AN EVALUATION OF WOMEN'S HEALTH STATUS IN AFRICA: PROGRESS, CHALLENGES AND PROSPECTS

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Abstract: *The promotion of women's health rights is also imperative for Africa's development. This is evident in its inclusion as one of the millennium development goals and the commitment of the African Union in the implementation of existing gender related principles, goals and actions set out in regional, continental and international instruments on women's rights and women's health in Africa. Despite the progress that Africa has made in this regard, many women do not have access to reproductive and health care resulting to complications and death from pregnancy and childbirth or other lifelong health problems. This work assesses the socio-economic implication of maternal health problems on Africa's development. It also evaluates the role of African Union in alleviating women's health issues. The secondary method of data analysis is employed though the review of reports, policy documents and books related to women's health in Africa. It identifies illiteracy, continual conflicts, harmful socio cultural practices and governance crisis as some of the challenges the African Union needs to overcome to improve women's health in Africa. It establishes that when women stay healthy, they are productive, have more opportunities for education, training and employment which in turn benefit their families, their communities and ultimately their nations. Political commitment and financial support to implement replicate and scale up successful policies and programs by government, civil society and the private sector is suggested to improve maternal rights in Africa.*

Keywords: Women, health rights, development, Africa, African Union, Gender.

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INTRODUCTION:

Africa has made significant strides in certain areas of social and economic development and has the potential to achieve even more if it can overcome the large burden of disease especially on women. While it is evident that women are central contributors to economic, social and political development as well as in environmental management, they have received

marginal benefits from economic growth and development, continue to be outside the decision making spheres and barely enjoy any human right (AU Gender Policy, 2008,) Sub Saharan Africa remains the region with the worst indicators of women's health which include highest mortality rate with women having a 3 in 31 chance of dying from pregnancy related cause, highest number of HIV positive women, harmful practices such as female circumcision/genital mutilation and inability of a woman to make decisions regarding her body and reproductive life (Protocol on Rights of Women, 2008). Despite the level of their social status and their large share of the burden of disease and death, women continue to be peacemakers, life-givers, entrepreneurs and providers of care for children; the builders of Africa's future (CWHIAR Report, 2012).

Since women account for over half of the continent human resources, improving their health is vital to achieving the goal of development. This is because favorable health policies, effective and equitable health services are critical to the broader development goal of breaking the circle of poverty. African countries have a leadership role in developing and implementing the required policies and programs to achieve progress in women's health. Consequently, the African Union Heads of State have been in the forefront in championing gender equality following the transformation of the Organization of African Unity (OAU) to African Union (AU). This is clearly demonstrated by its adoption of Gender equality among other principles guiding the transformed Union.

In 2004, the Head of States adopted the Maputo plan of Action which prioritizes African women's health, affirming their continued continental leadership in gender equality not only at the AU assembly, AU organs, and member states but providing a global example to other gender related commitments, principles, goals, and actions set out in regional continental and international instruments on gender equality, women's right and women's health (Protocol on Women's Right in Africa, 2006).

Despite past efforts of government at integrating women's health into the development agenda, maternal health in Africa is still dismissal and women are still subjected to socio-cultural and harmful practices that negatively affect their health and development. Hence, the current push for improvement in women's health status would not only ensure women empowerment, but a sustainable development for the country through gender equality policy initiatives and transform the institutions which continue to perpetrate gender injustice, poverty, and underdevelopment.

CONCEPTUAL CLARIFICATION

When the focus is on women, the question is why a definition of women's health as oppose to human health needed? The answer is that gender is a fundamental social variable that affects individual's social status, access to resources, such as education, income and health

care (Carol 1997). The effects of gender on health and illness thus can be studied for both men and women.

In its attempt to articulate a women's health research agenda, the National Institutes of Health (NIH) used a biomedical definition of women's health based on gender comparisons. It defines women's health issues as diseases or conditions unique to women or some sub group of women, diseases or condition more prevalent in women or some diseases or condition for which the interventions are different for women or sub group of women (Kirschstein 1991). The NIH definition has been criticised, however for its focus on diseases rather than on wellness and for its implicit use of male norm to define the subject matter of women's health (Dan, 1993).

Women centred conceptions of health on the other hand begin with the understanding of the needs of women and of the social factors that influence health while acknowledging biological differences between women and men. They also recognise that society constructs gender based social differences and that gender based inequalities affect health. Example of inequalities include women's more precarious economic status relative to men, women greater exposure to domestic violence and coercive sexual encounters and the stress associated with greater care giving responsibilities within their families and communities. An understanding of the social causes of health also helps in highlighting the diversity among women in their ability to access resources and a safe environment, adequate nutrition and health care.

Rozek, (1993) argues that for an inclusive social model of women's health that focuses on the social factors that affect health. In her view, women's health can be improved through intervention in the community, not just on women's bodies. A definition of women's health that reflects this perspective was adopted for example in the platform for Action of the Fourth World conference in Beijing in September 1995. Health care was defined as the complete physical, mental, and social wellbeing and not merely the absence of diseases or infirmity. Women's health care involves their emotional, social and physical well being and is determined by the social, political and economic condition of their lives as well as biology.

SOCIO ECONOMIC AND POLITICAL CONTEXT OF HEALTH

Women's health is above all a human rights issue and should be supported and promoted as such, but an awareness of the underlying economics of women's health in Africa may be considered valuable. Women in Africa represent slightly over 50% of the continent's human resources and so women's health has huge implications for the Region's development (CWHIAR Report, 2012).

A large socioeconomic benefit is derived from improving women's health. This benefit finds expression in greater productivity by a healthy workforce. Because women are the dominant source of farm labour in the region, and the mainstay of Africa's economy as a whole, investing in their health would generate significant economic gains. Similarly, it is evident that improving maternal health has socioeconomic benefits. The health of mothers is vital to the health of their unborn children. Investing in maternal health is therefore an investment in the health of future generations (Toure *et al.,* 2012). Mothers in Africa not only nurture, feed, clean and clothe their children in non-market settings such as homes and farms; they also direct household resources to the care and upbringing of their children in market settings, such as day care centers, schools and clinics. Where women earn incomes they are more likely, than men, to spend their earnings on goods and services that benefit the household and the children. Evidently any society that limits the role of women to childbearing and child rearing, constraining them only to the home environment, has a heavy price to pay in socioeconomic terms.

Focusing in particular on the unacceptably high level of maternal mortality in sub-Saharan Africa, this calls for a fundamental rethinking of approaches to improving women's health informed by an understanding of the socio-cultural determinants that are so important in shaping it. Health status is also influenced by complex biological, social and cultural factors that are highly interrelated. These factors affect men and women differently. Women's reproductive biology combined with their lower socio–economic status; result in women bearing the greater burden from unsafe sex, which includes both infections and the complication of unwanted pregnancy (Tinker, 2000). Therefore, a range of adverse socioeconomic pressures including inadequate health care prevents African women from realizing their full potential. In Nigeria, for example, 70% of women with breast cancer or cervical cancer report significant loss of revenue resulting from their illness, 62% report their inability to work, while 33% report that their illness disrupted a relative's work (Tsu *et al.,* 2008). It is also worth remembering that user fees are a particular problem for women in the African Region because they are often dependent financially on men. Interventions to improve women's health, focusing solely on "public health" issues miss the fundamental interconnectedness of health with other factors in society; recognizing this interconnectedness is the starting point for emphasizing the multi sector approach required in the African Region.

Arguably, investing in women's health is cost effective because it helps saves resources that would otherwise be spent on treatment and care for chronologically ill women at home or ill health institutions. In other words, a woman's health affects every area of her life. Thus for women to make meaningful contribution to development process, their health in its entirety (the well being of both body, mind and spirit) must be taken care of.

AFRICAN UNION AND THE PROMOTION OF WOMEN'S HEALTH IN AFRICA

Formal processes for prioritizing issues within African Union Assemblies include African Union Commission requests and recommendations; member state requests; and outcomes of regional ministerial conferences. The African Union Commission aims to prioritize health issues based on member state interests and concerns (as defined by conferences of African ministers, member state requests and assemblies). This gives programmes legitimacy and encourages their implementation by countries in addition to supporting the reflection of country priorities in the African Union agenda (http://www.africa-union.org/root/au/). The Commission for Social Affairs has successfully positioned women's and children's health as a crucial issue for the continent, and has been the principal voice behind the regional campaign targeting its improvement and launching of the Campaign for the Accelerated Reduction of Maternal Mortality in Africa (CARMMA) in 2009 (Toure *et al.*, 2012).

CARMMA was launched in 34 countries in partnership with UNICEF, UNFPA and WHO. CARMMA is derived from key priority areas enshrined in the 2005 AU Policy Framework for the Promotion of Sexual and Reproductive Health and Rights in Africa and the Maputo Plan of Action. The campaign seeks to reduce drastically maternal and associated infant mortality in Africa by mobilizing political commitment and support of key stakeholders including national authorities and communities, mobilizing additional domestic resources in support of maternal and newborn health. The campaign also seeks to engage the population through raising awareness actions, emphasizing on the role of every member of the community as an actor to reduce maternal mortality. CARMMA also aims to generate and provide data for a comprehensive action in the countries. The campaign acknowledges and seeks to build on existing initiatives that aim to promote maternal health and reduce maternal and infant mortality in order to develop a coordinated and coherent action among partners, government and civil society (AU, CARMMA Reflections, 2011).

In 1999, the African union became the first and only regional body to pass a charter on the rights of the child. In 2006, the protocol to the African Charter of Human and People Rights became the first convention to mandate state provision of comprehensive reproductive and sexual health services (Ngwena, 2010). This resulted in legal grounds for safe and legal abortion in many countries. African Union policies have also been instrumental in persuading some African policy makers to recognize HIV/AIDS leading to the establishment of HIV/AIDS commissions in all African countries. These commissions have played a role in reducing the annual total of new HIV infections which fell from 2.3 to 1.9 million from 2001 to 2008 (Audit of AU,2007).

The Africa Peer Review Mechanism (APRM) assesses progress on health through its socioeconomic development remit. For example, the APRM 2010 Review of Lesotho expresses concern at the lack of progress on women's and children's health. As of June 2009,

the APRM counted 29 states and reports have already been undertaken in at least 12 countries (APRM report, 2010). The results of this document review indicate that advocacy has indeed been a force behind the uptake of health policies since 2002. For example, during the Summit, health campaigners, development partners and Ministers of Health and Finance were invited to debate health financing during a high-level side event on health financing. Advocates were also invited to speak alongside Heads of States in the plenary session and some of their requests were included in the Summit outcome document.

The Pan African Parliament, created in 2001, to ensure a representation of the voices of African populations in regional decision-making, intervened in favour of maternal, newborn and child health during the July 2010 Summit. While the body currently does not have legislative powers, it aspires "to evolve into an institution with full legislative powers, whose members are elected by universal adult suffrage (Pan-African Parliament http://www.panafricanparliament.org). An assessment of the Parliament notes that adopting this model, which is already in existence in the European Parliament, could render the body much more effective. Currently relegated to an advisory role, the body still contributes to regional prioritization. For instance, in October 2010, the Pan African Parliament Assembly adopted a motion adopting the Africa Parliamentary Policy and Budget Action Plan for Implementation of July 2010 AU Summit Decisions on Maternal, Newborn and Child Health and Development in Africa, and Partnership for Eradication of Mother to Child Transmission of HIV and AIDS. In 2011, the Speakers of African Parliaments adopted Resolution on Declaration of Commitment for the Prioritization and Implementation of African Union Summit Decisions on Youth Development and Maternal, Newborn and Child Health.

Similarly, the African Court on Human and People's Rights has a strong health element to its work. To date, 45 African countries have ratified the charter on the rights of the child and 28 have ratified the protocol on the rights of women. (http://www.africancourt.org/en/.) These efforts have strengthened and improved the health of women and development in Africa.

SITUATION ANALYSIS AND A CHALLENGE FOR THE AFRICAN UNION

Although MDG 5 targets a 75% reduction of global maternal mortality between 1990 and 2015, requiring an average annual reduction of 5.5%, the actual annual average reduction in the African Region from1990 to 2010 was 2.7%. More than half of maternal deaths occur within 24 to 48 hours after delivery due to complications ranging from postpartum hemorrhage to sepsis and hypertensive disorders. Some African mothers simply bleed to death after delivery because no skilled health care professionals present to help. The situation is even more tragic considering that maternal mortality is largely preventable as evidenced by the global disparity in maternal health outcomes. Indeed, in Europe maternal mortality is a

rare event, occurring in only 20 out of 100000 live births, compared to 480 per 100000 in the African Region, the highest ratio of all the regions in the world (Sambo *et al.*, 2010).

While HIV/AIDS and maternal mortality continue to predominate in the morbidity and mortality statistics of the Region, other problems loom. In their advanced ages, African women suffer increasingly from non communicable diseases (NCDs), notably cardiovascular diseases, cancers, diabetes and chronic respiratory diseases. The NCD prevalence rates are generally not recorded by the health services in Africa, but the few studies undertaken suggest that they are high and even increasing. According to WHO, if nothing is done to address the issue of NCDs, they will represent at least 50% of mortality in the African Region by 2020.

Underinvestment in women's health care is one of the many challenges to be overcome. The failure of health systems in the majority of African countries to provide accessible care of adequate quality is one of the main drivers of the adverse trends in women's health indicators. This situation stems also from other factors such as inadequate empowerment of women and poor health systems design. Since 2003, average health spending as a percentage of total spending by African countries has hovered around 10%, i.e., two thirds of the level to which African leaders committed themselves in 2001. It is worth noting that over ten years after Abuja only Botswana, Burkina Faso, Democratic Republic of Congo, Liberia, Rwanda, Tanzania and Zambia are delivering on their pledges, while 13 African countries actually allocate less of their total government budgets to health now than they did prior to 2001 (CWHIAR Report, 2012).

According to the WHO data (2010), even with adequate funding, health systems in the Region will struggle to meet the needs of women unless fundamental changes are made in health systems design. This is because majority of modern health care services provided in the Region are clinic-based, physician-oriented and urban centered, leaving the predominantly rural population woefully underserved. It is therefore crucial that policy makers rethink health systems design, placing greater emphasis on primary health care (PHC). The organization of maternal health care delivery in particular needs to be reconsidered and reorganized with a view to improving access to basic and comprehensive emergency obstetric care.

Africa is a continent that has experienced a history of impunity due to bad governance perpetuated by African leaders as well as external forces in search of personal interest. This has resulted into disagreements and manipulation at the state level, causing the continent to suffer bouts of conflicts. During these conflicts women's bodies have become battle grounds, making them to experience a lot of physical, mental, and psychological pains that have grossly affected health and well being. The forms of abuse and violence inflicted on women

due to gender include; rape, sexual slavery, forced marriage, incest, and body mutilation estimated to be inflicted on more than two million girls between the ages of four and twelve, every year, while over 92 million girls and women above the age of 10 are thought to be living with the indignity and pain resulting from such abuse (Ruth 2004). Women also find themselves facing other effects of conflicts such as land mines and torture, burning, poor sanitation and inadequate food. Many countries of sub-Saharan Africa have passed laws penalizing the practice but legislation needs to be complemented by more broad based involvement of local communities in decision making.

Although some countries have achieved representation of 50% or more, on the whole; women are significantly underrepresented in politics in Africa as most countries in the Region have fewer than 10% female members of Parliament. This deficit begins at the grassroots level because gender discrimination, especially the absence of educational opportunities, gives women the impression that they have no voice. Fortunately, this situation is changing for the better in some countries. The picture is also bleak with regard to women holding cabinet posts or senior appointments in the civil service. Women's participation in the highest political structures of government is clearly crucial to the mainstreaming of women's health issues and has already been important in supporting the enactment of laws against gender-based discrimination and harmful cultural practices such as female genital mutilation.

Sub-Saharan Africa has the lowest percentage of female youth literacy, the lowest primary school enrolment ratio and the lowest primary school attendance ratio in the world, while the net secondary school attendance among girls in sub-Saharan Africa is 22%, compared with 52% in South Asia for example. Some African countries are already trying to address this issue, notably by waiving payment of school fees for girls and introducing free lunch programs. These simple initiatives have led to significant increases in school attendance but much more can be done. Educating women promotes socioeconomic empowerment. However, the empowerment will be incomplete unless women are also facilitated to participate fully in the job market and can enjoy the fruits of their labour.

CONCLUSION

There have been commendable efforts towards addressing the developmental challenges facing Africa particularly since the advent of the African Union. The indication of the impact of good investments and effective interventions on burden of disease and on economic indicators is becoming stronger. This is evident in the protocol to the African Charter of Human and People Rights passed in 2006, The Campaign for the Accelerated Reduction of Maternal Mortality in Africa (CARMMA) in 2009 and the commitment of the African Union in reducing HIV/AIDS in Africa.

Nonetheless, the reality remains that Africa's people particularly women face a huge burden of preventable and treatable health problems which continues to foster a barrier to development. Though they constitute a major source of Africa's human resource, Women still carry a disproportionate share of Africa's heavy disease burden, with many suffering or even dying from HIV/AIDS, malnutrition, sexual abuse, domestic violence and pregnancy and childbirth related cases. The specific challenges faced by African women at different stages of life prevent them from realizing their full potential and pose great challenges to development.

When a woman is healthy, she has the energy and strength to do her daily work, to fulfill the many roles she has in her family and community and to build satisfying relationships with others. Better women's health establishes the foundation for empowerment through education which in turn feeds back into health, drives socio-cultural enrichment and opens up the possibilities for advancement in all spheres of professional life.

A multi sector approach is imperative to improve women's health. Crucially, therefore, policy makers should adopt dynamic measures in dealing with women's health issues. For example, several of the major health issues affecting women in Africa are associated with poor living conditions, and addressing them requires their root causes to be addressed. As the main gatherers and sources of firewood and water, and the principal producers and processors of food in African households, women are exposed to particular health risks. There is ample evidence that improving infrastructure such as access to roads and providing safe and accessible water sources can considerably improve women's health, and economic well-being. As the main participants in these activities, women themselves have an important part to play in developing policy and designing projects to improve the fuel and water situations in African homes and should, in general, be involved in development processes at all levels of society.

One of the most important actions for positive change in the African Region is improving women's education. Policy makers need to commit more resources to improve girls' access to schools. They must challenge the social stereotyping that keeps girls at home and do the household chores while boys go school.

Promoting good governance and leadership is imperative to improve, support and invest in women's health. Health is a human right that is increasingly being recognized as enforceable. Governments have a responsibility for guaranteeing health care for all their citizens in an equitable manner and with clean and efficient governance, while using resources accountably. There should be committed action for health involving other ministries and levels of government to manage the socio-political environment within which the health system operates. This also includes the involvement of professional organizations and women's

groups in campaigns, as well as interaction with communities in addressing the cultural reasons for perpetuation of harmful practices against women.

Family planning has been shown to have direct socioeconomic benefits. World Health Organization estimates that in a number of low-income settings, including sub-Saharan Africa, investing one dollar in family planning can save four dollars that would otherwise have been spent on subsequently addressing the complications resulting from unplanned pregnancies. For example, by reducing the number of unplanned births among adolescents, policy makers can expect more young women to stay in school, which in turn improves women's social status and economic output. Limiting conception can also benefit the home by giving the mother time to recuperate between pregnancies, and by allowing her to devote more time and resources to each of her children.

Partnerships of government with communities, private sector, civil society organizations as well as development partners are also essential to make an environment conducive to good health status of women and Africa at large.

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