have to take the responsibility of being the primary providers of health care to the family. This increases women’s burden of work, especially for those who are poor. In addition their proximity to sick family members makes them more vulnerable to contracting infections, such as tuberculosis. Furthermore, the increased burden puts women at risk for stress-related disorders.

Men often make decisions about household expenditures, regardless of who earns the money. Gender-biased social norms favor men’s well-being over women’s. These norms influence patterns of households’ expenditure on health in ways that put girls and women at a disadvantage (Evers and Juarez, 2002: p.10). Women’s perceptions of diseases and illnesses and their access to treatment facilities are determined by their roles and responsibilities. Factors such as opportunity costs, time constraints and fees, cause them to neglect their own health.

**Women as consumers of health care**

1. **Access to and quality of health care services**

Women need access to quality health services, particularly during their reproductive years when their health risks are the greatest. Yet during these years, they face major constraints in accessing health care services. These constraints emerge from a host of reasons which include:
• Low priority given to the rights, needs, dignity and privacy of women;
• Lack of sensitivity given to women’s preferences and needs in the design and construction of maternal health centers and public health clinics;
• Insufficient priority given to malnutrition among young girls;
• Insufficient attention given to the attitudes of service providers; and
• Failure to take into account the effect of women's work on their reproductive health.\[24\]

The household socioeconomic status often determines women’s ability to seek antenatal care. Poor women are less likely to use antenatal services than their better off counterparts. In seven sub-Saharan African countries, the percentage of affluent women attending antenatal clinics was twice as high as that of poor women. Antenatal care coverage was also significantly higher in urban than in rural areas.

The MDG interim report shows that health systems in developing countries are in crisis. Women’s utilization of health services is hindered by the following problems:

• Users routinely describe abusive and humiliating treatment by health providers;
• Health providers report dehumanizing and demoralizing work conditions;
• Shortage in staffing health facilities makes reliable quality services virtually unattainable;
• Ministries of Health are grossly unprepared to manage the crisis, a situation often exacerbated by rapid decentralization and a proliferation of uncoordinated donor-driven initiatives; and
• The lack of basic drugs and equipment cripples functioning of health systems and inflates out-of-pocket costs to patients (Freedman et al., 2004: p.16).

2. Cost of health care services

The costs and time required by poor women to utilize public health facilities is already high. There is evidence of the gender impact of user fees for health services, mostly in sub-Saharan Africa. In Nigeria, the evidence points to a 50% increase in maternal deaths and a 4% decline in hospital deliveries in the Zaria region. A decline in the use of maternal and child health services in Zimbabwe has also been observed. Overall, the data show that:

• User fees do not guarantee greater efficiency and effectiveness of health services;
• The market does not necessarily work for health sector services;
• User fees collect a very modest amount compared with the budgetary resources allocated to basic social services;
• User fees lead to a reduction in the utilization of services, particularly among the poor.
• Protecting the poor is difficult because exemption schemes seldom perform well and are costly to administer; and
• User fees aggravate gender biases, seasonal variations, and regional disparities (Evers et al. 2002).

The quality of care in private sector services has also declined due to competitive pressures to cut costs. Globalization and increased integration in the region is accompanied by local trends towards social fragmentation and disintegration. Liberalization and integration processes have been asymmetric and uneven across countries, classes, and genders.\[25\] Therefore, globalization is associ-


\[25\] Grown et al., 2000, as quoted in Evers and Juarez, 2002: p. 1146
ated with a squeeze in resources devoted to care in the public, private, and domestic sectors.\[26\]

Additionally, sectoral reforms instituted in poor countries of sub-Saharan Africa prevent the majority of people from accessing basic health services. In the case of Ghana, this led to the infamous ‘cash and carry program’ under the last government (Bruce, 2003).

\[26\] The realities of cuts in public spending in response to an increasingly competitive international economic environment restrict many sources of revenues (e.g., trade tariffs, taxes on foreign investors) previously available to government to fund publicly provided services. Moreover, competitive pressures to cut costs compromise the quality of care in private sector services.
Women’s reproductive health has to be viewed within the broader context of their sociocultural and economic aspects of their lives. The separation of women’s reproductive health from other facets of their lives creates an artificial distinction. The failure to link women’s reproductive and productive roles undermines the development of health interventions and strategies that are effective and acceptable to women.

Today, women in Africa are the unsung heroes who are rising to the challenges of poverty, conflict, lack of democracy, good governance, and the HIV/AIDS epidemic. Their sheer survival is a testament to their capacity to fulfill multiple roles and rearrange priorities on a daily basis, under precarious and rapidly changing circumstances. It is clear from the issues elaborated above that there is a need for a holistic perspective which looks far beyond biomedical and clinical interventions, if efforts to improve the health of African women are to be truly effective. This section distills ten key recommendations resulting from the deliberations regarding the harmonization of such holistic approaches to the advancement of women’s health in the region.

1. Women’s empowerment should be redefined broadly, in order to reflect the complex sociocultural realities they face. Women’s empowerment should also be promoted individually, collectively, and across generations, through the effective engagement of men. Men should be recognized both as essential partners and as beneficiaries of efforts to empower and improve the health of women.

Women’s empowerment is a culture-specific construct that is difficult to measure. Women’s empowerment initiatives must be based upon the daily realities of their lives. It should take account of the culture and the communities women live in. Involving men in women’s health and empowerment efforts is vital.

Women’s health concerns should go beyond the focus on women’s oppression by men. It will be difficult to mobilize males as partners if they are portrayed only as predators and perpetrators of negative situations for women. Men who see the empowerment of women as a threat to their own power should not be excluded from these efforts. Rather, they should be sensitized to take responsibilities for women’s health and empowerment. For example, men can participate in traditional female roles such as caring
for children. They can assume responsibilities for seeking health care for women, for example, by arranging transport to health clinics. Negative attitudes of health providers may change if both men and women together seek quality care and accountability from them.

Efforts to involve men should emphasize that their support for women will lead to their own empowerment in the long run. The goal of empowering women will be achieved when both men and women understand, embrace, and promote this idea.

Inclusion of other groups such as religious leaders, policy makers, and donors is also necessary to promote women’s empowerment. These efforts should include promoting dialogue and changing laws and legislations. The concerted efforts of various stakeholders are needed to promote women’s empowerment as a national and global priority.

Empowerment should also be promoted as an inter-generational concept. Women may not be able to exercise their own individual empowerment because the social, economic, and cultural costs may be insurmountable. However, they can help the next generations of women, including their daughters, sisters, and nieces to accomplish their dreams. For instance, a mother can encourage her daughter to continue with her education. Mothers can also protect their adolescent children from unwanted pregnancies, STIs, and HIV/AIDS by making them aware of measures to prevent these problems.

Empowerment efforts must take account of the broader context and recognize that both individual and collective empowerment involving the entire community is necessary. Collective empowerment also means that cultural, social, and religious structures become agents of change supportive of women. In addition, women’s groups and associations whether formal or informal are important vehicles for promoting women’s access to power, status, and resources.

Women in African societies face hurdles in changing or adopting new behaviors without the sanction of their extended family and kin groups. The support of community groups in which women often play important roles, can be vital in this respect. Collectively, these groups can create opportunities for empowering women. For example, they can support women’s health outside the clinic walls and health centers. These groups provide untapped resources for promoting women’s health and rights.

2. Collaborative relationships among professional organizations and community groups at the grassroots level can provide valuable opportunities for promoting women’s health.

Professional associations play a valuable role in promoting women’s health in Africa both as practitioners and as advocates. However, mechanisms for collaboration among them have been limited to workshops, meetings, and conferences. Such associations rarely join forces with grassroots community groups working on women’s health issues. In sub-Saharan Africa, the relationships between grassroots and professional groups have not yet been adequately developed.

The benefits of such collaboration have been demonstrated by several examples. The contributions of African gynecologists, for instance, have led to the recognition of post abortion care as an important issue. Similarly, women lawyers’ associations in many African countries have worked for revisions in customary law on marital age, violence against women, inheritance rights, marriage, custody, and divorce rights.

Development activities have ignored the potential contributions professional associations can make towards empowering women. These groups have the potential to contribute to an individual initiative or an issue for which collaboration between disciplines is required. Groups of teachers, health care providers, lawyers, doctors, religious associations, and chambers of commerce can establish linkages with grassroot efforts so that their contribu-
tions can be effectively utilized for empowering women.

In sum, professional groups, such as journalists, lawyers, nurses, midwives, physicians, and grassroot women’s associations can play complementary roles in changing gender relations, promoting women’s empowerment, and reproductive rights.

3. Promoting the capacity of African researchers and research institutions can enhance their contributions to the advancement of women’s health in the region.

African researchers and academics often feel left out from processes for defining research agendas in the region. Their contributions as researchers often occur in subordinate roles to researchers in the developed world. In general, there is a paucity of research by developing country researchers. Lack of resources hinders the capacity of researchers in the region. Increasing the capacities of African researchers and research institutions in defining research agendas and conducting independent research is an important priority in the region.

The internet provides a valuable forum for information exchange among researchers, and this medium can be used for expanding this effort. Professionals working on different aspects of women’s health in Africa can share their experiences and ideas through internet-based forums.

4. A new paradigm supportive of women’s empowerment should be sought within the context of religion by emphasizing interpretations in support of gender equity and women’s rights. Women’s health concerns can be advanced by building on basic religious principles, such as charity and volunteerism and concepts of democracy, accountability, transparency, and social welfare which are embodied in religious doctrines.

Most religions sanction patriarchy and uphold the subordination of women. However, there are several instances across Africa where religious groups have provided health care to women and are dedicated to helping women and children. Many of these religious groups exist as legacies of the colonial rule in Africa. They are good examples of how religion can be interpreted in ways that can have a positive impact on women’s lives.

The conservative interpretations of religions, including Islam and Christianity, can be detrimental to women’s rights, gender equity and reproductive health. There is, however, a lack of clarity and consensus on the interpretation and application of religious principles with regard to women’s health and development. ‘Tithes’ among Christian groups and ‘Zacat’ among Muslim groups are principles that require members to help those who are less fortunate. Development programs can build on these religious principles. Democracy and governance issues such as accountability, transparency, and social welfare issues are embodied in religious doctrines and can be utilized as a foundation for building consensus on women’s empowerment. Issues related to violence against women, early age of marriage, and social welfare programs can be addressed through these efforts. The spirit of volunteerism advocated in most religions can also be used to support activities related to women’s health. Community participation in matters related to health and gender equity can be fostered by encouraging volunteerism among men and women.

5. Traditional forms of African medicine should be better understood, strengthened, and integrated into mainstream health services, in order to enhance women’s access to health care resources.

Typically, low-income households that do not have access to biomedical services turn to traditional forms of medicine for health care. Research is needed for understanding systems of traditional medicine, including self-care and home-based care. Such research may show notable gender dif-
differentials in access to and use of these alternative systems of traditional medicine. Gender differences have been noted in region in health care-seeking patterns for conditions such as trachoma and STIs. Women tend to try options such as self-treatment and traditional medicine more often. The reasons could be that they have less disposable income and time or that they feel alienated from the biomedical health system. At times, traditional treatments are the only health care options available to women. Many women also prefer the care provided by traditional birth attendants during their deliveries.

Factors which often limit women from accessing biomedical health care include the distance of facilities, the cost of the services they provide, and the lack of culturally appropriate care. Alternative forms of care based on traditional treatments have to be integrated into mainstream health services in order to reach women. Toward this end, strategies for delivering health care to women through channels other than clinics and hospitals have to be developed. Efforts have to go beyond providing basic training to traditional birth attendants. Instead, concerted and consistent efforts are required along with sufficient resources to meet this objective.

6. Women’s significant contributions within Africa’s informal sector should be recognized; support for their significant economic and social activities can help lessen the excessive work burdens and responsibilities placed on them and strengthen efforts aimed at improving their health and well-being.

Women are major contributors to Africa’s informal sector. African women have traditionally worked as traders; the task of going to the market for buying and selling has largely been considered the domain of women. Today, the informal sector is undergoing change, leading to a worsening situation for women. Factors such as lack of collateral, absence of the input of child labor when children go to school, and limited opportunities for men to find employment have increased women’s burdens substantially.

Moreover, a significant number of households in Africa are female-headed. In such households, women work independently to finance their own sustenance and that of their children. Often, they also have numerous other obligations including towards friends, members of their extended families, and aging parents.

Special strategies and interventions are needed to address the health needs of women living in these difficult circumstances.

7. The MDGs and other relevant global initiatives should be revised to include reproductive health as an explicit priority.

Six years after the International Conference on Population and Development in Cairo, attention to the reproductive health agenda seems to be on the decline. Reproductive health priorities have not been included in the MDGs. The addition of an explicit target on sexual and reproductive health services is now being advocated. The recommendations state that “Sexual and reproductive health and rights are essential to meeting all the MDGs, including MDGs 4 and 5 on child and maternal health” (Freedman et. al. 2004: p.12). Ensuring that sexual and reproductive health concerns receive the priority they warrant would require that:

- MDG strategies include the international agreement of universal access to reproductive health services through the primary care system, with appropriate indicators reflecting progress towards reducing unmet need for contraception;
- Initiatives addressing the HIV/AIDS pandemic, including the Global Fund and WHO’s ‘3 by 5 strategy’ be explicitly linked to programs, particularly those providing contraceptive and STI services and sexuality information and education; and
- Adolescents receive explicit attention and services sensitive to their special vulnerabilities
and designed to meet their particular needs (ibid).

HIV/AIDS, malaria and tuberculosis are the three infectious diseases that are being addressed on a priority basis through various national, regional, and international efforts such as the Global Fund. Reproductive health is being neglected. In the longterm, this will prevent overall health gains from being achieved.

8. Broader strategies are needed for addressing reproductive health in the context of efforts aimed at advancing gender equity and development initiatives for improving the quality of life in African communities. Such a broad foundation can provide the impetus for building effective HIV/AIDS programs. In turn, greater support is needed for ongoing HIV/AIDS prevention and care programs which give priority to women’s health; efforts should be made to capitalize on the opportunities that such programs provide for addressing the multiple needs of women.

The promotion of reproductive choice and rights for men and women for attaining reproductive health and gender equity was established during the Cairo Conference in 1994 (UN, 1994). The major accomplishment of the conference was situating reproductive health within the broader definition of development and gender equity. This shift in focus from demographic targets towards the broader objective of achieving sustainable results, which impact not only fertility, but also the quality of life of communities, was vital. [27]

Reproductive health allows women not only to take control of their biological reproduction, but also to have more choices and alternatives for empowerment. Efforts must go beyond increasing contraceptive use to encompassing broader health and development perspectives. As such, there is a need to address reproductive health in the region through broader strategies.

Enabling women to choose the number and spacing of their children should be viewed as a fundamental right. Towards this end, support is needed for legislation enforcing land rights, an acceptable minimum age at marriage, eradication of harmful traditional practices, and prevention of gender-based violence.

The foundation created by reproductive health programs provides a springboard for building HIV/AIDS programs. The HIV/AIDS epidemic should have strengthened the case for investments in the comprehensive health needs of women. On the contrary, the disease has taken on a dimension that cannot easily be accommodated within the women’s health agenda. In fact, to some extent and in some settings, reproductive health is being subsumed within the context of HIV/AIDS, rather than vice versa.

Family planning services to prevent unwanted pregnancies could be easily integrated within the context of HIV/AIDS programming. The impacts of specific socio-cultural and economic risk factors which expose populations to HIV/AIDS are the same for unwanted and unintended pregnancies. These include, early age of sexual intercourse, social norms and expectations which often limit women’s ability to negotiate if and when to have sex, and sexual exploitation or violence within or outside marriage (to be revised) (CHGE, 2004).

Thus, there have been missed opportunities in ongoing HIV/AIDS prevention and care programs for addressing women’s health needs. Women are disproportionately affected as both victims of HIV/AIDS and caretakers of those who have the disease. This additional burden only adds to other problems facing women’s health. Efforts are needed to:

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[27] Yet, exclusion of reproductive health concerns in the Millennium Development Goals (despite the fact that maternal conditions are the third leading cause of death among women in developing countries), is characteristic of the declining priority placed on women’s health, and in particular reproductive health and rights.
• Support HIV/AIDS interventions which focus on women’s health as a priority agenda and address the multiple needs of women;
• Collect and utilize data disaggregated by gender to understand where the priorities lie and develop strategies for addressing them;
• Develop integrated strategies to promote HIV/AIDS programs by investing in the overall wellbeing of women;
• Solicit and seek collaborations with organizations working in women’s health to build HIV/AIDS prevention and treatment programs;
• Mobilize resources for HIV/AIDS as part of a broader reproductive health agenda without compromising attention to other women’s health issues;
• Develop quantifiable indicators to measure the progress of women’s health with regards to global initiatives to combat malaria, HIV/AIDS, and tuberculosis; and
• Develop quantifiable indicators for measuring women’s health in order to monitor progress and accountability.

9. Greater attention should be given to the promotion of reproductive health among African adolescents.

The promotion of reproductive health awareness among adolescents needs more emphasis and focus than it is currently being given. Adolescence is a time when lifelong behavior patterns, especially those related to gender, are formed. Empowering youth with values and behaviors to be healthy and productive adults is necessary. Youth empowerment efforts should promote an appreciation for women’s work and worth. They can also seek to identify and reinforce positive new constructs for concepts of femininity and masculinity, including motherhood and fatherhood, with a view to creating an “environment for health” rather than an “environment for disease”.

10. Particular attention should be paid to the special reproductive health needs of refugees and IDPs throughout Africa.

In conflict-ridden areas, the reproductive health needs of refugees and internally displaced persons should be addressed. A policy called the Minimum Initial Service Package (MISP) recommends a series of actions needed to respond to the reproductive health needs of populations in the early phases of a refugee situation. Its objectives are to:

• Prevent and manage the consequences of sexual violence;
• Reduce HIV transmission;
• Prevent excess neonatal and maternal morbidity and mortality; and
• Plan for comprehensive reproductive health services when the situation permits.

In conflict-ridden areas, the scope of violence against women is different and the sanctions against men who perpetrate violence are eroded. When conflict and displacement occurs, there are few safeguards that are available to women to redress violence; consequently, unsanctioned behavior often goes unpunished. The loss of identity and dignity for women is particularly acute in conflict situations. The breakdown of traditional support systems, for example, as male members flee or become a part of the conflict, further exacerbates the situation.[28]

Policies and programs are needed by governments and international partners to protect women in conflict situations and provide them with information and services for their sexual and reproductive health needs.

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[28] Sanctions against men who engage in such violence can come from other family members, religious or cultural institutions, or informal women’s groups. Even though violence against women occurs in traditional settings, its scope in situations of conflict is different. When conflict and displacement occurs, the loss of identity and dignity, further distort traditional gender inequities, thus essentially rendering women the spoils of war.
Thirty-eight of the world’s 63 low-income countries are in Africa. Of its 500 million people, over 40% live on less than US$1 a day and the situation is becoming worse.

Most African governments allocate low expenditures for health care, typically less than US$15 per person a year. Forecasts anticipate per capita growth in the region averaging 1.5% over the 2005–2015 period—a reversal of the region’s long-term historical decline. However, even this is far short of the growth needed to reduce poverty to half of that of the 1990 level. In fact, in sub-Saharan Africa the number of the poor is expected to rise from 315 million in 1999 to 404 million by 2015.

Africa also remains highly dependent on commodity exports and is still experiencing political and economic instability. Slow growth in sub-Saharan Africa has meant increases in both the share and the number of the poor in the 1990s, making it the region with the largest share of people living on less than US$1 a day. (use of term “share” may be unfamiliar to some—recommend changing to “percentage”)

Modest investments in women’s development can have far-reaching benefits. Investments in women’s health, education, and income generation translate into significant gains in family health and welfare. Women can pass on the benefits of investments made in their health to their families by earning more and investing in the next generation.

While the gains that have been made to promote gender equity have been small, they have resulted in increased enrollment in education and participation in the workforce. These developments have not been sufficient, however, to achieve gender equity, which is a complex and longer-term challenge. The new opportunities created for women have increased the costs associated with stress and overwork. Women now have additional burdens but no longer have the traditional systems of support at their disposal. For example, women who have migrated to urban areas do not have access to the traditional support systems that exist in rural communities. The health conditions of poor urban women are thus, at greater risk.

Throughout the region, human-made and natural disasters, such as conflict and famine, have dislocated families, particularly women and children who are most vulnerable. Gender-based violence, in particular rape, occurs at an alarming rate during periods of chaos and dislocation. Violence also disrupts the already precarious levels of safety and security women have within traditional systems.
Migration, a byproduct of both poverty and urbanization, has increased the number of women-headed households in the region. Marriage patterns are changing due to declining disposable incomes, and increasing instability and insecurity. Transaction sex is occurring at higher rates and the risk of infections and unwanted pregnancies has increased. Another challenge is the HIV/AIDS epidemic which disproportionately affects women due to both biological and social vulnerabilities.

The productive and reproductive roles of women should remain the rallying point for all sectors to attain successfully goals and objectives for promoting development, peace, and good governance. Women should be considered as partners who can accelerate the development agenda if given choices and alternatives. Their current potential and contribution should be testament to the capacity they have to mobilize and organize resources and to invest in their families. Their health, therefore, should be of paramount importance.
## Appendix

**List of External Participants***

| Embassy of Algeria          | H.E. Idriss Jazairy            |
| Embassy of Angola           | H.E. Josefina Diakite          |
| Embassy of Benin            | H.E. Cyrille S. Oguin          |
| Embassy of Burkina Faso     | Mr. Charles B. Todjinou        |
| Embassy of Cameroun         | Mrs. Ma Ouedraogo              |
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| Embassy of Ethiopia         | Mr. Gizachew Bizuayehu         |
| Embassy of Gabon            | H.E. Jules Marius Ogouebandja  |
| Embassy of Guinea           | H.E. Rafiou Barry              |
| Embassy of Lesotho          | H.E. Molelekeng Rapolaki       |
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| Embassy of Mali             | H.E. Abdoulaye Diop            |
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| Embassy of Mauritius        | H.E. Usha Jeetah               |
| Embassy of Mauritius        | Rajkuwar Sookun                |
| Embassy of Mozambique       | H.E. Armando A. Panguene       |
| Embassy of Namibia          | H.E. Leonard N Iipumbu         |
| Embassy of Nigeria          | Mr. Enaruna E. Imohe           |
| Embassy of South Africa     | H.E. Barbara Masekela          |
| Embassy of South Africa     | Mrs. Nobayeni Dladla           |
| Embassy of Swaziland        | Nomalungelo Magagula           |
| Embassy of Uganda           | H.E. Edith G Ssempala          |
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*Additional external and WB participants who joined the dialogue after the official registration time are not listed here.
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RBM. Roll Back Malaria (RBM) is a global partnership of national governments, civil society, non-governmental organizations, research institutions, professional associations, the United Nations, and development agencies, development banks, the private sector and the media. Roll Back Malaria aims to halve the world’s malaria burden by 2010. (see: www.rbm. who.int/)


