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Welcome remarks

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Your Excellencies, Ladies and Gentlemen, good morning, bonjour à tous et à toutes.

I am very honoured to be here, to participate in this important discussion about the advancement of women and health in Africa.

I bring you the greetings of Dr Chan, the Director-General of the World Health Organization, who was unfortunately unable to be here because of preparations for the Executive Board meeting which starts in a couple of days.

The issues to be discussed here are close to Dr Chan's heart. As you may be aware, when she took office in 2007, she asked that her performance be judged by results in terms of improvements in the health of women and the health of the people of Africa.

In November last year, Dr Chan released WHO's report on Women and Health. The report reviews available evidence on the health issues that affect girls and women throughout their life course. The reality is that, despite considerable progress over the last 2 decades, societies are still failing women at key moments in their lives. These failures are most acute in poor countries, and among the poorest women in all countries. Not everyone has benefitted equally from recent progress and too many girls and women are

still unable to reach their full potential because of persistent health, social and gender inequalities and health system inadequacies.

African women face the greatest challenges. While the health of women and girls in other parts of the world is generally improving, most African women are actually facing reduced life expectancies compared to a few years back, largely because of the AIDS epidemic.

Globally, the leading causes of death among women of reproductive age is HIV/AIDS, followed by maternal conditions. As you will have guessed, the predominance of these causes of death among women is largely driven by the situation in Africa.

The most important risk factors for death and disability from later adolescence through adulthood in African countries are lack of contraception and unsafe sex. These result in unwanted pregnancies, unsafe abortions, complications of pregnancy and childbirth and sexually transmitted infections, including HIV. Girls and women are particularly vulnerable to HIV infection due to a combination of biological factors and gender-based inequalities, particularly in contexts that limit women's knowledge about HIV and their ability to protect themselves and negotiate safer sex.

The situation is complex, however. The most consistent finding from the report relates to the great diversity in health status and the huge health inequities that can be seen both between countries and within countries.

It is well known that the most striking difference between rich and poor countries is in maternal mortality - 99% of the more than half a million maternal deaths each year happen in developing countries. What perhaps is less well recognized is that this inequity between those who have and those who have not is played out as well within countries. This should not surprise us however, if we think

of maternal mortality not as an outcome of a biological process that went wrong, but as a key indicator of women's health and status. There is nothing inevitable about these deaths. In fact, with the appropriate care, maternal mortality is a very rare event. Maternal mortality shows most poignantly the difference between rich and poor, both between countries and within them.

This underlines a key concern that will be addressed during this conference: women's health is profoundly affected by their status in society. Where women continue to be discriminated against or subjected to violence, their health suffers. Where they are excluded by law from the ownership of land or property their social and physical vulnerability is increased. What is clear is that we will not make progress on any of the health-related MDGs, MDGs 4, 5 or 6, unless we also address the other MDGs, especially the goals on women's empowerment and on poverty alleviation. All the MDGs are linked.

What can we say about progress towards the MDGs in the region? On present trends, Africa may not reach any of the health-related MDGs. Progress is patchy, or too slow, or entirely stalled, as is the case with maternal mortality. It is easy to feel discouraged, as we move into the last 5 years towards 2015. How can progress be accelerated?

We believe that we need to dig deeper and uncover the success stories in many areas of health and learn from the tremendous innovations that we have seen in so many African countries in recent years. The successes are many. The gains in malaria control, for example, and the extraordinary achievements in Africa with respect to reducing measles mortality. These bear witness to the remarkable capacity, talent, energy and committed leadership that can be found in Africa.

There is no room in this conference for sweeping generalizations. The region as a whole may not reach the MDGs, but individual countries are showing how they can overcome problems posed by poverty, poor infrastructure and insecurity, and make a difference.

The picture is not so much one of slow, incremental change but rather of leaps and bounds, made possible by bold leadership and transformational social changes in which concerns about social equity and women's empowerment are made explicit policy objectives.

I look forward to learning more about the reforms that are making a difference to women's health in Africa in the coming two days.

Thank you for your attention.

In this presentation I will discuss the critical importance of reducing maternal mortality for improving women's health in Africa.

Slide 2: Structure of the presentation

My presentation will be in 4 parts. First I shall discuss the role of maternal health within the broader context of women's health in the world today. Second I shall give a brief overview of maternal health in Africa. Third I shall touch upon the key intervention approaches to reduce maternal mortality. Finally I shall end on key policy responses that can take us forward.

Slide 3: Understanding women's health…

The Women and health report outlined critical issues that help us understand women's health in the world today. One of these is the increasing life expectancy of women.

This slide shows the female life expectancy at birth in different country income groups and regions. In most parts of the world, there have been improvements over the years. Life expectancy for women is now more than 80 years in at least 35 countries.

Not all women have benefitted however. For instance, a woman born in East and Southern Africa can expect to live only for 50 years, and her future is actually looking bleaker, largely because of the AIDS epidemic.

Women generally live longer (but not necessarily healthier) lives than men - on average 6 to 8 years longer, due to biological and behavioural factors. However, in some low-income countries, women's life expectancy is equal to or shorter than men's as a result of the social disadvantages that they face.

Slide 4: Inequities in access to health care..
As mentioned earlier this morning, the other key issue highlighted in the report relates to the large inequities that are seen in women's health, both between countries and within countries. Nearly everywhere, poverty and low socioeconomic status are associated with worse health outcomes. In both high income and low income countries, levels of maternal mortality may be up to 3 times higher among disadvantaged groups than among other women. There are similar differentials in terms of use of health care services. For instance, women in the poorest households are least likely to have a skilled birth attendant with them during childbirth, as shown in this slide for a number of countries, including Chad and Gabon.

Slide 5: Adolescent girls…
Problem periods for African women come early, as shown in the huge burden of premature mortality that they face. Adolescence is generally the healthiest period of life. However, societies as a whole do not provide girls the support they need to make a healthy transition to adulthood.

Adolescent girls, especially those who are disadvantaged, are at risk of unsafe and often unwanted sexual activity that leads to HIV and other sexually transmitted infections, and unwanted pregnancy. In developing countries, complications of pregnancy and childbirth are the leading cause of death in young women between the ages of 15 and 19. About 15% of total maternal deaths worldwide, and a whopping 26% in Africa, occur among adolescents. Because many adolescents face unwanted pregnancy, rates of unsafe abortion among young women are high, especially in Africa where girls aged 15-19 years account for one in every four unsafe abortions.

Slide 6: …reproductive age
This slide identifies the leading causes of death among women in the years between puberty and menopause. Globally, the leading cause of death in this age group is HIV/AIDS, followed by maternal conditions.

The leading risk factors for death and disability from late adolescence through adulthood are unsafe sex and lack of contraception, globally and most particularly in Africa. Women who do not know how to protect themselves from sexually transmitted infections, such as HIV, or unwanted pregnancy, or who are unable to do so, face greatly increased risks of death or illness.

Slide 7: Structure….
I now move to the second part of the presentation…

Slide 8: maternal health situation in Africa

Slide 9-10: MDGs

Slide 11: MMR
Maternal mortality is a key indicator of women's health and status, and shows most poignantly the difference between rich and poor, both between countries and within them. More than half a million maternal deaths occur every year. Of these nearly *all* happen in developing countries, and about half of them happen in Africa. In Africa we unfortunately still see high and very high maternal mortality ratios. In this slide the darker and redder colours indicate the countries where maternal mortality ratios are the highest.

Slide 12: Causes …
This slide shows our best estimate of the causes of maternal deaths that occurred in the African Region in 2004.

The majority of deaths were due to direct obstetric complications, primarily hemorrhage, sepsis, unsafe abortion, pre-eclampsia and eclampsia, and prolonged or obstructed labor, which are largely preventable.

I draw your attention to the large portion of deaths due to indirect causes, that is, they due to pre-existing medical conditions such as HIV infection. There is now substantial evidence that HIV infection increases the risk of maternal mortality by a factor of 6 at least, such that in some countries with high HIV prevalence, HIV is now the leading cause of maternal mortality, accounting for about half of all deaths during pregnancy and in the few weeks post-partum, related to AIDS, but also conditions such as haemorrhage and sepsis. These conditions are considerably aggravated by the immuno-suppression associated with HIV infection. The AIDS epidemic in many countries, such as South Africa, is reversing previous progress in maternal health. Again, the MDGs are all linked.

Slide 13: Structure…

Slide 14-17: Key interventions

Slide 18: Structure

Slide 19: A shared agenda for action
African women face a 42%, almost a one in two risk of premature death, often associated with HIV/AIDS or tuberculosis, or complications of pregnancy and childbirth.

The bottom line is that despite huge advances in health in recent years, women on this continent still face health problems that should have been tackled many years ago.

What can be done about this? I now turn to the last part of my presentation, which proposes some ways forward.

Policy action in the following four areas is proposed.

First, strong leadership is required at national, regional and international levels, given the current tendency for fragmented and limited responses that only address some parts of the problem.

For example, the Millennium Development Goals have been vitally important in maintaining a focus on health in an overall developmental framework, and in setting benchmarks for progress. The existence of a separate goal on maternal health calls our attention to the stunning lack of progress in this area, attracting both political and financial support for accelerating change. The addition of the target on universal access to reproductive health has helped broaden the scope of the goal. But again, all the MDGs are linked and progress depends on broad-based action that takes into account the realities on the ground.

Second, we need to build health systems that work for women. This requires attention to increasing access, to reach out to those who are currently excluded, and to expanding the range of services that are offered, to encompass a range of sexual and reproductive health services along a continuum of care.

Health systems reflect the societies that create them. We must reverse the situation in which health systems perpetuate health inequities and gender inequality, for example when women are refused services without their partner's consent.

Urgent attention must also be paid to ensuring financial protection, by moving away from user charges, which are particularly hard on women, and promoting prepayment and pooling schemes.

Third, action is required that reaches beyond the health sector. The health sector can contribute by drawing attention to ways in which policy in other sectors affects the health of women. Also in encouraging intersectoral collaboration to make life better for women and at the very least avoid making it worse. For example, we can expect major health benefits from making sure that girls everywhere enrol in and stay in school, together with providing school meals, constructing separate toilets, ensuring schools stay safe for girls, and promoting later marriage.

My **final** point is to highlight the urgent need for investing in systems for the collection and use of data disaggregated by age and sex, and the tracking of progress in improving women's health. To take but one example, how are we to going to be able to push along with what needs to be done if we cannot track maternal mortality, a powerful indicator both of women's health and of the responsiveness of a health system. How can it still be that maternal mortality remains poorly measured in most settings where mothers die?

In the words of the Director-General of WHO: "what gets measured gets done".

Slide 20: H4

Here I should like to draw attention to a new partnership that has emerged. H4 is an inter-agency mechanism aimed at harmonizing and accelerating actions to improve maternal and newborn health. The H4 consist of UNICEF, WHO, UNFPA and The World Bank. This slides shows the joint letter issued by the four agencies in 2008 expressing the commitment to work together in supporting countries to achieve **MDG 5** and contribute to the achievement of **MDG 4** (newborn health). 25 priority countries (18 in the African region) at this stage are hosting this initiative. Hopefully together we can better meet country needs and expectations.

(Seven agreed programme components:

1. Support **needs assessments** to identify constraints to improving MNH/RH in countries and ensure that health plans are MDG-driven and performance-based
2. **Develop and cost national plans** and rapidly mobilize required resources
3. Scale up **quality health services** to ensure universal access to reproductive health (4 pillars)
4. Address the urgent need for **skilled health workers**, particularly midwives and other related cadre of personnel and for HR management including supervision.
5. Address **financial barriers to access**, especially for the poorest
6. Tackle the **root causes of maternal mortality and morbidity** including gender inequality, low access to education -especially for girls-, child marriage and adolescent pregnancy
7. Strengthen **monitoring and evaluation systems)**

Slide 21: Thank you.