ECOSOC Annual Ministerial Review

Regional Preparatory Meeting on Women and Health
Dakar, Senegal, 12-13 January, 2010

Background Note

1. Background

The 2010 Annual Ministerial Review (AMR) will be held in June in New York, and will focus on "Implementing the internationally agreed goals and commitments in regard to gender equality and the empowerment of women."

The AMR process features three main elements: a global review of the United Nations development agenda based on a comprehensive report by the Secretary General; country-led thematic reviews at the regional level; and a series of national voluntary presentations of both developing and developed countries on their progress in implementing internationally agreed development goals. These elements are complemented by an innovation fair and e-discussions on the theme of the AMR to stimulate dialogue and engagement around the Review.

The Regional Preparatory Meeting for Africa hosted by the Government of Senegal will examine the challenges of access to health services in the region and initiatives in promoting women's health, and especially maternal health, including in the context of the HIV/AIDS pandemic.

More specifically, the meeting will add value to the discussion during the AMR and help advance the international gender goals by:

- Reviewing the health status of women in Africa in the broader context of the achievement of the gender-related MDGs;
- Examining progress in achieving the gender- and health-related goals of the UN Development Agenda in the African region and related challenges, especially those that could best be addressed through regional cooperation;
- Exchanging lessons learned and proposing ways forward and recommendations to improve women's health conditions and make women's health a reality;
- Promoting stakeholder engagement – governments, civil society, UN system institutions and private sector – early on in the AMR process;
- Providing an opportunity to prepare the launch of new partnership initiatives at the AMR July 2010 session in New York.

2. Introduction

The continent continues to make progress toward gender equality and empowerment of women. However, despite gains in girls' enrollment in primary education, female employment and female political representation, women and girls still bear the brunt of poor health care. Throughout Africa, gender inequality gives rise to inequities between men and women in health status and healthcare access. Compared to all other regions in the world, African women face the highest likelihood of experiencing fatal complications during childbirth, and contracting HIV/AIDS. Gender inequality is seen as a major reason why many countries in Africa are not on track to meet the health-related MDGs regarding maternal health and HIV/AIDS. Gender-based discrimination prevents women and girls from accessing knowledge that could help them prevent illness; obtaining the funds necessary to pay for care; and/or negotiating their own health concerns within their families.

This note begins by addressing the issue of maternal mortality, and analyzing the reasons why women do not receive the care they need before, during and after childbirth. Next, it explores the feminization of the HIV/AIDS pandemic in Africa, where existing gender inequalities increase women's risk of HIV infection, and prevent proper treatment, care and support. The final section turns to the economic, political and social barriers that hinder women's empowerment, and reinforce the negative impact on their health status. Each section includes a series of questions to facilitate discussion during the meeting.

3. Maternal Health

The international community agreed to address the issue of maternal mortality – the most striking inequality in public health – by agreeing to Millennium Development Goal 5, to improve maternal health, with one of its boldest targets the reduction of the maternal mortality ratio (MMR) by three quarters between 1990 and 2015. Despite resolve at the highest political level, at the present rate of progress, the world will fall well short of the 75% target for reduction (between 1990 and 2015) of maternal mortality, which requires a 5.5% annual decline rate.

Sub-Saharan Africa stands the biggest risk of failing to meet this goal. A major explanation for the high MMR in Africa is the lack of access to adequate medical care. In many instances, even when access is available, it is often inequitable. The largest ratio of worldwide maternal deaths occurs in sub-Saharan Africa, which has also made the least progress in reducing the MMR, at an annual rate of 0.1%. Africa (all AU members) accounts for 51% of all maternal deaths in the world.[1]

In sub-Saharan Africa, a woman's risk of dying from complications of pregnancy and childbirth over the course of her lifetime is 1 in 22, compared to 1 in 7,300 in the developed world.[2] The maternal mortality rate for the whole African continent is estimated at 820 deaths per 100,000 live births, compared to 9 deaths per 100,000 live births in the developed regions.[3] Sierra Leone is the country with the highest maternal mortality rate in the world, estimated at 2,100.[4] Eighty

[1] UNICEF 2008.
[2] UNFPA 2008.
[3] Ibid.
[4] Kristof and WuDunn 2009.

per cent of maternal deaths could be averted, if women had access to basic health care services and skilled health care providers.[5]

In some regions of the world, primarily in sub-Saharan Africa and South Asia, women are still facing very high risks of dying during pregnancy and childbirth. The causes of maternal mortality and morbidity are clear, and effective interventions to combat them are well known. There is a need to improve antenatal care, increase attendance of skilled personnel at childbirth, provide timely lifesaving emergency obstetric care, and promote quality facility-based deliveries and post partum care. In low-income countries a third of all pregnant women receive none of these services during pregnancy and lack access to family planning services.

Access, coverage, quality: The inequities

Poverty, inequity, women's low status, and societal attitudes towards women and their needs are still the underlying factors affecting women's access to healthcare services. Although effective interventions to prevent mortality are known, for many women and newborns, appropriate care remains unavailable, unused, inaccessible, or of poor quality. This suggests that successful strategies to reduce maternal mortality must also address women's disadvantaged social, political, and economic status and promote attitudinal change. This requires comprehensive strategies which include aspects outside the immediate realm of the health sector areas such as education and transport.

Although there is an improvement in antenatal care, the recommended norm of four antenatal visits is still not accessible to 55% of women in sub-Saharan Africa. In low income countries, 60% of deliveries take place outside health facilities, and only about 60% of all deliveries are attended by skilled staff.

The use of contraception has improved impressively during the past two decades in many regions. However, the unmet need for family planning is still unacceptably high. In sub-Saharan Africa, 24% of women who want to delay or stop childbearing have no access to family planning.

Most maternal deaths occur during childbirth or the first 24 hours post partum, and most complications cannot be predicted or prevented. Individual complications are quite rare, and timely diagnosis and appropriate interventions require considerable skills to prevent deaths and to avoid introducing further complications and harm. The location of women when they start labour and then deliver, who is attending them, and how quickly they can be transported to referral-level care are thus crucial factors determining access to interventions that are needed and feasible.

Progress has slowed down and is increasingly uneven, leaving large disparities between regions and countries. Within one single country there are often striking inequities and differences between population groups, and national figures mask substantial internal variations—geographical, economic, and social. Rural populations have less access to skilled and emergency care than urban dwellers; among urban dwellers, mortality is higher in urban slum populations; rates can vary widely by ethnicity or by wealth status, and remote areas often bear a heavy burden of deaths.

[5] Landers 2009.

When access is hindered by lack of money, poor transport, and distance, ill health among pregnant women, and particularly the occurrence of major unpredictable obstetric problems and delayed care seeking, can lead to catastrophic expenditure that may push households into poverty and further exclusion in the future. Unless efforts are increased radically, there is little hope of eliminating the avoidable maternal and newborn mortality in many countries. Aside from these geographic and financial barriers, cultural barriers are also likely to prevent people from seeking emergency help. All of the health care therefore must be given in an appropriate environment (usually in decentralised, first-level facilities) close to women's homes, and in a way that respects their culture.

During political instability or in conflict zones, the situation can deteriorate even further. Interventions that can prevent mortality from the major causes of maternal death are known, and can be made available even in resource-poor settings. These include focusing on adequate care and preparation in the household, assuring quality services close to where women live and systematically detecting and managing complications at an early stage.

Innovative Approaches

The challenges of making pregnancy safer and addressing inequities are not new technologies nor new knowledge about effective interventions. The challenge is how to deliver these services and scale-up the coverage and utilization of interventions, particularly to those who are vulnerable, hard to reach, marginalized and excluded.

Availability of facilities does not always ensure optimal utilization. In addition to improving quality of care at facilities, innovative approaches are needed to improve demand and utilization. This will require innovative approaches, including empowering women to avail themselves of the services offered.

The introduction of results-based financing and social insurance in Rwanda has contributed to an increase in childbirth and emergency obstetric care in facilities from 39% to 52% over a 3-year period. The government also invested in building new facilities, providing equipment and supplies, as well as making available an adequate number of skilled healthcare providers at every facility.

In Senegal, the United Nations Population Fund (UNFPA) and the Ministry of Health jointly fund the work of community health workers, who ride their bikes to visit women in their villages and communities providing women with better access to healthcare throughout their pregnancy. They are trained to monitor the health status of pregnant women and to refer the women to local heath centers, where skilled attendants can assist them with delivery. In addition, UNFPA provides the villages with about US$50 in seed money to set up community health funds, which are used for emergency cases, such as rushing a woman to a district hospital, when complications related to pregnancy and childbirth occur.[6]

In Morocco, the maternal mortality ratio has significantly decreased from 610 deaths per 100,000 live births in 1990 to 220 deaths in 2000, because of increased use of contraception to delay and

[6] Kimani 2009.

limit childbearing, better access to and use of high-quality health-care services, as well as broader social changes such as increased education and enhanced status for women.[7]

The continuing high incidence of maternal and perinatal mortality and morbidity is unacceptable precisely because it is solvable. Successfully reducing maternal mortality requires policy makers and program managers to refocus program content, to shift the focus from development of new technologies toward development of viable organizational strategies that manage and ensure a continuum of care. It also requires managers to enable women to access health services by addressing the root causes of the high incidence of maternal mortality.

For discussion:

- *What are the cultural barriers that might prevent women from seeking maternal health care? What type of programmes can address these barriers?*
- *How can family planning programs be scaled up to decrease the maternal mortality ratio?*
- *How can geographic barriers be overcome so that women in rural areas are provided with quality care?*
- *What additional action could be taken by governments to ensure the equitable and efficient provision of health services for women?*
- *What programmes have been put in place to increase demand for maternal services?*

4. Women and HIV/AIDS

In 2006, world leaders unanimously committed – through the Political Declaration on HIV/AIDS – to achieve universal access to HIV prevention, treatment, care and support by 2010, as a critical milestone towards the achievement of the MDGs by 2015.

Achieving the goals of gender equality and combating the spread of HIV are closely linked and mutually reinforcing. The increased vulnerability of women and girls to HIV is not only due to their greater physiological susceptibility to the infection, but also due to social, legal and economic inequalities, which affect their capacity to protect themselves from HIV infection and to effectively cope with the impact of the epidemic. Lack of legal rights, education and economic opportunities for women and girls limit their capacity to refuse sex or to negotiate safer sex and to resist sexual violence and coercion, including transactional sex and early or forced marriage. Women and girls also carry a disproportionate burden of AIDS-related care, often missing out on education and employment opportunities for their own advancement. Once HIV-positive, the stigma and discrimination associated with HIV makes it even more difficult for women and girls to exercise their rights.

The issue of women, girls and HIV is of particular relevance and significance in Africa. The continent remains the region most affected by the AIDS epidemic, which continues to have an enormous impact on the lives and well-being of individuals and on the social and economic development of communities and countries. Sub-Saharan Africa is home to some 22.4 million people living with HIV (67% of HIV infections worldwide). It also accounts for nearly three quarters of all AIDS-related deaths (1.4 million in 2008, out of 2 million globally). Though there has been some decline in the number of new infections, around 1.9 million people became

[7] WHO 2009a.

infected with HIV in sub-Saharan Africa in 2008 alone, accounting for 71% of all new infections globally.[8]

At the same time, sub-Saharan Africa continues to have the highest rate of HIV among women, whereby they account for over 60% of HIV infections in the region (globally, women represent about 50% of all people living with HIV). Of particular concern is the fact that young women in sub-Saharan Africa now account for 76% of all young people living with HIV. In Southern Africa, prevalence among young women aged 15-24 years is on average about three times higher than among men of the same age.[9] Women and girls bear a disproportionate burden of the impact of the epidemic. For example, in countries hardest hit by AIDS, women and girls account between two thirds to 90% of all care-givers.[10]

Strengthening access to HIV/AIDS health interventions in Africa

Notwithstanding these difficult challenges, significant strides have been made in sub-Saharan Africa in responding to the AIDS epidemic, especially with regard to treatment.

With around three million people receiving antiretroviral treatment (ART) in sub-Saharan Africa, the ART coverage in the region reached 44% in 2008 as compared with only 2% in 2003. However, important access gaps remain, as more than half of all people in need of treatment still do not receive it. In general, ART coverage is higher in Eastern and Southern Africa (48%) than in West and Central Africa (30%).

In 2008, 45% of HIV-positive pregnant women received anti-retroviral prophylaxis to prevent mother-to-child transmission of HIV (PMTCT), up from 9% in 2004. In Botswana, Namibia and Swaziland, more than 90% of all HIV-infected pregnant women already receive antiretroviral prophylaxis to prevent the vertical transmission of HIV.[11] However, only one third of women are assessed for their own ART needs to continue with treatment after pregnancy. Despite progress in PMTCT, around 390,000 children were still infected with HIV in sub-Saharan Africa in 2008, accounting for 91% of all HIV infections among children worldwide. At the same time, progress has been uneven, with PMTCT coverage being much higher in Eastern and Southern Africa (64%) than in West and Central Africa (27%). UNAIDS has called for the virtual elimination of vertical transmission by 2015.

AIDS policies and programmes are more effective when women's organizations—particularly those of HIV-positive women—help form their content and direction. In a UNAIDS survey (2007) of 80 countries, only one third of these countries had full formal participation from women living with HIV, and only 28% had full formal participation from women's organizations. Also, while over 80% of countries report addressing women's issues as a component of their national HIV strategy, only about half of them (52%) report budget allocations specifically devoted to HIV-related programmes for women and girls. The largest proportions of countries with reported budgets for such efforts are in Asia (69%) and sub-Saharan Africa (68%).[12]

[8] UNAIDS and WHO 2009.
[9] Ibid.
[10] See Secretary General's Task Force 2004. Southern Africa Partnership Programme 2005: Impact of Home Based Care on Women and Girls in Southern Africa.
[11] UNICEF 2009.
[12] UNAIDS 2008.

In many countries, especially those hardest hit by the epidemic, most of the care for people living with HIV is home-based and is provided largely by women and girls (accounting for up to 90% of AIDS-related caregiving work). Many women and children also have to serve as breadwinners, compensating for lost family income due to AIDS deaths or sickness of family member(s). In most cases, the caregiving work is unremunerated and often accompanied by HIV-related stigma and discrimination. A range of broad gender-sensitive strategies to reduce the overall impact of AIDS on affected households and communities is necessary, including state assistance to families and community and faith based organizations to meet the burden of care, as well as social protection services for persons affected by AIDS, psychosocial support, and free access to legal support.

Analysis of the data also indicate that the impact of the AIDS response is high where HIV programmes have been integrated with other health and social welfare services. Taken out of isolation, the AIDS response can be effectively leveraged to promote achievement of other MDGs and contributes to the broader health and development agenda. Recent evidence shows that HIV may have a significant impact on maternal mortality, i.e. 50,000 maternal deaths in South Africa were associated with HIV in 2008. The disease also accounts for up to 30% of infant deaths in sub-Saharan Africa. Programmes on HIV, maternal and child health must work in synergy in order to contribute significantly to the achievement of their common goals (MDGs 4-6). Effective integration of voluntary family planning services, sexual and reproductive health, and HIV programmes will not only help prevent babies from becoming infected with HIV, but will also protect and enhance the health of HIV-positive women and allow them to better exercise their reproductive rights.

Scaling up efforts to prevent the spread of HIV/AIDS

It is obvious that despite the significant progress made in treatment, the epidemic continues to outpace the response in sub-Saharan Africa, whereby more people become infected as compared with those accessing treatment. In order to sustain the valuable gains achieved thus far and to mount a more effective response to the epidemic, it is critical to **strengthen HIV prevention** and to match it with actual needs, including protecting women and girls and mitigating the impact of the epidemic.

HIV prevention programmes are showing some positive impact on sexual behaviors. For example, available data indicates a trend towards safer sexual behavior among both young men and young women (15-24 years old) in Southern Africa in the period of 2000-2007, as well as an increased delay of sexual debut among young people in many countries. However, the high prevalence of inter-generational sexual partnerships can play an important role in young women's disproportionate risk of HIV infection. Mixed results are emerging from the studies on men having multiple sexual partnerships (i.e. decreased in Swaziland, but increased in Uganda). At the same time, as epidemics matured in sub-Saharan Africa, it is estimated that the proportion of new infections among people in stable "low-risk" partnerships is often high, thus underscoring the high prevalence of serodiscordant partnerships.

HIV prevention programmes must be strengthened and matched to actual needs. According to recent data, funding for HIV prevention has become the smallest percentage of the HIV budgets of many countries. For example in Swaziland, just 17% of the country's total budget for AIDS was spent on prevention in 2008. Between 2005 and 2007, the prevention budget declined

by 43% in Ghana and by 24% in Lesotho. However, in Uganda, prevention resources as a share of national HIV spending rose from 13% to 33.6% between 2003 and 2007.

Prevention strategies also often fail to address the evolving patterns of the epidemics across and within countries. Data show that few HIV prevention programmes exist for people over 25, for serodiscordant couples, people in stable relationships, widowers and divorcees. These are the same groups in which HIV prevalence has been found to be high in many sub-Saharan countries.

Of particular concern is the recent trend in Africa towards the overly broad **criminalisation of HIV transmission** and those most affected by HIV, such as sex workers, injecting drug users and men who have sex with men. The criminalisation of HIV transmission can have significant negative implications for women. Women often learn about their HIV-positive status before their male partners because they are more likely to access health services and thus, are blamed for "bringing HIV into the relationship." Women may also face prosecution as a result of their failure to disclose out of fear of violence, abandonment or other negative consequences. An alternative – and more effective approach – for protecting public health is to ensure access to voluntary and confidential HIV testing and counseling, as well as access to HIV information and commodities; enact and enforce laws against sexual violence; eliminate discrimination based on gender and HIV status; and ensure equal rights and opportunities for women and girls in education, employment, and domestic relations including property ownership, inheritance and child custody.

A multi-country study conducted by the WHO found that between 1% and 21% of women reported sexual abuse before the age of 15, and between 20% and 50% of females reported that their first sexual experience was forced. Children who are sexually abused are more likely to engage in behaviors known to be risky for HIV as adults. Violence against women and girls is both a cause and consequence of HIV infection, and therefore needs to be dealt with as an integral part of HIV programmes.

Critical to this is also the need to raise awareness and improve HIV knowledge among young women, both through formal and non-formal education. This will be addressed in the next section.

For discussion:

- *Have HIV/AIDS budgets been impacted by the financial crisis and limited financing of healthcare? How is this issue being addressed?*
- *How can public-private partnerships, domestic NGOs and local communities best complement government efforts to provide quality primary health care to all?*
- *How are HIV/AIDS programmes being integrated with other social services to work towards the attainment of other MDGs? What are examples of these synergies?*
- *What actions can governments take to empower women to contain the spread of the HIV/AIDS pandemic?*
- *How can gender-sensitive policies be implemented in other areas (i.e. economic, education) to prevent the spread of HIV/AIDS?*

5. Empowering women to improve their health

Women's empowerment is necessary across all institutions in order to improve health outcomes for women, with spillover affects that will benefit their families, communities and societies.

Empowerment is about people taking control over their lives: setting their own agendas, gaining skills, building self-confidence, solving problems, developing self-reliance, and expressing their voice. It is both a process and an outcome.[13]

A multitude of barriers hinder women's empowerment, reinforcing the negative impact on their health status. Inequalities in the allocation of resources, such as income, credit, education, health care, nutrition and political voice, are strongly associated with poor health and reduced well-being.[14] Overall, women face a greater health burden because they lack autonomy in decision-making, and are limited in expressing their voice and choice. Moreover, women lack access to the information that would enable them to take a more active role in their well-being, or even save their lives. Therefore, health policy makers should consider women's complex role and status within the economic, political and social spheres in order to create impactful health reforms.

Economic Empowerment

Poverty and low socioeconomic status are associated with worse health outcomes. An important linkage exists between labour market equality and empowerment in terms of women's involvement in the decision-making process and bargaining power. Inequalities in the labour market spill over to inequality in health, education, political involvement and other demographic vulnerabilities. Women in the poorest households experience higher levels of maternal mortality and are less likely to have a skilled birth attendant with them during childbirth.[15] Job market participation and accessibility to remunerative and productive work allows women to spend on their health by relaxing family budget constraints that generally affect women adversely in terms of intra-household inequality of resources.[16]

According to the World Bank, 59.9% of females above the age of 15 in Africa participate in the labour force, in comparison to 80% of males.[17] However, the majority of Africa's labour force is in the informal economy. It is estimated than as many as nine in ten rural and urban workers have informal jobs, and this is especially the case for women and young people who have no other choice than the informal economy for their survival and livelihood.[18] They work in low productivity jobs, earn low wages, or perform unpaid work, and are exposed to dangerous working conditions. They face difficulties finding decent work and becoming entrepreneurs. This is one area where the availability of gender-disaggregated data would be useful by country to monitor progress.[19]

In sub-Saharan Africa, men monopolize labor market opportunities and dominate sexual and reproductive health decision-making. Thus, many young women turn to "transactional sex"—where money and gifts are exchanged within non-marital sexual relationships—as an alternative strategy to gain economic benefits, thereby increasing their health risks and exposure to

[13] UNECA et al. 2008a.
[14] WHO 2009a.
[15] WHO 2009a.
[16] Mitra 2005.
[17] World Bank 2009.
18 ILO 2007.
[19] UNECA et al. 2009.

HIV/AIDS.[20] A study that took place in Zanzibar found that income-generating activities that were launched for women resulted in greater involvement in household decision making about their health. Women who participated in the income activities said they felt capable of asking their husbands to wear condoms.[21]

In addition to accessing employment, women in Africa face other barriers to the market, with many unable to access credit, market information, technology, and infrastructure. Oftentimes, household assets are less readily available to women regardless of who was responsible for obtaining them. Women farmers in Africa receive only 1% of total credit to agriculture.[22] The inability to obtain financial credit hinders women from participating in entrepreneurial activities. This lack of asset ownership is shown to have adverse health outcomes for women. Studies show that when women have control over their own earnings and other assets, households are more likely to allocate more resources to health and education.[23] A microfinance and training project designed to empower South African women was associated with a significant reduction in HIV risk behaviour and partner violence.[24]

Land is crucial for increasing women's empowerment, as it is an important factor of production for a wide range of economic activities, particularly in Africa where natural resources provide a main source of income and livelihood. According to the OECD, as of 2007, women owned less than 1% of the African continent's landmass.[25] Widespread limits on the ability of African women to own land has serious repercussions on their effective engagement in economic activities,[26] thereby limiting their decision-making in the household. Research conducted by Human Rights Watch in Kenya and Zambia shows that women with HIV are particularly vulnerable to violations of property-based rights, and that depriving them of their property can lead to ill health and other negative consequences.[27] Ownership of land is affected by gender biased family laws, customary practices and land policies. In Rwanda, the government passed a law in 1999 giving women inheritance rights equal to those of males, overruling traditional norms by which only male children could inherit. This has enabled widows and female orphans of the 1994 genocide to secure land.[28]

A number of policies can be enacted to provide women with economic empowerment as a means to improve their own health. The generation of rural employment opportunities both off and on the farm is vital for creating a dynamic economy. Taking account of the gendered impacts of agricultural policies and social protection for informal workers is also important with regards to women's health. A sound investment climate for women can be created through securing property rights for women, providing access to technical assistance, improving communications and transport, removing barriers to finance and providing legal protection. Women's access to land and an extension of labor rights can be ensured through legal reforms and state led programs.

[20] Mudege and Ezeh 2009.
[21] Blumberg 2005.
[22] OECD 2007.
[23] Blumberg 1988.
[24] Alcorn 2008.
[25] OECD 2007.
[26] UNECA et al. 2008b.
[27] Gerntholtz 2009.
[28] UNECA et al. 2008b.

Political empowerment

Women in sub-Saharan Africa on average hold 18.2% of the seats in national parliaments, close to the global average of 18.6%. The proportion for the Middle East and North Africa is much lower at 8.6%.[29] The UN Commission on the Status of Women (CSW) recommends a critical 30% participation threshold as the minimum for decision-making positions to be held by women at the national level. Six African countries now surpass this threshold, with Rwanda's parliament comprising the highest female representation in the world, at 56.3%.[30] Although some progress has been achieved towards gender equality in African national parliaments, women continue to be under-represented in most structures of power and decision-making, including leadership positions in political parties, local government, the public and private sectors and civil society organizations. Passing of laws and policies alone does not bring about substantial gender equality in political participation.

Culture and tradition serve as the biggest impediments, with societies regarding women as incapable leaders. Balanced political representation helps guarantee that all voices are heard, and that a greater span of needs is addressed. Political leadership, by women, for women, can be effective in addressing discrimination against women in all spheres of life. Women are generally in a better position to voice women's concerns, and to take legislative action that addresses women's needs. For example, protection against rape, incest and other forms of sexual violence cannot be legislated without women's voice. Women parliamentarians, more so at the local level, tend to emphasise social issues, such as childcare, equal pay, parental leave and pensions; health issues, including reproductive rights, physical safety and gender-based violence; the alleviation of poverty and delivery of services.[31] Women have joined together in Senegal and Burkina Faso to press for changes to the law on female genital mutilation, and organized for inheritance rights in Rwanda.[32]

Measures that can address political misrepresentation of women are the adoption of gender quotas to correct historical imbalances in national parliaments and increasing female prominence in political parties. Quotas should be considered for elected offices, as well as for the civil service, judiciary, and other public leadership positions with a large gender gap. Political parties should also include women on their party lists or should comprise a certain percentage of female party members.

In 1994, South Africa ranked 141st in the world in the percentage of legislative seats held by women. After the African National Congress enacted a 30% quota for female candidates, South Africa jumped to 13th place in 2004 with women elected to 32.8% of its lower parliamentary seats.[33]

Social empowerment

The social dimension of gender inequality in relation to health in Africa include women's lack of power in family decision-making, women's lack of choice on matters that affect their lives such as

[29] IPU 2009a.
[30] IPU 2009b.
[31] IPU 2008.
[32] UNIFEM 2009.
[33] International Women's Democracy Center 2008.

when to get married, when to initiate sex, when to go to school and when to stop going to school, when to have babies, how many to have, and how the children should be spaced.[34]

These gender inequalities and limitations on women's decision-making are reflective of the attitudes and ideas that pervade a society or culture. In every society, people have ideas about what men and women should be and do, and may even espouse overt preferences for boys over girls. Reflecting religion, culture, tradition, as well as experience, attitudes are part of complex ideologies that have been constructed over long periods of time.

While every society follows its own path of socialization, certain mindsets have become deeply entrenched and have fueled attitudes of male superiority and gender discrimination to various degrees throughout the continent of Africa. These attitudes influence justice systems, social institutions, economic structures, and have created certain cultural norms and practices that are harmful to women, such as genital mutilation. Patriarchy – or the system of embedding masculine dominance in society - reinforces gender-based discrimination and strengthens divisions between men and women in social and economic life. This has resulted in grave inequalities for women and girls, and also sets behavioural expectations for men.

Educating girls produces many additional socio-economic gains that can empower women and benefit entire societies. These benefits include increased economic productivity, higher family incomes, delayed marriages, reduced fertility rates, and improved health and survival rates for infants and children.[35] Achievement of higher levels of education leads to delay in the sexual debut among girls,[36] and those who have completed secondary school have lower risks of HIV infection and practice safer sex than those who had completed primary school only.[37] In addition, poorly educated women more frequently experience domestic violence with serious physical and/or psychological health outcomes, as observed in studies conducted in Sudan.[38]

Africa has made improvements in making sure more girls are attending school. Girls' primary school enrollment rate outstripped that of boys between 2000 and 2006, with most countries having a gender parity index over 0.90. Despite these gains, girls still account for 55% of the out-of-school population in the region. However, the gender gap continues to widen in secondary education and is widest in tertiary education.[39]

Increasing enrollment of young girls and women at all levels of the education system will better empower them to better negotiate their health and sexual relationships. Only 23% of females in sub-Saharan Africa aged 15-24 years have comprehensive correct knowledge of HIV/AIDS. This compares to a regional average of 30% for males.[40] This knowledge is growing, facilitated by increasing youth literacy rates across all the countries in Africa. The increase in primary

[34] UNECA et al. 2008b.
[35] UNECA et al. 2009.
[36] UNAIDS and WHO 2009.
[37] UNIFEM 2009.
[38] Ahmed 2005.
[39] UNECA et al. 2009.
[40] WHO 2009b.

enrollment and completion rates means that more African youth can now read and write, thereby facilitating their access to information and services related to sexual and reproductive health. In addition to mandatory universal education, better-functioning schools and gender-sensitive learning content and environments can address inequities in education.

However, a country's literacy rate is not a clear indication of a population's level of health literacy, defined as the "cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health."[41] For example, Zimbabwe and South Africa have some of the highest literacy rates in Africa, yet they are also the countries most severely challenged by HIV/AIDS. The proportion of adults living with HIV is 18.1% in South Africa and 15.3%in Zimbabwe.[42]

Health literacy campaigns must include components that address access to information and knowledge, informed consent, and negotiating skills. The media is increasingly becoming a key source of health information for many people, and is influential in shaping culture in both developed and developing countries. They can provide learning opportunities that are more interactive and visual than pamphlets and older forms of health instruction.[43]

A Way Forward

"Gender inequality is not one homogeneous phenomenon, but a collection of disparate and interlinked problems."[44] In order to address gender inequality in healthcare, women must be empowered in all other spheres so that they are equipped with the knowledge, power and voice to be able to make decisions regarding their own health. The gender component should be considered across all national policies and development plans.

Too often, initiatives to combat gender discrimination and increase female empowerment are stand-alone projects, which largely fail to challenge or change systemic discrimination. These 'women's projects' sometimes have little or no affect on the hierarchies of power and privilege that form the basis for women's marginalization.[45]

Gender mainstreaming attempts to resolve the issue of treating gender as an "add-on" to existing policies. The Beijing Platform for Action called on governments and development actors to promote the mainstreaming of a gender perspective in all policies and programmes *before* decisions are taken, rather than ad hoc.[46] Mainstreaming is a strategy for making women's as well as men's concerns integral to all stages of development plans, from design to implementation to monitoring and evaluation.

Gender needs can also be addressed through national budgets and government financing schemes, as budgetary policies have different impacts across gender. While budgets may appear to be gender neutral, they may in fact be favourable towards men due to differences in the socially determined roles played by men and women and their different socio-economic levels. Therefore, budgetary policies that are gender neutral can actually be gender blind. Analysis of

[41] http://www.who.int/healthpromotion/conferences/7gchp/track2/en/index.html
[42] http://www.unaids.org/en/KnowledgeCentre/HIVData/mapping_progress.asp
[43] Kickbusch 2001.
[44] Sen 2001.
[45] Razavi and Miller 1995.

[46] UN 1996.

the entire budget through a gender lens to identify the differences in gendered impacts and to translate gender commitments into budgetary commitments can enhance transparency and accountability for revenue and public expenditure. Fiscal decentralization can also take into account gender differentiated needs at a local level.[47]

Cultural norms and attitudes that fuel gender inequality and prohibit women from making decisions about their health and overall well-being can be addressed through educational programs, media campaigns and grass roots activities. Harmful attitudes can be addressed by enlisting civil society, the media, academia, religious organizations, businesses and politicians to promote the benefits of women's participation for families and communities as a whole.

For discussion:

- *What government policies and programmes have been most successful in creating more inclusive markets for women?*
- *What legal frameworks are in place to guarantee decent work, labour rights, property rights, and asset ownership for women? Conversely, what types of customary laws or patriarchal norms hinder women's economic empowerment?*
- *How can civil society groups and local communities best complement government efforts to change attitudes and gender-biased mindsets to increase women's political voice and participation?*
- *Have female leaders in Africa implemented more gender-sensitive policies, or put in place more social-oriented programmes, during conflict resolution and during peace time?*
- *Have political quotes helped to create more balanced gender representation in political bodies?*
- *How might new information technologies be applied to reach wider audiences on health education?*
- *How can health literacy programmes be targeted to hard-to-reach populations?*
- *What are the trends in the region to mainstream the gender component into national development programmes and priorities?*

[47] Chakraborty and Bagchi 2007.

References

Ahmed AM, Elmardi AE. "A Study of Domestic Violence Among Women Attending a Medical Centre in Sudan. *Eastern Mediterranean Health Journal* 11(1/2):164–174.

Alcorn, Keith. 2008. "Microfinance Project Reduces HIV Risk in South African Women, Gold Standard Trial Shows." *aidsmap news.* 4 August 2008. [http://www.aidsmap.com/en/news/C561AE87-0EFE-4873-811A-21E05A714AF8.asp].

Blumber, Rae L. 2005. "Women's Economic Empowerment as the "Magic Potion" of Development?" Paper presented at the 100th Annual Meeting of the American Sociological Association. Philadelphia: August 2005.

Blumberg, Rae L. 1988. "Income Under Female Versus Male Control: Hypotheses From a Theory of Gender Stratification and Data from the Third World." *Journal of Family Issues* 9 (1): 51-84.

Chakraborty, Lekha S., and Amaresh Bagchi. 2007. "Fiscal Decentralization and Gender Responsive Budgeting in South Africa: An Appraisal." *National institute of Public Finance and Policy* Working Paper 45.

Gerntholtz, Liesl. 2009. "Women's Land Rights Can Help Battle Hunger in Africa." *Boston Globe.* 19 March 2009. [http://www.boston.com/bostonglobe/editorial_opinion/oped/articles/2009/03/19/womens_land_rights_can_help_battle_hunger_in_africa/]

ILO (International Labour Organisation). 2007. Information Note - Parallel Session III: Integrated employment and social protection policies to upgrade the informal economy. Prepared for 11th Annual African Regional Meeting. Addis Ababa: 26 April. [http://www.ilo.org/public/english/region/afpro/addisababa/pdf/informaleconomy.pdf].

International Women's Democracy Center. 2008. Fact Sheet: Women's Political Participation. [http://www.iwdc.org/resources/fact_sheet.htm].

IPU (Inter-Parliamentary Union). 2009a. Women in National Parliaments – World Average. [http://www.ipu.org/wmn-e/world.htm].

IPU (Inter-Parliamentary Union). 2009b. Women in National Parliaments – World Classification. [http://www.ipu.org/wmn-e/classif.htm].

IPU (Inter-Parliamentary Union). 2008. Equality in Politics: A Survey of Women and Men in Parliaments. Reports and Documents n° 54.

Kickbusch, Ilona. 2001. Health Literacy: Addressing the Health and Education Divide" *Health Promotion International* 16: 3 (289-297).

Kimani, Mary. n.d. "Social Hurdles to Better Maternal Health in Africa." United Nations *Africa Renewal*. [http://www.un.org/ecosocdev/geninfo/afrec/newrels/214-social-hurdles.html].

Kristof, Nicholas D., and Sheryl WuDunn. 2009. Half the Sky – Turning Oppression into Opportunity for Women Worldwide. New York: Alfred A. Knopf.

Landers, Cassie. 2009. Maternal and Newborn Health: A Global Challenge. New York: U.S. Fund for UNICEF.

Mitra, Arup. 2005. 'Women in the Urban Informal Sector: Perpetuation of Meagre Earnings.' *Development and Change* Vol. 36, No. 2, 291-316.

Mudege, Netsayi N., and Alex Ezeh. 2009. IUSSP on Gender Empowerment in the 21st Century in Africa – Meeting Report and Recommendations. Nairobi: APHRC.

OECD (Organisation for Economic Cooperation and Development). 2007. "Gender and Economic Empowerment of Women." Presented at the 8th Meeting of the Africa Partnership Forum. Berlin: 22-23 May 2007. [http://www.oecd.org/dataoecd/16/42/39921766.pdf]

Razavi, S, and Carol Miller. 1995. From WID to GAD: Conceptual Shifts in the Women and Development Discourse. Geneva: United Nations Research Institute for Social Development.

Sen, Amartya. 2001. "Many Faces of Gender Inequality". *Frontline.* 27 October – 09 November. [http://www.hinduonnet.com/fline/fl1822/18220040.htm].

UN (United Nations). 1996. Report of the Fourth World Conference on Women. A/CONF.177/20/Rev.1. New York: United Nations. [http://www.un.org/womenwatch/daw/beijing/pdf/Beijing%20full%20report%20E.pdf]. Last accessed on November 2009.

UNAIDS (United Nations Programme on HIV/AIDS), and WHO (World Health Organization). 2009. AIDS Epidemic Update. Geneva: Joint United Nations Programme on HIV/AIDS and World Health Organization.

UNAIDS (United Nations Programme on HIV/AIDS). 2008. 2008 Report on the Global AIDS Epidemic. Geneva: United Nations Programme on HIV/AIDS

UNECA (United Nations Economic Commission for Africa), African Union, and African Development Bank. 2009. MDG Report 2009 – Assessing Progress in Africa Toward the Millennium Development Goals. Addis Ababa: United Nations Economic Commission for Africa, African Union, and African Development Bank.

UNECA (United Nations Economic Commission for Africa), African Union, and African Development Bank. 2008a. Achieving Gender Equality and Women's Empowerment in Africa, Progress Report. Prepared for the 6th African Development Forum. Addis Ababa: 19-21 November 2008.

UNECA (United Nations Economic Commission for Africa), African Union, and African Development Bank. 2008b. Empowering African Women – Issues Paper 2. Prepared for the 6th African Development Forum. Addis Ababa: 19-21 November 2008.

UNFPA (United Nations Population Fund). State of the World Population 2008 – Reaching Common Ground: Culture, Gender and Human Rights. New York: United Nations Population Fund.

UNICEF (United Nations Children's Fund). 2009. Children and AIDS – Fourth Stocktaking Report, 2009. Geneva and New York: United Nations Children's Fund, United Nations Programme on HIV/AIDS, World Health Organization, and United Nations Population Fund.

UNICEF (United Nations Children's Fund). 2008. The State of the World's Children 2009 – Maternal and Newborn Health. New York: United Nations Children's Fund.

UNIFEM (United Nations Development Fund for Women). 2009. Progress of the World's Women 2008/2009. New York: United Nations Development Fund for Women.

WHO (World Health Organization). 2009a. Women and Health – Today's Evidence Tomorrow's Agenda. Geneva: World Health Organization.

WHO (World Health Organization). 2009b. World Health Statistics 2009. France: World Health Organization.

World Bank.2009. World Development Indicators Online 2009.
[https://publications.worldbank.org/register/WDI?return%5furl=%2fextop