

Chapter 3:

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

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



High fertility rate

Sub-Saharan Africa has the highest fertility rate worldwide, estimated at 5.2. In some countries, e.g., Chad, Democratic Republic of Congo, Niger and Uganda, fertility rates may be as high as 6.0 and beyond.³ A high fertility rate is associated with low contraceptive prevalence.⁴ According to WHO one in four women wishing to delay or stop childbearing in the African Region does not use any family planning method.⁵ The reasons for this include the poor quality of available services and the

limited choice of methods on offer. The low uptake of contraception is often blamed on knowledge of and attitudes toward family planning, the accessibility of contraception and gender relations as regards women's power to negotiate the terms of sexual activity.⁶ However, this issue is also significantly influenced by cultural constructs that should be taken into account in any meaningful discussion of women's health. Indeed in many African cultures, motherhood is at the very core of the social nexus and high expectations are placed on women of reproductive age regarding the children they must bear.⁷ Thus, a woman's identity is often associated with her capacity to give birth and in some traditional settings the main purpose of socialization of women is to enable them to give birth, to serve as a midwife to others, and to nurture children. Therefore, under cultural pressure to bear children, women tend to regard contraception not so much as a way of avoiding pregnancy but as a means to manage their reproductive life in ways that will secure their position in a society dominated by their in-laws. They may even

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

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

The neglected problem of unsafe abortion

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

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

The scourge of HIV

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

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

Region	Estimated number of women above 15 years living with HIV (thousands)	HIV prevalence among young people aged 15 to 24 %
Sub-Saharan Africa	12 000	3.2
Eastern and Southern Africa	8 970	4.5
West and Central Africa	3 000	1.9
Middle East and North Africa	220	0.2
South Asia	930	0.2
East Asia and the Pacific	750	0.1
Latin America and the Caribbean	660	0.4
CEE/CIS (Central and Eastern Europe and the Commonwealth of Independent States)	460	0.5

Source: UNAIDS: Geneva; 2008.

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

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



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

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

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

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

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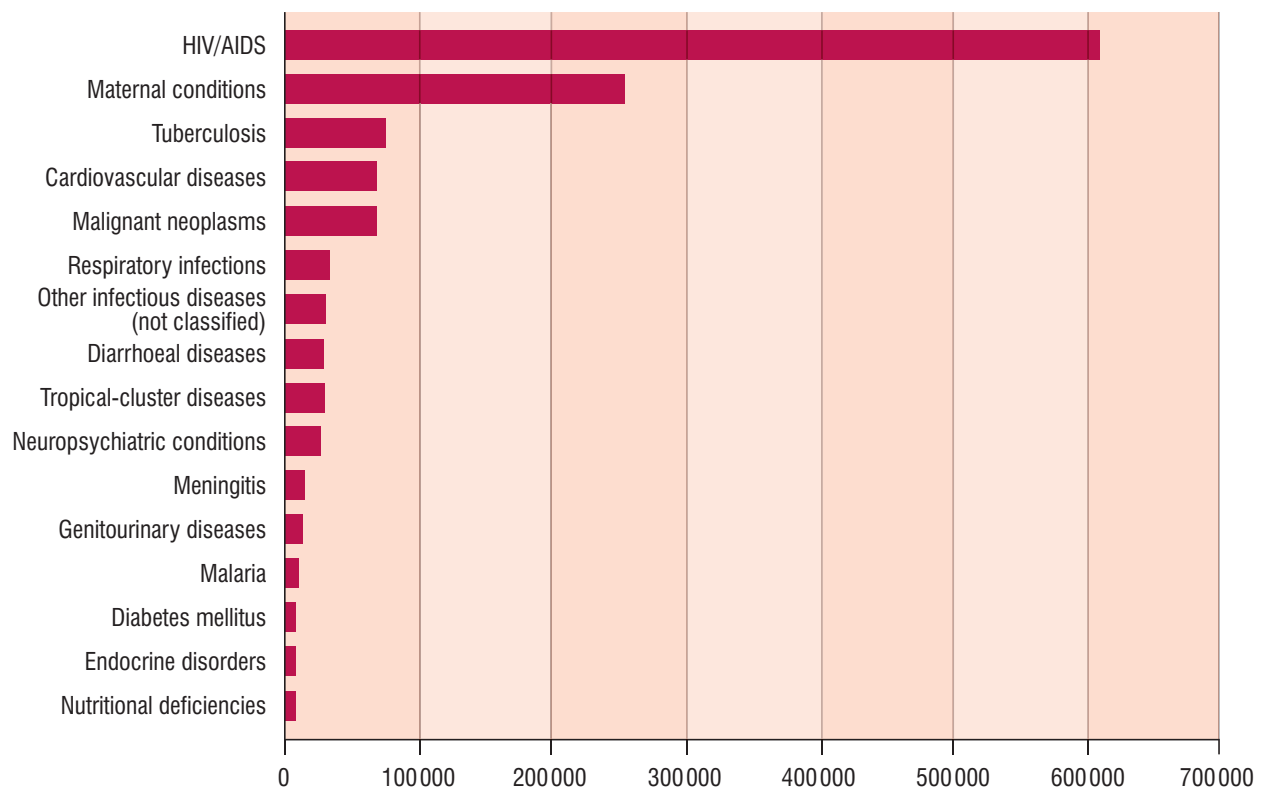
The high unmet sexual and reproductive health needs especially of young women, a population that is severely affected by both HIV and violence, underscores the urgent need to address MDGs 3, 4, 5 and 6 put together, i.e., to take a multisectoral approach to what is truly a multisectoral problem. This also means embarking upon a wide consultation on women's health issues and actively bringing together stakeholders from multiple sectors to convince leaders to allocate more resources for women's health.²⁴ In some countries this process has already started. In Cameroon, for example, the involvement of the ministry of finance in the development of the reproductive health commodity security strategic plan helped raise awareness of the need to make provision for contraceptives in the national budget.²⁵

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

Poor maternal health care

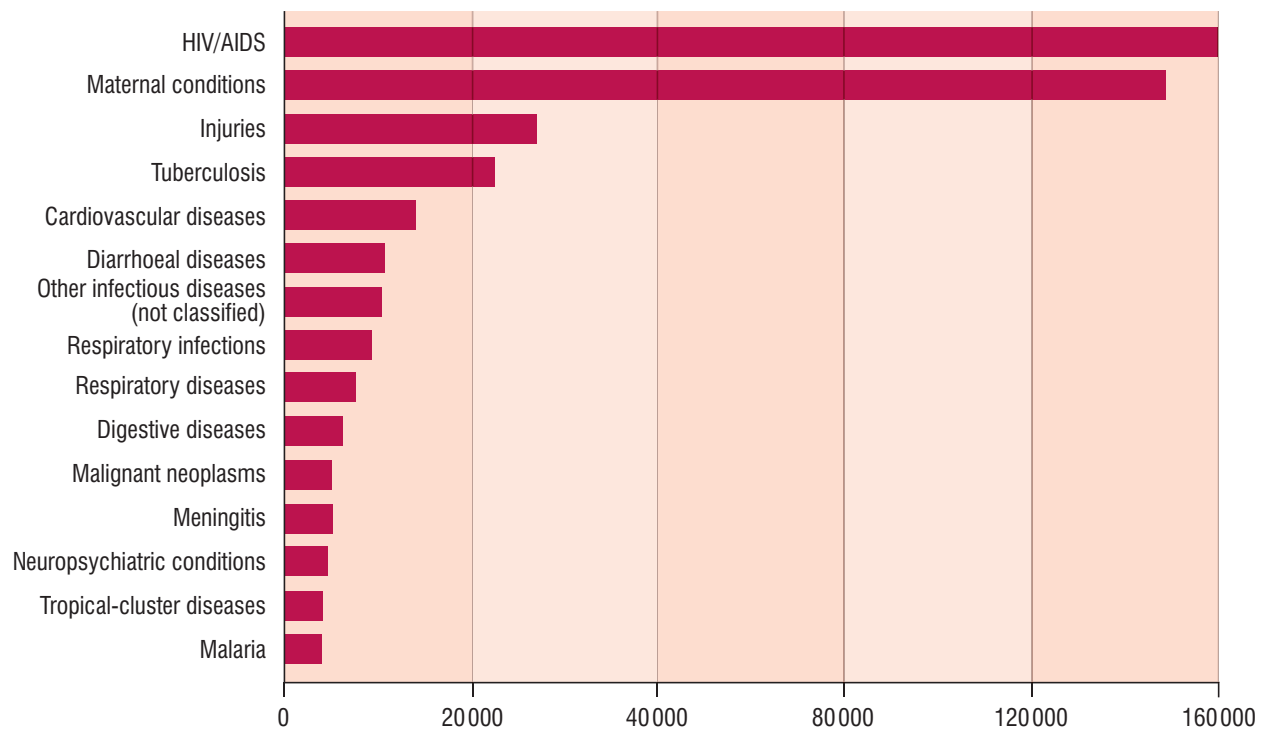
While HIV/AIDS may be the leading cause of death of African women in their reproductive years, maternal conditions also take their toll (**Figure 3.2**). Particularly in the 15-to-29 age bracket (**Figure 3.3**), the incidence of maternal mortality is even greater. In fact, roughly 51% of all maternal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

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



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

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



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

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

Table 3.2 Antenatal and delivery care coverage

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

* Central and Eastern Europe and the Commonwealth of Independent States

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

Shortage of skilled care

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

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

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



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

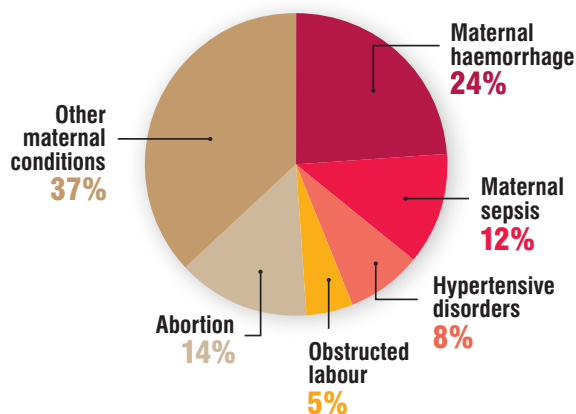
High maternal mortality

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

In the African Region where women bear many children (the overall fertility rate in the Region is 5.2), women have a 1 in 42 risk of dying prematurely from childbearing compared with the 1 in 2900 risk faced by women in Europe. In some parts of the Region, the statistics are even more chilling. One out of every 32 girls born in West and Central Africa will die because of a pregnancy-related complication in their

lifetime. In addition, for every maternal death in the Region, there are at least thirty women who suffer short- or long-term disabilities.

Figure 3.4 Causes of maternal death in the African Region



Source: World Health Organization, Geneva; 2008.

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

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

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

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

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

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

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



The importance of keeping promises to African mothers

Over the past several decades the United Nations General Assembly, the World Health Assembly, the WHO Regional Committee for Africa and other international conferences have adopted a number of resolutions designed to promote the health of African women. National governments, working with their development partners in Africa, have also made global, regional and national commitments. The right to health is enshrined in several core international human rights treaties[†] to which most countries in the African Region are State Parties. As previously stated in this report, specific to women's health is the United Nations Convention on the elimination of All Forms of Discrimination Against Women (CEDAW), which specifies state obligations in the prevention of maternal morbidity and mortality, and the provision of appropriate health care services for women. All 46 countries of the African Region are signatories to CEDAW. At the Regional level the African Charter on Human and People's Rights (Banjul Charter), together with the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, recognize the right to health of women and identify different measures to be taken by State Parties in ensuring full implementation of the instruments. At national level the right to health, which includes the health of women, has been enshrined in over 80% of the constitutions of countries in the African Region.



In 2000 the United Nations adopted the Millennium Declaration which sets eight Millennium Development Goals (MDGs) to be achieved by 2015 including: (a) MDG 5A which is specifically aimed at reducing maternal mortality by three quarters between 1990 and 2015; and (b) MDG 5B which aims to achieve universal access to reproductive health. It is important to note that the other goals also relate, directly or indirectly, to women's health particularly MDG 3 which seeks to promote gender equality and the empowerment of women, and MDG 4 which targets the reduction of

child mortality. More recently, in May 2010, the World Bank announced a five-year Reproductive Health Action Plan to reduce maternal deaths, and fertility rates in 58 low-income countries. Under the plan the Bank pledges to increase its lending to help expand access to contraception, antenatal care and education for women and girls. The lending will also help provide training for health workers on the common causes of maternal death.

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

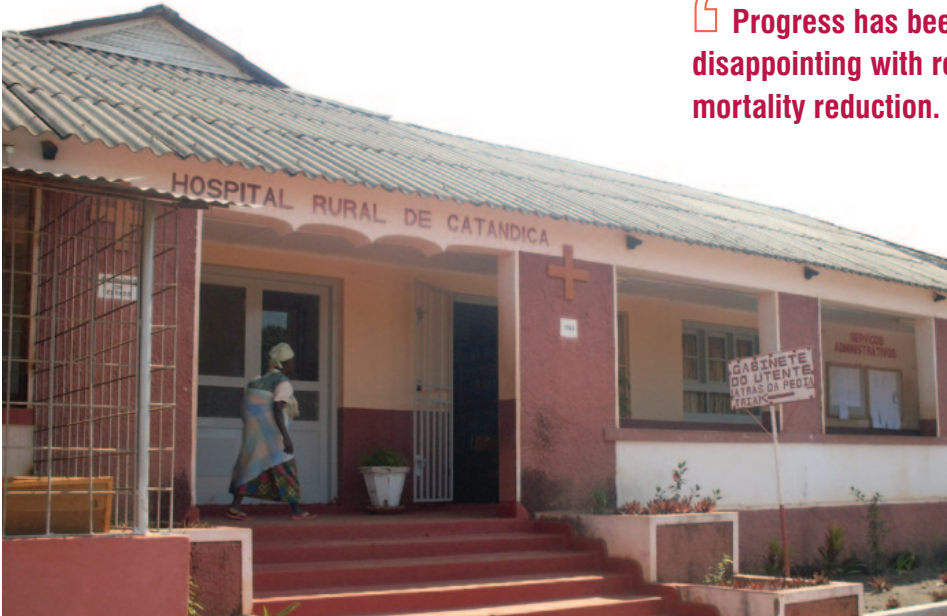
[†] Which include the International Covenant of Economic, Social and Cultural Rights (ICESCR), the Convention on the Rights of the Child (CRC), and the Elimination of all Forms of Discrimination Against Women (CEDAW).

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

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

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

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



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

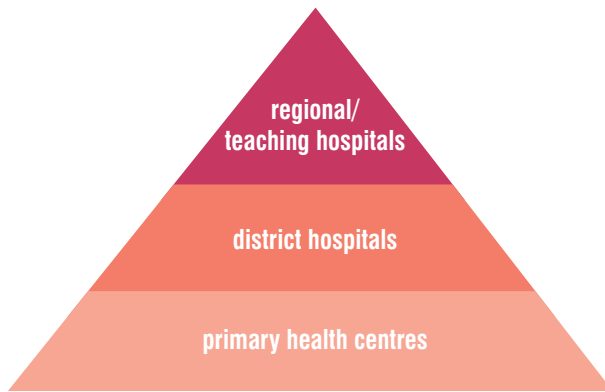


Figure 3.5 The three levels of health care in the African Region

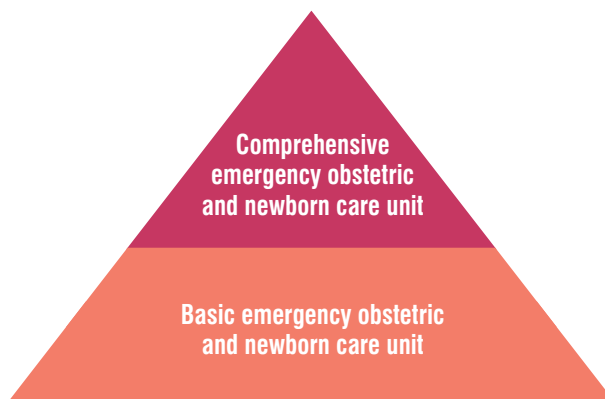


Figure 3.6 Optimal maternity care model

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

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

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

User fees penalize poor women

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

resulted in structural adjustment policies restricting government expenditures.^{36,37}

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

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

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

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

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

Health care that is lacking in gender and cultural sensitivity

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

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

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

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

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

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

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

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



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

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

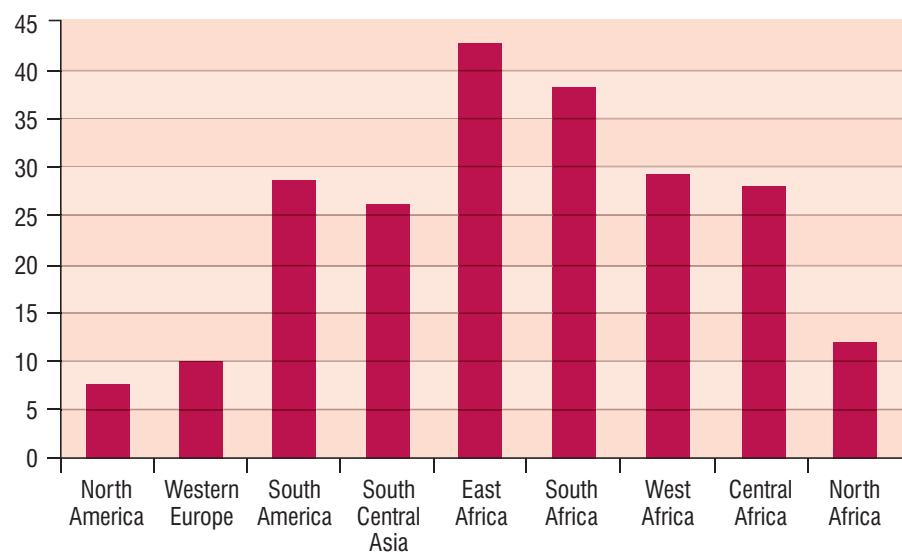
Cervical cancer

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

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

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

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



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

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

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

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

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

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

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

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

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

Other risks

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

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

Key considerations and points for action

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

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