

a measure of commitment

**WOMEN'S SEXUAL AND REPRODUCTIVE RISK
INDEX FOR SUB SAHARAN AFRICA**

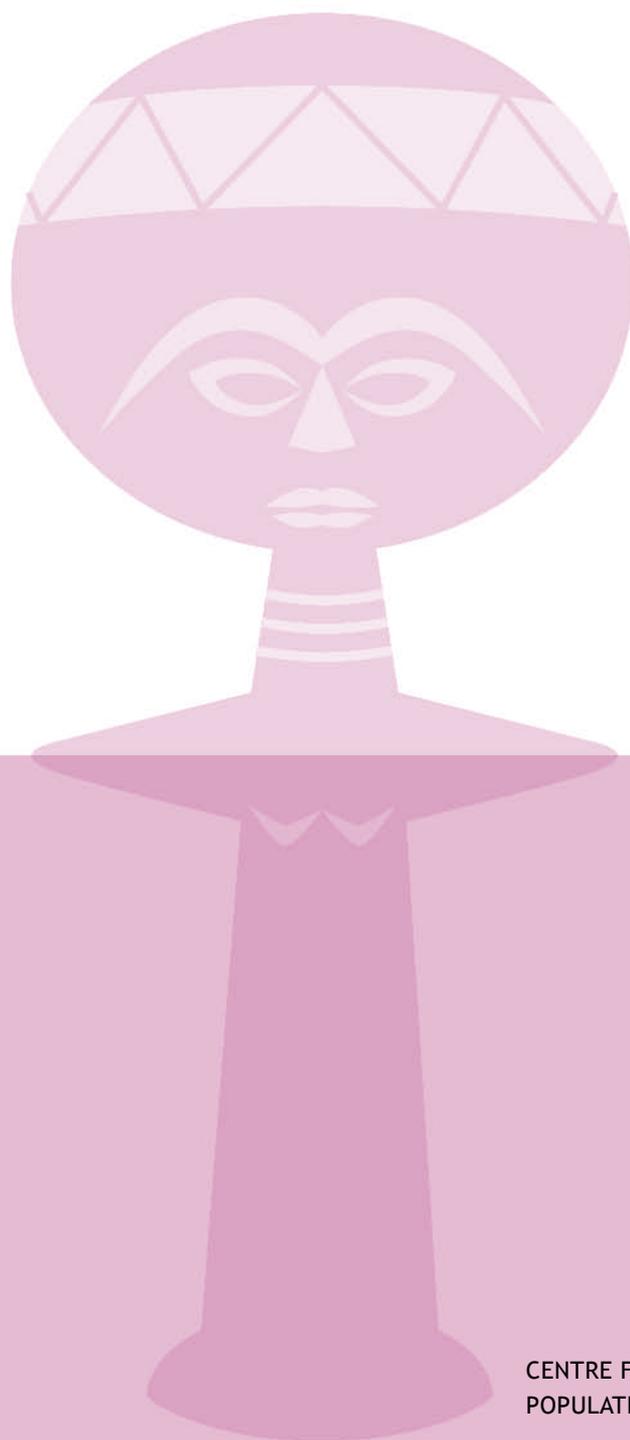


CENTRE FOR THE STUDY OF ADOLESCENCE
POPULATION ACTION INTERNATIONAL



a measure of commitment

WOMEN'S SEXUAL AND REPRODUCTIVE RISK INDEX FOR SUB SAHARAN AFRICA



CENTRE FOR THE STUDY OF ADOLESCENCE
POPULATION ACTION INTERNATIONAL

Acknowledgements

This report is a collaborative effort between the Centre for the Study of Adolescence (CSA), Nairobi and Population Action International (PAI). This study would not have been possible without the invaluable support of the following organizations and individuals to whom we are extremely grateful:

- Population Studies Research Institute (PSRI), University of Nairobi, Kenya who provided the technical support for the report. We are particularly grateful to the following people: Dr. Lawrence Ikamari and Dr. Alfred Titus Agwanda.
- Division of Reproductive Health, Ministry of Public Health and Sanitation for their participation and invaluable input in the development of this report. In particular, we thank Dr. Janet Wasiche and her staff.
- Dr. Sarah Onyango of the Planned Parenthood Federation of America (PPFA) Africa Regional Office, for providing technical support.
- WHO Office, Nairobi particularly Dr. Joyce Lavusa for providing technical support for this publication.

We are grateful to PAI for facilitating this work, particularly Wendy Turnbull and Suzane Ehlers for their invaluable guidance and support and Meher Rehman for reviewing the document. We are sincerely indebted to Roberto Hinojosa for the beautiful cover design and to Noel Creative Media for the design and layout of the document.

We would also like to thank, Phoebe Ndayala and Joan Kabaria for doing the background research, Collette Aloo Obunga and Joseph Karueru for helping compile the report. Finally we would like to thank Rosemarie Muganda-Onyando for coordinating the compilation and editing the report and the following staff of the Centre for Study of Adolescence who provided support for this publication: Tijara Alawi, John Nyaga, Martin Omondi and Albert Obbuyi.

Design & Printing by Noel Creative Media Limited

© 2009, **Centre for the Study of Adolescence (CSA)** and **Population Action International (PAI)**. Any part of this document may be reproduced or adapted to meet local needs without prior permission from the Centre for the Study of Adolescence, provided appropriate acknowledgement is given and the material is made available free of charge.

ISBN: 9966-9845-3-4

Table of contents

Acronyms	ii
Executive Summary	iii
A Measure of Commitment - Calculating Women’s Sexual and Reproductive Risk in sub-Sahara Africa	iv
Background	vii
Reproductive Risk in sub-Saharan Africa.....	x
Factors Contributing to Reproductive Risk in sub-Saharan Africa	xi
Maternal Health in sub-Saharan Africa	1
Access to Ante Natal Care Critical for Ensuring Safe Pregnancy.....	4
Skilled Attendance at Birth	6
Family Planning Saves Lives.....	10
Unsafe Abortion: The Forgotten Epidemic.....	12
Reproductive Tract Infections (RTIs) and Sexually Transmitted Infections (STIs)	16
HIV/AIDS and Women in sub-Saharan Africa.....	19
Adolescent Sexual & Reproductive Health.....	22
Education can be a Powerful Tool in Improving Maternal Health in sub-Sahara Africa.....	25
Harmful Practices: Violating the Rights of Girls and Women	27
Sexual and Gender Based Violence: The New Epidemic.....	29
Strengthening Health Systems is critical to improving maternal health	33
A Measure of Commitment: Health Care financing in sub-Sahara Africa: A grim scenario.....	35
Broken Promises and Misplaced Priorities.....	37
Call To Action.....	39
Measuring Reproductive Risk in sub-Saharan Africa	42
Highest Risk Category.....	42
Very High Risk Category.....	44
Moderate Risk Category	46
Low Risk Category	48
Bibliography	50

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti Retroviral Therapy
CEDAW	Convention on the Elimination of All forms of Discrimination Against Women
CSA	Centre for the Study of Adolescence
DfID	Department for International Development
DHS	Demographic and Health Surveys
GER	Gross Enrolment Rate
HIV	Human Immune deficiency Virus
IAWG	Inter-Agency Working Group
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
KDHS	Kenya Demographic and Health Survey
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
OECD	Organization for Economic Co-operation and Development
PAC	Post Abortion Care
PAI	Population Action International
PEP	Post Exposure Prophylaxis
PRB	Population Reference Bureau
PSRI	Population Studies Research Institute
RH	Reproductive Health
RHS	Reproductive Health Supplies
RTI	Reproductive Tract Infections
SGBV	Sexual and Gender Based Violence
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
UDHS	Uganda Demographic and Health Survey
UNFPA	United Nations Population Fund
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNICEF	United Nations Children’s Fund
UON	University of Nairobi
VAW	Violence Against Women
WHO	World Health Organization

Executive Summary

In 2008 the number of African women who died from pregnancy and child birth was much higher than the number of casualties from all the major conflicts in Africa combined. Maternal mortality continues to be the major cause of death among women of reproductive age (15-49) in Sub-Saharan Africa (SSA). Most of these women die from complications that can often be effectively treated in a health system that has adequate skilled personnel, a functioning referral system and can respond to obstetric emergencies when they occur.

Maternal mortality is one of Africa's most neglected problems and little progress has been made in reducing the Maternal Mortality Ratio (MMR) in the region despite progress in other parts of the world. Africa accounts for half of all maternal deaths in the developing world and has by far the highest maternal mortality ratio in the world. The lifetime risk of maternal death in SSA is 100 times higher than in other parts of the world.

It is a big irony that a continent that places such a high premium on childbearing invests so little to prevent pregnancy related deaths. SSA has made little progress in reducing maternal mortality and in some instances even earlier gains have been eroded. While some countries in the region have increased investment in maternal health overall the lack of political commitment is holding back progress.

Health systems are plagued by severe staff shortages, dilapidated and rundown infrastructure, frequent stock-outs of essential RH supplies including contraceptives, inefficiency and mismanagement and inadequate financing for reproductive health. In addition, high fertility and unplanned pregnancies as well as discriminatory cultural and traditional practices all work in concert to increase reproductive risk among women and girls.

Many countries have signed internationally recognized agreements such as the International

Conference on Population and Development, ICPD (the Cairo Agenda); and the Millennium Development Goals (MDGs) endorsed by the international community in 2000, but there is a clear mismatch between policy priorities and financial commitment. Few countries have budget lines for reproductive health and those that do invest less than 1 percent of the total sector budgets on RH. As a result few countries will meet MDG 5 and even fewer will meet regional targets such as the Abuja commitment of ensuring that the health budget makes up 15% of the GDP.

The lack of political commitment is further evidenced by the weak and uncoordinated approach to policy implementation and the overwhelming reliance on donors to support maternal health programs. Even countries enjoying relative peace and stability are still spending more on defence than on maternal health.

This report looks at the performance of SSA countries in meeting reproductive health targets in 47 countries and ranks them using a set of ten indicators in order of the highest to lowest risk. It highlights the need to increase the level of investment in reproductive health, step up policy reform and implementation, expand access to services in rural areas, strengthen health systems, promote the realization of rights and abolish retrogressive cultural practices that perpetuate gender inequities and put the lives of women and girls at risk.

The first part of the report discusses the methodology and the background and looks at the factors contributing to reproductive risk in sub Saharan Africa. The second part looks at the status of the ten indicators and highlights factors that have a bearing on the same. The third part presents a call to action highlighting key actions that would contribute to improving maternal health in sub Saharan Africa.

A Measure of Commitment - Calculating Women's Sexual and Reproductive Risk in sub Saharan Africa

Every year more than half a million women die from pregnancy and childbirth. Millions of others who survive suffer from disability, infection and injury often with lifelong consequences. Approximately 80 percent of maternal deaths can be averted if access to essential maternity and basic health care services was expanded for women especially in remote rural areas where access is limited.

Global efforts to reduce pregnancy related deaths have had less success than other areas of human development and pregnancy remains one of the most dangerous and risky undertakings especially for poor women. Most deaths occur in less developed countries especially among poor, marginalised women. Infant Maternal mortality shows the largest divide between industrialized and developing countries. Based on 2005 data the average lifetime risk of death from pregnancy and childbirth for a woman in a developing country is 300 times higher than for a woman in a developed country.¹ Sub Saharan Africa and South Asia account for most of these deaths, with the former accounting for almost half of all deaths.

The situation is very severe in SSA where only five countries account for 26% of the total estimated deaths world wide.² High levels of poverty and deprivation in most parts of the continent, inadequate supplies especially in rural areas, limited access to emergency obstetric care, harmful social norms that perpetuate gender inequity, low investment in reproductive health and the lack of political will all work in concert in contributing to increased risk within countries and across the region.

The lifetime risk of death from pregnancy is higher in SSA than in any other regions in the world. High fertility multiplies the dangers women face over a lifetime. In SSA 1 in 16 women is likely to die as a consequence of pregnancy and childbirth. There are significant variations based on socio-economic status with the risk as high as 1 in 7 in some parts of the continent.

There is evidence that effective interventions have worked in certain countries and settings to significantly reduce reproductive risk, but in SSA progress has been slow. Countries such as Sri Lanka that managed to reduce maternal mortality clearly demonstrate that even poor countries in sub-Saharan

Africa can significantly improve maternal health if they can expand services in rural areas, intensify training of midwives and strengthen family planning and obstetric care.

Reducing women's sexual and reproductive risk also requires the political will to reduce inequities in reproductive health status and in access to services and a focus on reforming and strengthening health systems. At the same time, there should be emphasis on the eradication of harmful practices that perpetuate inequality and increase women's vulnerability and risk of maternal death.

Methodology

In 1995, Population Action International (PAI) began assessing the sexual health status of nations through a series of studies.^{3,4,5,6} In 2007, PAI working with experts in the field of population and health developed the Reproductive

1 UNICEF 2009. State of the World's Children: Maternal and Newborn Health. New York, 2009.

2 UNICEF 2008. Progress for Children. A Report Card on Maternal Mortality. Number 7, September 2008. UNICEF, New York.

3 Population Action International. 2007. A Measure of survival: Calculating Women's Sexual and Reproductive Risk, PAI Report Card 2007. Washington, DC: Population Action International.

4 Population Action International. 1995. Reproductive Risk: A Worldwide Assessment of Women's Sexual and Maternal Health. Washington, DC: Population Action International.

5 Population Action International. 2001. A World of Difference: Sexual Reproductive Health and Risks. Washington, DC: Population Action International.

6 Chaya, Nada and Jennifer Dusenberry. 2004. ICPD at ten: Where are we now? Washington DC: Population Action International.

Risk Index (RRI).⁷ The framework for measuring reproductive risk was constructed according to the basic elements of reproduction — sex, pregnancy, childbirth and survival—as these are among the more direct causes of increased vulnerability to death and injury for women around the world.

As a single measure of reproductive risk overall, the RRI is a guide for reproductive rights advocates committed to ensuring that women everywhere can exercise their reproductive rights and make informed choices and decisions regarding their sexuality and general well being.

This study uses PAI’s RRI to provide a benchmark of where women in 47 sub-Saharan African countries stand on a range of indicators that were incorporated into the International Conference on Population and Development (ICPD) Programme of Action in 1994 or into the Millennium Development Goals (MDGs) in 2000.

For each of the 47 countries, the study combines a range of RH indicators into a manageable set by putting them into one single measure—the Reproductive Risk Index (RRI). The ten indicators composing the RRI are: HIV/AIDS prevalence among adults; Adolescent fertility; Infant mortality; Antenatal care coverage; Percent of family planning demand met; Births attended by skilled health personnel; Grounds on which abortion is permitted; Maternal Mortality Ratio (MMR); and Infant Mortality Rate (IMR) and Female literacy.

Selection of the indicators: The selected indicators were based on the ICPD, MDGs and WHO/UNFPA core indicators of reproductive health. They are similar to those used by Population Action International in the 2007 report card except for the inclusion of education related variables.

⁷ Population Action International 2007. Measure of Survival: Calculating Women’s Sexual and Reproductive Health Risk, PAI Report Card 2007.

Data Quality: The study encountered a number of data problems. In a number of sub Saharan countries, the evidence for maternal health is weak. Data for key indicators is not available or is outdated making it difficult to assess progress. The national level statistics also mask differentials in reproductive health within countries and data on coverage of health services do not reflect the quality of care. Two of the countries included here had missing data for 5 or more of the 10 indicators.

Table 1: Selected Indicators for the reproductive health risk score card for sub Saharan Africa

	Indicator	Measurement
1	HIV Prevalence Among Adults 15-49	Quantitative
2	Adolescent fertility	Quantitative
3	Female Secondary School Enrolment (Gross)	Quantitative
4	Female Illiteracy Rate	Quantitative
5	Ante Natal Care (ANC) Coverage at least 4 Visits	Quantitative
6	Contraceptive Prevalence Rate (CPR)	Quantitative
7	Births Attended by Skilled Health Personnel	Quantitative
8	Grounds on Which Abortion is permitted*	Qualitative
9	Maternal Mortality Rate (MMR)	Quantitative
10	Infant Mortality Rate (IMR)	Quantitative

Computation of the Reproductive Risk Index

The quantitative indicators were all rescaled (transformed) on a scale of 0 to 100 where 100 was the worst case and 0 the best case. The 8th indicator was an ordinal indicator and scored as follows: to save a woman’s life or prohibited altogether 95, to preserve a woman’s life 70, to preserve woman’s mental health – 40, socio economic grounds 15, no restriction 5. All the 10 indicators were merged into a simple composite

score called the reproductive health risk by computing a simple arithmetic mean of the scores.

The countries were then ranked from the highest to the lowest. The highest score is about 75 indicating the country with highest risk and the lowest score is 11 indicating the country

with lowest risk in sub Saharan Africa. Eleven countries which have a score 60 points or higher are in the highest risk category. The next category of very high risk contains 21 countries with scores ranging between 45 to below 60. 13 countries have scores ranging from 20 to 44 are in moderate but still high risk category. Only one country falls in low risk category of scores below 20.

Sources of data and information

- UNICEF (2006) statistics on mother and child health indicators per country from [http:// www.unicef.org](http://www.unicef.org)
- UNICEF (2006) statistics on mother and child health indicators per country from [http:// www.unicef.org](http://www.unicef.org)
- UNFPA State of World Population Report (2008): Reaching Common Ground: Culture, Gender and Human Rights
- WHO World Health Statistics (2007): Health status indicators, Health services statistics, Mortality, Life expectancy, Demography Statistics.
- UNICEF (2008). Tracking progress in maternal newborn and child survival. The 2008 report
- UNICEF State of the Worlds Children, 2005, 2006, 2007, 2008, 2009
- Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization (WHO) 2007. Sub-Saharan Africa AIDS epidemic update regional summary
- UNSTATS Millennium Development Goals (MDG's) 2008
- HIV/AIDS indicator Surveys for different countries
- UN 2007 Department of Economic and Social Affairs Population Division. World Abortion Policies 2007 a UN Publication
- Demographic and Health Surveys (DHS) conducted by Macro International.

Background

In the period immediately after independence, African governments declared war on ignorance, disease and poverty. More than four decades later many of these promises remain unfulfilled in most countries with key social and development indicators looking worse than they did at independence. There is a high disease burden and preventable diseases such as malaria, vaccine preventable and water borne diseases remain the most common causes of mortality and morbidity in parts of the continent. Further more, pregnancy related complications contribute significantly to mortality and morbidity among women of reproductive age (15-49). The impact of HIV/AIDS is clearly being felt as AIDS related mortality and morbidity increases, life expectancy drops and productivity is reduced indirectly raising impoverishment especially among children and women.

Health sectors in many countries are plagued by severe staff shortages, dilapidated and rundown infrastructure, frequent stock-outs of essential supplies including contraceptives, inefficiency and mismanagement and the lack of adequate financing to enable countries meet the reproductive health needs of their citizens. Service utilization is low with less than half of women delivering with skilled attendance significantly increasing the risk of maternal and new born morbidity and mortality. Across the continent, there is limited funding for reproductive health services, referral systems are non-functional and emergency obstetric care is limited in rural areas where the majority of women live.

Maternal mortality is one of Africa's most neglected problems and little progress has been made in reducing the Maternal Mortality Ratio (MMR). According to the UN inter-agency estimates sub Saharan Africa accounts for half of

all maternal deaths in the world and has by far the highest maternal mortality ratios and lifetime risk of maternal death. Of the 10 countries that account for two thirds of maternal deaths in the world, five are in sub-Saharan Africa. The five - Niger, Nigeria, United Republic of Tanzania, Democratic Republic of the Congo and Ethiopia - accounted for 26% of the total estimated deaths world wide in 2005.⁸

The lifetime risk of maternal death in developing countries is 1 in 76 compared to 1 in 8000 for women in industrialized countries. In SSA the lifetime risk of maternal death is 1 in 16 with wide disparities between and within countries. In Niger it is 1 in 7, in Sierra Leone 1 in 8 and in Nigeria 1 in 9

The progress in reducing maternal mortality varies greatly between regions and within countries. While some regions have recorded some progress in improving maternal health, in sub-Saharan Africa, there has been no appreciable progress over the past decade and a half and pregnancy related deaths remain unacceptably high. There is also evidence that conflict and instability is making the situation worse in some countries.

As more African countries embrace democratic principles, issues of human rights have taken centre stage in public discourse and debate on social policy issues has increased citizen participation. In the area of Reproductive Health there has been little if any meaningful discussion. Reproductive rights remain elusive for the majority of people. Culture is still commonly used as an excuse for the

⁸ UNICEF 2008. Progress for Children. A Report Card Maternal Mortality No.7, September 2008, UNICEF New York

violation of rights especially of women and girls while harmful practices such as early and forced marriage, female genital mutilation/cutting and violence are quite easily accepted.

Among policy makers who control government budgets and spending there is little knowledge of their government's commitments to internationally-recognized agreements and frameworks such as the International Conference on Population and Development, (ICPD) 1994 (the Cairo Agenda); The Beijing Platform for Action, 1995; The Millennium Development Goals (MDGs) endorsed by the international community in 2000, the Safe Motherhood Initiative (SMI) launched in Nairobi in 1987 or even the Partnership for Maternal and Newborn Health launched in 2005.

In many countries, population and health policies clearly align global targets with local priorities. But a closer scrutiny however shows a clear mismatch between the policy priorities and financial commitments. The lack of political commitment is further evidenced by the weak and uncoordinated approach to policy implementation and the low investment in reproductive health and the overwhelming reliance on donors to support RH programs in the continent.

At the same time few countries will meet health related regional and global targets such as MDGs and Abuja of ensuring that the health budget makes up 15% of the GDP. Only a handful of countries out of those that signed the Abuja Declaration are likely to meet this target and even fewer are committed to doing so. There is little political will to increase investment in maternal

health. Where funds for RH are included in health budgets, they make up less than 1% of the total sector budgets.

Conflict and political stability have compounded an already bad situation. In the Democratic Republic of the Congo (DRC), Somalia, Sudan, Chad, Burundi, Liberia and Sierra Leone which are either experiencing or emerging from conflict, the massive disruption of social services has taken its toll on the health sectors, making access to RH services difficult. In these countries, the death toll from pregnancy related complications is high and rising. Conflict is also driving Sexual and Gender Based Violence (SGBV) levels up, creating a new epidemic.

This report highlights the need to increase the level of investment in reproductive health, expand access to services in rural areas, strengthen obstetric care services, strengthen health systems, promote the realization of rights and abolish retrogressive cultural practices that perpetuate gender inequities and put the lives of women and girls at risk.

The report shows that political commitment is one of the most important factors in reducing maternal mortality in sub-Saharan Africa. A country's wealth is not the most important determinant of the status of maternal health, but the commitment of its leaders. Liberia and Rwanda only emerged from conflict recently but invest more in health clearly outpacing bigger and richer nations. If wealth and size were all that mattered, Nigeria would be doing extremely well.

While African countries align health policy priorities with regional and global commitments a closer look reveals a mismatch between the policy priorities and financial commitments.



Reproductive Risk in Sub Saharan Africa

Highest risk category (11 Countries)

There are 11 countries in this category all of which are characterised by low skilled care during pregnancy and childbirth, high or very high infant and maternal mortality and very high unmet need for contraception. Maternal mortality ranges from 700 in Burkina Faso to 2100 deaths per 100,000 live births in Sierra Leone. Less than half the women deliver with skilled care in almost all the countries. Two countries have skilled attendance at delivery of less than 20 percent.

There is a high unmet need for Family Planning with 5 out of the 11 countries having a CPR of less than 10 percent. Only one country has ANC coverage of over 50%. In 4 countries ANC coverage is less than 20 percent. The two countries with the lowest ANC coverage in this category also have the lowest skilled care at delivery and the lowest CPR. Additionally, early marriage is common, adolescent fertility is high and abortion policies are mostly restrictive.

High risk category (21 Countries)

Most SSA countries fall in this category. In these countries skilled care during pregnancy and childbirth is limited but there are variations with some countries. Maternal and infant mortality is very high. Unmet need for contraception is highest in the Western African countries. Very early marriage is common and adolescent fertility is generally high. Access to ANC is limited in many countries.

Moderate to High risk category (13 Countries)

The countries in this category are considered to have moderate risk, but maternal mortality is still high in some of them. ANC coverage is generally high with between 6 out of 10 to 9 out of 10 women making at least 4 visits. Performance on various indicators is fairly mixed. A significant proportion of family planning demand is met. Level of contraceptive prevalence is generally high with Zimbabwe, Mauritius and South Africa registering CPR of 60 or above. Ghana and Sudan are the only countries with CPR below 20 – 17 and 8 percent respectively. Adolescent fertility is high in the Congo and the Gambia. Most women deliver with skilled care except in Ghana where less than half the women deliver without skilled care.

HIV prevalence is low except in South Africa and Botswana where HIV prevalence still remains high although this represents major declines over the past few years.

Low risk category (1 country)

Only one country in sub Saharan Africa falls under this category. There is a high contraceptive prevalence and almost all births – 9 out of 10 - are delivered with skilled care. Maternal mortality is relatively low, compared to other countries. There is also good political will towards improving health targets. Cape Verde is one of the few countries that have met the 15% Abuja target and is also expected to meet the Millennium Development Goals.



Factors Contributing to Reproductive Risk in Sub Saharan Africa

The lifetime risk of maternal death in sub Saharan Africa is 1 in 16. There are variations between regions and countries. West and Central Africa have the highest lifetime risk followed by East and Southern Africa.

Poor infrastructure, inadequate financing, staff shortages, harmful social norms which condone discrimination and promote the low status of women, a key factor in access to and utilization of reproductive health services. Other factors contributing to increased risk include;

High Fertility increases a woman's cumulative lifetime risk of death from pregnancy and childbirth. Sub-Saharan Africa was the only region in which the number of maternal deaths increased between 1990 and 2005, driven by increasing number of births and negligible decline in maternal mortality ratio.⁹ The Total Fertility Rate (TFR) in sub-Saharan Africa ranges from 7.7 children per woman in Niger to 2.0 in Mauritius. Available data indicate that countries with high

total fertility rates such as Niger also have high maternal mortality ratios (1800) while those with low total fertility rates are likely to have lower maternal deaths. Mauritius has maternal mortality of 24 compared to 1800 for Niger.

Out of the 47 countries included in this report over half (26) have total fertility rates of over 5.0 per woman. Countries such as Uganda, Chad, Benin with high fertility levels also have higher lifetime risks of pregnancy related deaths than those that have lower levels. Nigeria with a fertility rate of 5.4 and about 6 million births

⁹ WHO, 2007. Reproductive health matters vol. 15: November 30 2007. Maternal Mortality and Morbidity: is pregnancy getting safer for Women?

per year has a 1 in 9 lifetime risk of death from pregnancy and childbirth.¹⁰

Limited access to family planning contributes to increased risk: In developing countries, 41 percent of all pregnancies and 26 percent of all births are unintended.¹¹ In these countries, 35 percent of maternal deaths result from unintended pregnancies, and 13 percent are attributed to induced abortion. One study found that if unwanted pregnancies were prevented, between a quarter and two-fifths of maternal deaths could be eliminated.¹²

Data indicate that SSA countries with high percentages of women using modern methods have low maternal mortality. Mauritius with a CPR of 76% and South Africa with 56% have a MMR of 24 and 230 deaths per 100,000 live births respectively. Compare this with Mali, Angola and Guinea Bissau with high unmet need for family planning and a Total Fertility Rates (TFR) of over 6 children per woman and high infant mortality rates of over 100 deaths per 1000 live births.¹³

Poor access to services increases risk: One barrier to accessing emergency obstetric care is lack of facilities near rural communities. Across Africa there is no guarantee that a facility will have supplies and services that women require when they reach one. In Ethiopia, 90 to 95 percent of women deliver at home and are two hours or more away from a health facility.¹⁴

Severe shortages of skilled health providers is holding back progress in sub Saharan Africa: Shortage of skilled health personnel is one of the biggest challenges for maternal and neonatal health in sub Saharan Africa. SSA accounts for 24 percent of global disease burden and has only 3 percent of

world's skilled health professionals. The situation is dire in some countries where emergency obstetric care is extremely limited severely increasing risk as women deliver at home at the hands of Traditional Birth Attendants (TBA) or family members.¹⁵

Of the 57 countries that fall below the minimum WHO desired level of coverage for skilled attendance at delivery (2.28 health care professionals per 1000 people) globally, 36 are in SSA. In order to meet the required level, sub Saharan Africa would need to increase the number of health workers by 140 percent, an almost impossible feat given the current levels of investment.

Although the countries with the largest health worker shortages are found in Asia, the largest relative need is in sub Saharan Africa

Migration of health workers to industrialized nations has also taken a huge toll on Africa. A survey of 10 African countries showed that the number of locally trained doctors now working in eight Organization for Economic Co-operation and Development (OECD) countries was equivalent to 23 per cent of the doctors still domestically employed in those countries.

Limited funding for maternity services: Maternity services in the developing countries have probably been the most grossly under funded priority. In sub-Saharan Africa countries rarely include funding for reproductive health in sector budgets and do not also single maternity services as a priority for which substantial resources need to be invested.

Poverty, discrimination and a mother's survival: In sub-Saharan Africa poverty increases the risks inherent in childbearing. Within countries, the wealthiest women have much better access to skilled obstetric care than the poor.

10 United Nations Children's Fund, *The State of the World's Children 2009: Maternal and Newborn Health*, UNICEF, New York, 2009, pp. 19.

11 Vlassof M, S. Singh, E Darroch, E Carborne, and S. Bernstein 3004 "Assessing costs and benefits of sexual reproductive health interventions. Occasional Report Number 11. New York: Guttmacher Institute

12 Population Action International 2007. *Measure of Survival: Calculating Women's Sexual and Reproductive Health Risk*, PAI Report Card 2007.

13 Population Action International 2007. *Measure of Survival: Calculating Women's Sexual and Reproductive Health Risk*, PAI Report Card 2007.

14 Ronsmans, Carine and Wendy J Graham. 2006. "Maternal mortality: Who, when, where and why." *The Lancet* 368: 1189-1199.

15 UNFPA, 2007 on website <http://www.unfpa.org/news/news.cfm?ID=776> Accessed on 10th October 2008). According to the WHO 2007 Report (WHO, 2007)

Poor women are more likely to delay seeking care in emergency situations and also more likely to deliver at home without skilled care. Women in the lower-income quintiles are also less likely to be using any method of contraception, even though they express the desire to limit or delay child birth.¹⁶

Maternal death and disability rates reflect the huge discrepancies that exist between the haves and the have-nots both within and between countries. In 16 West and Central African countries women from the richest quintile are three and half times more likely than those from the poorest to deliver with skilled care. The disparity is greatest in Chad where only 1% of the poorest women have skilled care at delivery compared with 48% of the wealthiest women.¹⁷

High levels of maternal mortality are associated with gender inequality: Cultural attitudes and practices that discriminate against women and girls contribute to increased risk of maternal mortality and morbidity in Africa. Early and forced marriage and high rates of adolescent pregnancy are common in many parts of Africa. FGM also increases risk of obstructed labour yet it continues to be practiced in many African countries.

Gender discrimination in access to education and health care and the general lack of control over economic resources and reproductive decisions further increase risk for women and girls.

Conflict, natural disaster and forced displacement take a heavy toll on the reproductive health of adolescent girls and women. Some of the countries with very high maternal deaths are those affected by conflict. According to the 2006 Sudan Household Health Survey, the maternal mortality ratio for Western Equatorial, a province in Southern Sudan, stood at 2,327 deaths per 100,000 live births, one

of the highest in the world. The 2006 neonatal mortality rate was 51 deaths per 1,000 live births, significantly above the Sudan's national ratio of 41 per 1,000 live births.

Ensuring adequate commodities and supplies would contribute immensely to improving maternal health outcomes: Developing countries face critical shortfalls of RH supplies including medicines, and condoms due in part to the rising demand from a rapidly rising population, a growing desire for smaller families, high HIV prevalence, and declining donor funding. In sub-Saharan Africa the situation is worse, reproductive health commodities are in short supply and contraceptive commodity stock-outs a common occurrence.

Increasing access to family planning and strengthening Emergency Obstetric Care are critical elements in reducing risk of maternal death: To reduce maternal mortality countries should ensure that all women have access to contraception to avoid unintended pregnancies; all pregnant women have access to skilled care at the time of birth and all those with complications have timely access to quality emergency obstetric care.

Investing in girls' education is key to improving maternal and neonatal health: Empowerment begins with education. Education makes a significant difference in the lives of women. Educated women are more likely to participate in decision making, claim rights and use reproductive health services. Although much remains to be done, many countries are beginning to make strides in this direction.

Implement policies and laws: Implementation of laws and policies related to reproductive health remains weak and uncoordinated. Strengthening this will ensure empowerment and greater autonomy for women.

¹⁶ UNFPA 2008. State of the World's Population Report 2008

¹⁷ United Nations Children's Fund, The State of the World's Children 2009: Maternal and Newborn Health UNICEF, New York, 2009, pp. 35-37

Text Box 1: Reproductive Health in Conflict and Emergency Situation

Crisis and emergency situations compound reproductive risks significantly. In sub-Saharan Africa some of the countries with very high MMR are those affected by conflict.

Conflict and emergencies often result in the collapse of social systems. Access to social services including health is severely compromised leaving women and girls vulnerable. Crises often lead to the disintegration of community and family protections and the lack of health services often contributes to a sharp increase in infant and maternal mortality rates. Child abuse often increases with forcible recruitment of children and adolescents as soldiers and enslavement for domestic work and sex.

In Somalia continued conflict has led to a complete breakdown of social services. Women have limited access to obstetric care services and most deliver at home. Skilled health care professionals have left the country leaving only volunteers to provide care. Even when conflict ends it takes a while to rebuild and set up systems. In Southern Sudan, health-care coverage remains limited, mostly managed through a small number of non-governmental organizations as the new government establishes systems.

Increase in Gender Based Violence: Apart from the lack of access to maternal health services, SGBV has become even more pronounced in conflict and post-conflict states of Africa including Burundi, Chad, the Democratic Republic of Congo, Somalia and Sudan. Rape is commonly used as a weapon of war, leaving millions of women traumatized, forcibly impregnated or infected with HIV.

In the DRC, an increase in sexual violence continues to compromise the safety and lives of women and girls. Thousands of Congolese girls and women suffer from vaginal fistula—tissue tears in the vagina, bladder and rectum—after surviving brutal rapes. A survey of rape survivors in one region revealed that 91 percent suffered from one or several rape-related illnesses.¹⁸

Limited Access to Emergency Obstetric care: In 2004, the Inter-agency Working Group (IAWG) on Reproductive Health in Crisis Situations highlighted the need to enhance efforts to provide EmOC. Emergency obstetric care services are insufficient to meet the basic needs of refugees and internally displaced persons (IDPs).

Humanitarian efforts often overlook EmOC and other reproductive health related services for pregnant women and girls in emergency settings. The health risks experienced by all women and girls in pregnancy and childbirth are worse for refugees and IDPs by the lack of structures.

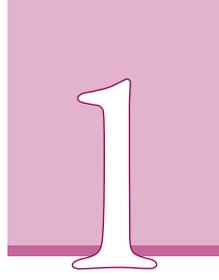
Lack of access to family planning in conflict situations, family planning and other reproductive health services are not treated as basic necessities and are often not taken care of.

Reproductive Health Supplies (RHS) in Emergencies: To meet the reproductive health needs of refugees and IDPs, it is imperative that Reproductive Health Supplies (RHS) are available and accessible. In such situations, life saving RHS should include Family Planning services, maternal and neonatal drugs and supplies for STI treatment. The Minimum Initial Service Package (MISP) includes: Safe delivery kits, condoms to prevent STIs and unwanted pregnancy, contraceptive supplies for family planning, rape prevention and management and HIV/AIDS prevention among others. The reality however is that many humanitarian agencies put priority on meeting basic needs such as shelter. They have also focused on treatment and prevention of HIV/AIDS, malaria, and TB without including RHS. Efforts aimed at making RHS available therefore remain weak.

Funding for Reproductive Health in Conflict: There is limited funding for RHS in conflict situations. The allocation per capita for RH in 18 conflict countries supported through the oDA is estimated at \$1.30 and for family planning is even lower at \$1.7.¹⁹

¹⁸ Inter-agency Working Group (IAWG) on Reproductive Health in Crisis Situations

¹⁹ Inter-agency Working Group (IAWG) on Reproductive Health in Crisis Situations



Maternal Health in Sub Saharan Africa

The leading cause of death for women in sub Saharan Africa is preventable

Pregnancy remains the leading killer of women in their reproductive years in developing countries. More than half a million women—typically women who are poor, uneducated and living in rural areas or urban slums—continue to die every year during pregnancy and childbirth. Ninety-nine percent of these deaths take place in developing countries. For every woman who dies, as many as 30 others suffer chronic illness or disability.

Maternal deaths and mortality ratios remain highest in Sub-Saharan Africa: There is a saying that once a woman gets pregnant she has one foot in the grave. No where is this more true than in sub Saharan Africa where pregnancy can be the beginning of a journey to the end of a woman's life.

Pregnancy is dangerous business in Sub Saharan Africa where a woman is 100 times more likely to die from pregnancy related complication than in a developed country

Every year, nearly half of all maternal deaths (270,000) occur in Sub-Saharan Africa. Countries like Angola, Benin, Burundi, Cameroon, Central African Republic, Cote d'Ivoire, Democratic Republic of Congo, Liberia, Ghana, Guinea Bissau, Malawi, Niger, Rwanda, Senegal, Sierra Leone, Somalia, and Tanzania have mortality ratios of over 750 per 100,000 live births. Only nine countries Botswana, Cape Verde, Comoros, Eritrea, Mauritius, Namibia, South Africa, Sudan and Swaziland had MMR of less than 500 per 100,000 live births in 2005.

All these countries are characterised by high fertility and unplanned pregnancies, poor health infrastructure, limited resources for health and low availability of health personnel. In addition, harmful social norms condone discrimination and promote the low status of women, a key factor in access to and utilization of reproductive health services.

The number of child deaths is also highest in SSA: While the actual number of deaths is highest in Asia, the rates for both neonatal deaths and stillbirths are greatest in sub-Saharan Africa. One in five African women loses a baby during her lifetime, compared with one in 25 in rich countries.

West and Central Africa: Where Mothers are most at risk: West and Central Africa have the highest maternal mortality in the world and little progress has been made over the past two decades in reducing maternal deaths. When viewed in global terms, the burden of maternal death is brought into stark reality: One in five maternal deaths worldwide occurs in three sub-Saharan African countries. Nigeria alone is responsible for 1 in 9 deaths. Three countries DRC, Niger and Nigeria, all together account for two thirds of all maternal deaths in SSA.

East and Southern Africa: Minimal Progress: East and Southern Africa accounts for one fifth of the world's maternal deaths and has the second highest maternal mortality ratio among all regions. In 5 countries in the region MMR is greater than 1,000 – Angola and Somalia (1400), Rwanda (1300), Burundi and Malawi (1,100). Overall the lifetime risk of maternal death is 1 in 29 and six countries have lifetime risks greater than 1 in 50.²⁰

The highest lifetime risk is in Angola and Somalia (1 in 12) while the lowest is in Mauritius where the lifetime risk (1 in 3,300) is comparable to that of some industrialised countries.

No other mortality rate is so unequal! Maternal mortality—especially the lifetime risk of dying in pregnancy or childbirth—shows the largest gap between the rich and poor of all public health/development statistics. The average lifetime risk of a woman in a least developed country dying from complications related to pregnancy or child birth is more than 300 times greater than for a woman living in an industrialized country. At the same time, many of the poorest women or those with least access to safe delivery or family planning services, have high fertility and are at higher obstetric risk of death from pregnancy or childbirth.

Generally rural populations and the poor are at highest risk. In many remote parts of sub-Saharan Africa women die because they have limited or no access to health care, or because the quality of care is poor. Their deaths are caused by complications that can often be effectively treated in a functioning health system. In Ethiopia, 90 to 95 percent of women deliver at home and are two hours or more away from a health facility.

The most common cause of maternal death is bleeding, which can kill even a healthy woman within two hours if left unattended. Half of the deaths caused by hemorrhage in sub-Saharan Africa occur mostly in rural areas where quality delivery care is largely unavailable. Proper delivery care—where women deliver, who attends them and what emergency measures are available—is critical to the survival of mothers and babies.

20 UNICEF, 2008. Progress for Children. A Report card on Maternal Mortality, November 2008, UNICEF, New York.

Reducing Maternal and Neonatal mortality is possible if there is political will

Some countries, including low-income countries, have successfully reduced maternal mortality. Some of these countries are Romania, Thailand, Malaysia, Sri Lanka, Egypt and Honduras. Their successes stem from a number of factors, including increasing access to hospital and midwifery care, improving quality of care and referrals through training, and controlling infectious diseases.

- **Investment in improving service delivery.** They also invested in expanding access by building on and improving already existing service delivery models, networks of health centres and outposts, health care infrastructure, and health care personnel. All this leads to more timely access to quality services, to better knowledge on how to use these services and, consequently, to reduction in maternal mortality.
- **Improving Nutrition:** Children whose mothers die may have three to 10 times' higher risk of dying than those with living parents. Nearly three-quarters of all infant deaths could be prevented if women were adequately nourished and received appropriate care during pregnancy, childbirth and the postnatal period.²¹
- **Promote integration of RH/HIV AIDS services:** Every day, 1,800 children, most of them newborn, become infected with HIV. HIV makes these children more vulnerable to other childhood diseases, less responsive to drugs that treat these diseases, and more likely to die from these diseases than HIV-negative children. Without antiretroviral therapy, 45 percent of HIV-infected children die before the age of 2.²²

While the prevention of mother-to-child transmission (PMTCT) of HIV has gained more attention recently, in high-prevalence countries in SSA most pregnant women do not have access to HIV testing. Even when women are tested during pregnancy, cultural attitudes and practices that disempower women prevent them from benefiting from related services.

21 Population Action International. 2007. Measure of Survival: Calculating Women's Sexual and Reproductive Risk. PAI Report Card 2007

22 Population Action International. 2007. Measure of Survival: Calculating Women's Sexual and Reproductive Risk. PAI Report Card 2007

Text Box 2: *The Gravity of Maternal and Neonatal Mortality in Nigeria*

Nigeria is Africa's most populous country, with 148 million inhabitants in 2007, 25 million of them under age five. With almost 6 million births in 2007 and a total fertility rate of 5.4, Nigeria's population growth continues to be rapid in absolute terms. According to the 2007 World Development Indicators, published by the World Bank, more than 70 per cent of Nigerians live on less than US\$1 per day, impairing their ability to afford health care. Poverty, demographic pressures and insufficient investment in public health care are some of the factors contributing to high levels and ratios of maternal and neonatal mortality.

The latest United Nations inter-agency estimates place the 2005 average national maternal mortality ratio at 1,100 deaths per 100,000 live births and the lifetime risk of maternal death at 1 in 18. When viewed in global terms, the burden of maternal death is brought into stark reality: approximately 1 in every 9 maternal deaths occurs in Nigeria alone. The women who survive pregnancy and childbirth may face compromised health; studies suggest that between 100,000 and 1 million women in Nigeria may be suffering from obstetric fistula. Neonatal deaths in 2004 stood at 249,000, according to the latest World Health Organization figures, with 76 per cent taking place in the early neonatal period (first week of life).

Inadequate health facilities, lack of transportation to institutional care, inability to pay for services and resistance among some populations to modern health care are key factors behind the country's high rates of maternal, newborn and child mortality and morbidity.

There are significant disparities between and within states. Low levels of education, especially among women, and discriminatory cultural attitudes and practices are barriers to reducing high maternal mortality rates. A study at the Jos University Teaching Hospital in the north-central region shows that nearly three quarters of maternal deaths in 2005 occurred among illiterate women. The mortality rate among women who did not receive antenatal care was about 20 times higher than among those who did.

Given these complex realities, developing strategies to accelerate progress on maternal and newborn health remains a considerable challenge. In 2007, Nigeria began to implement a national Integrated Maternal, Newborn and Child Health (IMNCH) Strategy to fast-track high-impact intervention packages that include nutritional supplements, immunization, insecticide-treated mosquito nets and prevention of mother-to-child transmission of HIV.

The IMNCH strategy, if implemented in full and on time, can markedly improve maternal and newborn health. Together with this package, the country has recently passed the National Health Insurance Scheme, which integrates the public and private health sectors to make health care more affordable for Nigerians.

Source: Adapted from United Nations Children's Fund, *The State of the World's Children 2009: Maternal and Newborn Health*, UNICEF, New York, 2009, pp. 19.

2

Access to Ante Natal Care Critical for Ensuring Safe Pregnancy

Pregnancy and childbirth and their consequences remain the leading causes of death and disability among women of reproductive age in developing countries today. Millions of women around the world do not have the means to either prevent unwanted pregnancies, or to prevent complications and disease in pregnancy. There is evidence that women who make at least 4 ANC visits are more likely to deliver in a health facility and use post partum services. However in SSA the relationship between antenatal care and skilled attendance at delivery is very weak.

Antenatal care coverage has increased globally.²³ Coverage is greater than or equal to 90 percent in 20 developing countries, although coverage rates alone do not indicate the quality of care women receive. Still, antenatal care coverage remains notably low in Africa and parts of Asia.

ANC Coverage in Eastern and Southern Africa: Seventy-one percent of women receive antenatal care at least once during their pregnancy. In all countries except Ethiopia and Somalia which continue to lag behind, at least two thirds of women have access to basic antenatal care in every country. In most countries with available data, at least 4 out of 10 women receive the recommended minimum of four visits.²⁴

ANC Coverage in West and Central Africa: About 67% of women in west and central Africa receive ANC at least once, which masks the wide variations in coverage. An estimated 39% of women in Chad receive ANC at least once compared to 99% in Cape Verde. Only 44% of women in the region receive the recommended minimum of 4 ANC visits. The widest differential is in Burkina Faso where 85% of women receive at least 1 ANC visit but only 18% receive a minimum 4 or more visits.²⁵

Money and location determine babies' chances of survival. Across regions, the use of antenatal care

is significantly influenced by wealth, and there are vast disparities in access to antenatal care between rural and urban areas. Women in urban areas are, on average, twice as likely as those in rural areas to receive four antenatal visits, but in general, these disparities are greatest in areas where use of antenatal care is low overall.

Women's status is a strong determinant of access to services. Education makes a significant difference in the lives of women. Educated women are more likely to use ANC services.

Antenatal care coverage can be used as a measure of women's exposure to the health system.

Women who receive at least four antenatal care visits are about 3.3 times more likely to deliver in a medical facility than other women. In SSA countries with high ANC coverage also have a higher number of women delivering in a health facilities with the help of a skilled professional and are also more likely to receive post partum care.

Antenatal care can be a key entry point for family planning, nutrition and TB services, and prevention and care for HIV and other sexually transmitted infections (STIs). In countries, such as Kenya HIV screening for pregnant women is done within the ANC clinic. In Kenya, integration of PMTCT services within the ANC clinic makes it easier for women to access HIV related services.²⁶ A study in Rakai, Uganda, found that pregnant women are twice as likely to become infected with HIV than non-pregnant or lactating women, indicating a critical

²³ Population Action International, 2007. A Measure of Survival: Calculating Women's Sexual and Reproductive Risk, 2007 Report Card. 2007. Washington DC

²⁴ UNICEF, 2009. The State of the World's Children 2009: Maternal and Newborn Health, UNICEF, New York, 2009, pp. 19.

²⁵ UNICEF, 2009. The State of the World's Children 2009: Maternal and Newborn Health, UNICEF, New York, 2009, pp. 19.

²⁶ CBS, 2005. Kenya Service Provision Assessment, Nairobi, 2005.

need for HIV-prevention services as well as testing, care and PMTCT services (See PMTCT Box).

ANC Provides opportunity for expanding access to other services: Due to its generally wide coverage, antenatal care has an enormous potential to expand access to a wide range of interventions.

Every year, roughly 50 million women living in malaria-endemic countries become pregnant, and 10,000 of them and 200,000 of their infants die as a result.²⁷ In East Africa malaria prevention programs use ANC service as an entry point for prevention of malaria in pregnancy.

Text Box 3: Preventing Mother-to-Child Transmission of HIV

In 2006, an estimated 530,000 children were newly infected with HIV, contributing to an estimated 2.3 million children living with HIV worldwide.²⁸ The majority of these infections occurred in sub-Saharan Africa and were acquired from mothers during pregnancy, labor, delivery or breast-feeding.

To prevent HIV infection in infants, United Nations agencies recommend a four-pronged approach that includes:

- preventing primary HIV infection in women;
- preventing unintended pregnancy among women with HIV infection;
- preventing transmission of HIV from infected pregnant women to their infants; and
- providing care, treatment and support to HIV-infected women.

Prevention of primary HIV infection in the general population is the foremost strategy for preventing mother-to-child transmission. Recent research shows that lowering HIV infection rates among sexually active adults by 1 to 5 percent can, in fact, achieve the same reduction in infant HIV infections as interventions administering Nevirapine to infants.²⁹

All women, including HIV-positive women, should be enabled to reach their desired fertility and avoid unintended pregnancy. Emerging research on the relationship between pregnancy and HIV suggests that pregnancy can pose risks to HIV-positive women. HIV infection in pregnancy increases the risk of obstetric complications and HIV-related illnesses such as anemia and tuberculosis might be aggravated by pregnancy. Pregnancy may also place women at a higher risk of contracting HIV; a study in Uganda found that women's susceptibility to HIV acquisition doubled during pregnancy.³⁰

In addition to preventing primary HIV infections and avoiding unintended pregnancies, reducing HIV infection in children depends upon secondary prevention. This includes identifying HIV-positive pregnant women and providing them with antiretroviral (ARV) prophylaxis and guidance on infant feeding. Worldwide, an estimated 2.2 million women living with HIV/AIDS give birth each year. The number of HIV positive women reached by PMTCT remains small, but in recent years some countries have expanded access to services by intensifying training of health care providers. In Kenya for example about 30 However, PMTCT programs only reach an estimated 5 percent of the HIV-positive population.

Reducing HIV infection in children demands a range of PMTCT strategies, with antenatal care remaining a critical, yet underexploited entry point for a continuum of services for HIV-positive mothers. Given that most women are unaware of their HIV status, the range of strategies to address PMTCT should account for the known influences of viral load; such strategies include prevention and control of STIs and malaria, exclusive breast-feeding and strengthened family planning programs. These services reduce the risk of PMTCT, as well as promote health among all pregnant women and their children, and should exist alongside scaled-up VCT and drug treatment.

Source: Adapted from Population Action International 2007. *Measure of Survival: Calculating Women's Sexual and Reproductive Risk*. PAI Report Card 2007. Washington DC.

27 Ronsmans, Carine and Wendy J Graham. 2006. "Maternal mortality: Who, when, where and why." *The Lancet* 368: 1189-1199.

28 UNAIDS. December 2006 AIDS Epidemic Update. Geneva: UNAIDS

29 Population Action International 2007. *Measure of Survival: Calculating Women's Sexual and Reproductive Risk*. PAI Report Card 2007. Washington DC.

30 Gray, Ron H, Li, X, Kigozi G, et al. 2005. "Increased risk of incident HIV during pregnancy I Rakai, Uganda: A Prospective Study" *The Lancet* 366:189-1188

3

Skilled Attendance at Birth

Skilled attendance at childbirth can make the difference between life and death. The presence of a skilled attendant at delivery is associated with better delivery outcomes, including reduced maternal and neonatal deaths.

The determination of who is counted as a skilled attendant has changed over time. According to the official WHO definition, the term refers to an accredited health professional (doctor, nurse or midwife) who has been educated and trained to proficiency in the skills needed to manage uncomplicated pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns. The quality of care provided by health personnel is crucial. Particularly when complications occur, skilled personnel need access to essential drugs, supplies, equipment and emergency obstetric care. Skilled attendants can provide emergency obstetric first aid and facilitate prompt referral to emergency obstetric care services. Skilled attendance at birth is a key indicator for monitoring a country's progress in achieving MDG 5.

Around 50 million births in the developing world, or about 4 in 10 of all births worldwide, are not attended by skilled health personnel. Sub-Saharan Africa and South Asia have the lowest levels of skilled birth attendance and therefore bear the greatest burden of maternal mortality. In contrast, 95 per cent of deliveries in developed countries are attended by skilled personnel³¹.

Sub-Saharan Africa is not only characterized by the lowest coverage of births attended by skilled health personnel, but also by the absence of any progress in this indicator over the past few decades.³² In all sub-regions of Africa the percentages of births attended by skilled personnel were lowest in West (40%) and East Africa (34%).³³

More than half (26) of the 47 SSA countries included in this report have less than 50% of births attended by skilled personnel. But there are significant variations within countries. In Kenya, less than 5% of births in Northern part of the country are attended by skilled personnel.

Skilled Attendance in Eastern and Southern Africa: Only 1 in 4 pregnant women in Eastern and Southern Africa as a whole deliver their babies with the assistance of skilled health care provider. There has been little progress in recent years, but there are variations between countries. Rwanda and Swaziland have made progress. In South Africa, Mauritius and Botswana skilled attendance is almost universal (92, 98 and 99 percent) respectively.³⁴

In all sub-regions of Africa the percentages of births attended by skilled personnel were lowest in West (40%) and East Africa (34%)

Skilled Attendance in West and Central Africa: Only 46% of women in the region give birth with the help of skilled health care professional. Urban women are twice as likely as rural women to have skilled health personnel during delivery. There has been some progress with percentage of births attended by skilled personnel increasing from 37% to 44% between 1995 and 2005. This represents

31 UNICEF, 2008. Progress for children. A Report Card on Maternal Mortality. UNICEF

32 UNICEF, 2008. Progress for children. A Report Card on Maternal Mortality. UNICEF

33 UNICEF, 2008. Progress for children. A Report Card on Maternal Mortality. UNICEF

34 UNICEF, 2008. Progress for children. A Report Card on Maternal Mortality. UNICEF

one of the largest regional improvements in coverage in the world. Countries that have made notable progress include Benin, Burkina Faso, Cote d'Ivoire and Togo where coverage increased at least by 10% and half of all births are currently attended by skilled personnel.

Limited progress Overall: There has been limited progress reported on this indicator for almost two decades in SSA. DHS data show that among women who reported deliveries in the three years prior to 2007, only 1 in 4 women in Chad, Mali, Mozambique, Uganda was assisted by a trained doctor, nurse or midwife during the most recent birth³⁵. Ethiopia has the lowest skilled birth attendance in region.³⁶

Variations based on residence and wealth: Overall progress in increasing skilled attendance has been hindered by the lack of expansion of services to rural areas where the majority of African women live. Poverty prevents women from accessing skilled care during pregnancy and delivery. Women from the poorest households who give birth are half as likely to benefit from skilled delivery attendants as those from the richest households.³⁷

Women living in urban areas in Eastern and Southern Africa are two and a half times more likely than those in rural areas to have skilled health personnel at delivery.

Emergency Obstetric Care limited in rural areas: Emergency obstetric care services are weak in most rural areas. The caesarean-section rate is a good measure of access to obstetric care services. South Africa is the only country with a caesarean-section rate of more than 5 percent an indication that many rural women do not have access to emergency obstetric care. By general agreement, rates of less than 5 per cent indicate that a substantial proportion of women lack access to caesarean sections and could die as a result.

Data from the WHO 2007 skilled attendance estimates show that all the Sub Saharan African countries where data was available had less than 7 % of the births by caesarean section apart from South Africa with 16%.³⁸

Facility surveys in Kenya and Tanzania reveal the lack of emergency obstetric services. In both countries obstetric care services fall below the recommended levels and need to be expanded. In Kenya only 9 percent of facilities can provide Comprehensive Emergency Obstetric Care (CEOC) and only 15 percent are able to provide basic emergency obstetric care services.

There are significant variations based on household wealth status: Of the countries where this data is available, Eritrea, Kenya, Madagascar, Mozambique and Somalia coverage among women from the richest fifth is more than 75 percent while coverage for the poorest women is low . In Eritrea the difference is 12 to 1.³⁹

The situation is made worse by the low ratio of health personnel to patients. Even where women receive skilled care at birth, their health may still be jeopardized by the poor quality of care. Facilities also lack the full range of care from pregnancy to the end of the postpartum period.

Poverty plays an important role in hindering women's access to skilled care at delivery. Women from the poorest households are half as likely to access skilled attendance at birth as those from the richest households

35 Paxton A., Bailey p, Lubis SM, ET.AL. Global Patterns in availability of emergency obstetrics care. International Journal of Gynaecology and Obstetrics 2006; 93(3):300-07).

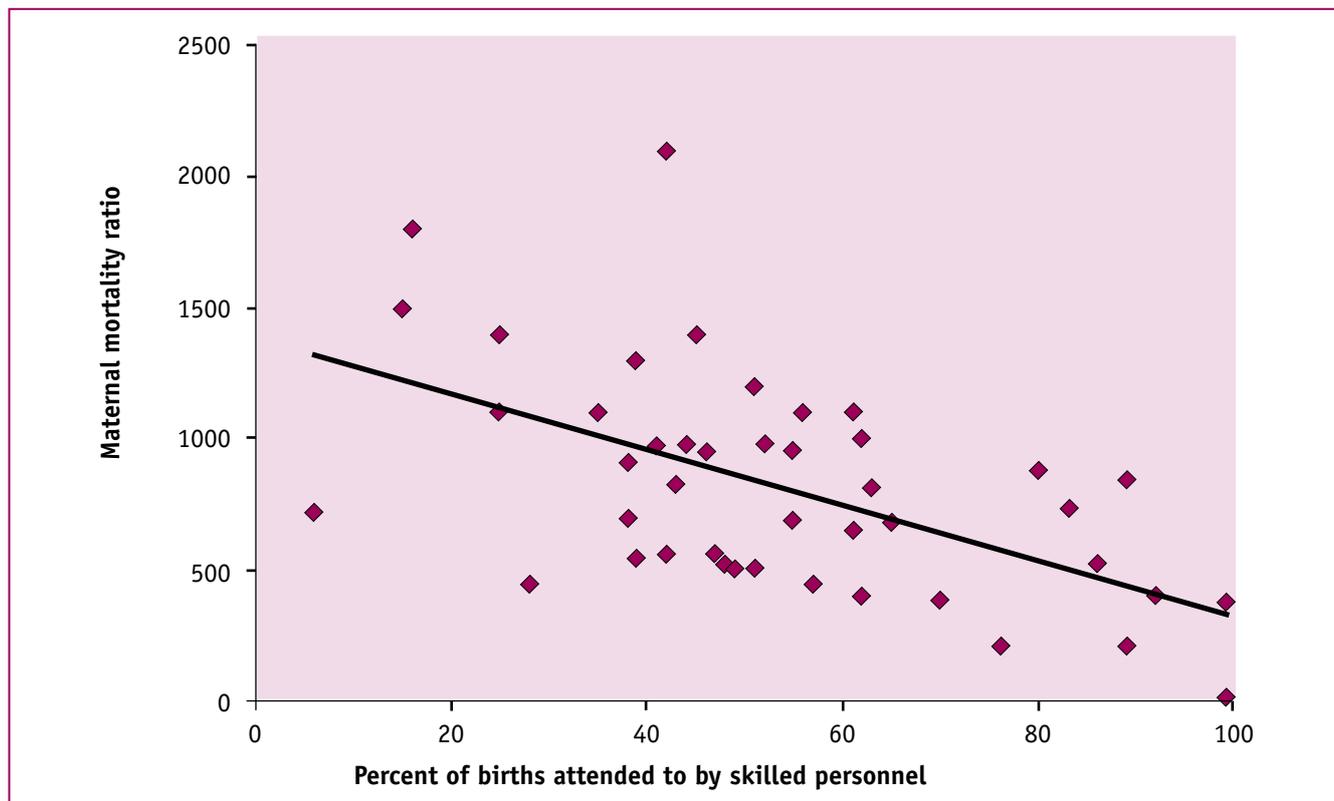
36 WHO. 2007.WHO Global database on births attended by skilled health personnel, Geneva, WHO).

37 WHO. 2007.WHO Global database on births attended by skilled health personnel, Geneva, WHO).

38 WHO. 2007. Skilled attendant at birth—2007 updates. Available at http://www.who.int/reproductive-health/global_monitoring/skilled_attendant.html#definitions; accessed on October 27, 2008.

39 UNICEF, 2008.Progress for children. A Report Card on Maternal Mortality. UNICEF

Fig. 2: Births attended by skilled personnel and maternal mortality ratio



Access to emergency obstetric care is of particular importance to women who have undergone female genital mutilation/cutting (FGM) as they are more likely to experience complications including postpartum hemorrhage and prolonged hospitalization. The severity of complications increases according to the extent of the FGM. Furthermore, the infant death rate is 15 to 55 percent higher among babies born to mothers who have FGM, depending upon its extent.⁴⁰

FGM increases the likelihood of complications. The severity of complications increases according to the extent of the FGM. Furthermore, the infant death rate is 15 to 55 percent higher among those born to mothers who have undergone FGM, depending upon its extent⁴¹

Country-level data masks disparities in access to care⁴². In most countries delivery with the help of a skilled birth attendant is closely linked to wealth, with a few noteworthy countries, such as Mauritius in which it is equitable across income groups. In Kenya for example, disparities in access to skilled care at birth are quite stark. In Northern Kenya, almost all women (96 percent) deliver without skilled care compared to Central Kenya where more than half of women have skilled care at delivery.⁴³

Countries that have successfully reduced maternal mortality such as Mauritius and South Africa have put emphasis on training, recruiting and supporting skilled attendants.⁴⁴ Given the current resource shortages, strategic distribution of personnel is key to addressing skilled birth coverage in the short term.

40 WHO study group on female genital mutilation and obstetric outcome. "Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries." The Lancet 367: 1835-41.

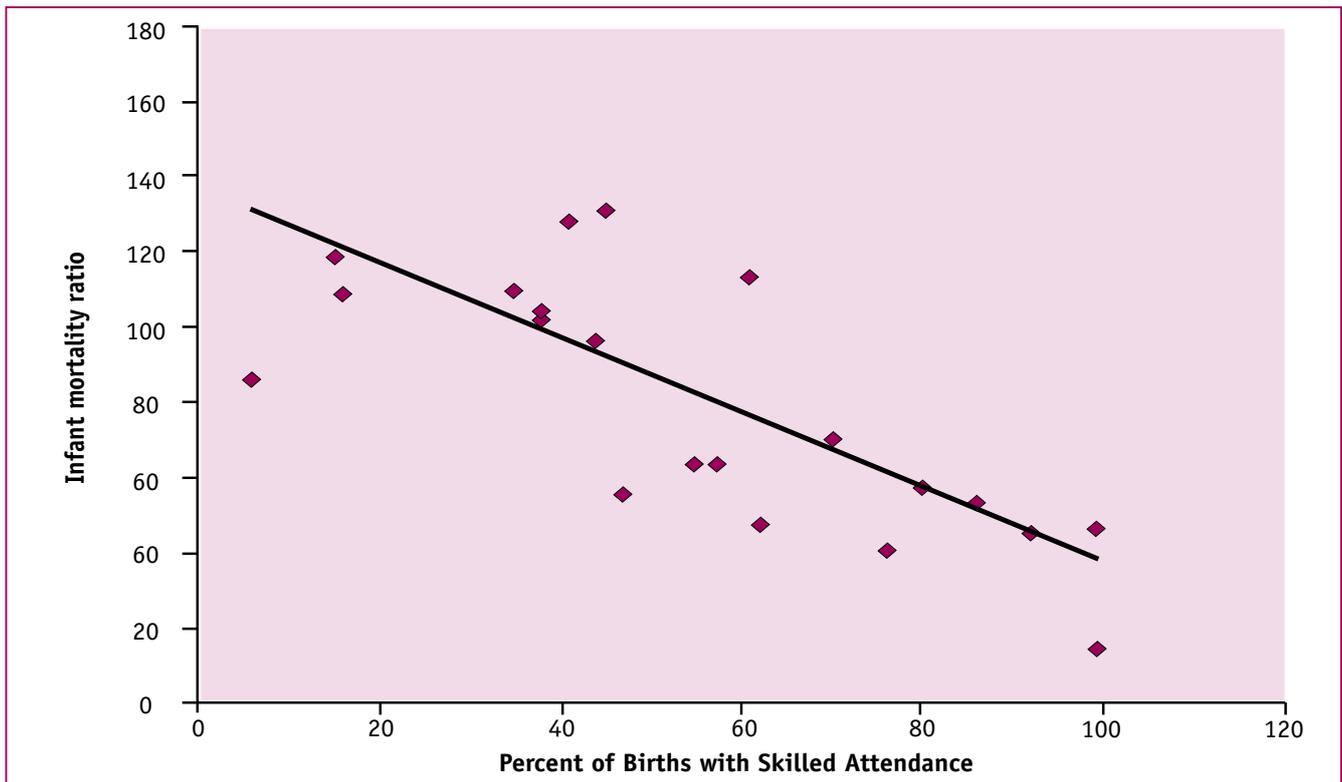
41 WHO study group on female genital mutilation and obstetric outcome. "Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries." The Lancet 367: 1835-41.

42 Abou Zahr C and Wardlaw T. 2001. "Maternal Mortality at the end of a decade: signs of progress?" Bulletin of the World Health Organization 79(6). WHO: Geneva.

43 CBS, Kenya Service Provision Assessment, 2005, Central Bureau of Statistics, Nairobi

44 Koblinsky, Marjorie A., ed. 2003. Reducing Maternal Mortality: Learning from Bolivia, China, Egypt, Honduras, Indonesia, Jamaica and Zimbabwe. Washington DC: The World Bank.

Fig. 3: Skilled care at delivery and infant mortality



Text Box 4: South Africa

Improving access to skilled attendance at birth makes a significant impact in reducing maternal mortality

South Africa is Middle income country (Average per capita income: US\$9,560 (purchasing power parity (PPP) rate)⁴⁵ with a population of about 48.3 million. It also has one of the lowest poverty levels in Sub-Saharan Africa (34%) living on 2 USD per day.⁴⁶ The country has a fairly well developed health infrastructure, availability of staff, legal abortion, and free health care for pregnant women and high levels of utilization of delivery services.⁴⁷

The country has seen remarkable social and economic stability with a strong influence on the African continent as well as internationally. Despite its successes, South Africa remains a highly unequal society and experiences what former South Africa’s President, Thabo Mbeki, referred to as “two economies” – a vibrant first world economy and the much larger informal rural and urban economy where poverty is still rife. The Gross female secondary school enrolment is 98%⁴⁸ which indicates that most of the girls are better equipped to make better decision on their Reproductive health choices.

According to data from WHO 2007 South Africa has Maternal Mortality Rates of: 400 per 100,000. Although this ratio is amongst the lowest in SSA it is still viewed as high when considered globally. UNICEF, WHO and UNFPA define low maternal mortality as a ration of less than 100 deaths per 100,000 live births.

Assistance at delivery by a skilled health professional is one of the key indicators for improving maternal health. The 1998 -2003 period showed a major increase in the percentage of women who were attended to by skilled health professionals during labor, especially by a nurse or midwife. Assistance at delivery by a nurse, midwife or a doctor increased from 84.4% in 1998 to 92.0% in 2003. Over the last few years, SA has made concerted efforts to ensure access to safe and affordable drugs, dispensed by appropriately trained personnel.

45 <http://www.dfid.gov.uk>. Accessed on 11thJune 2009

46 PRB, 2008 and African Population & Health Research Center (APHRC). Africa Population, Data Sheet. Washington DC)

47 Department of Health, Medical Research Council, Orc Macro. 2007. South Africa. Demographic and Health Survey 2003. Pretoria: Department of Health key findings of the survey)

48 Department of Health, Medical Research Council, Orc Macro. 2007. South Africa. Demographic and Health Survey 2003. Pretoria: Department of Health key findings of the survey)

4

Family Planning Saves Lives

The freedom to choose how many children, and when to have them, is a fundamental human right. Therefore every woman has the right to plan her pregnancies and have access to effective family planning methods to space or limit births and to prevent unintended pregnancies. The health benefits of spacing and limiting births for mothers and children are well known. Planned pregnancies lead to healthy mothers and families. In addition filling the unmet need for family planning also has economic benefits.

Family Planning is an urgent global priority. The right of men and women to determine the number, timing and spacing of their children is a fundamental right, yet over 120 million women say they would prefer to avoid a pregnancy, but are not using any form of contraception.⁴⁹

Contraceptive prevalence rates vary across sub Saharan Africa: Somalia has the lowest percentage of women using modern methods of Family Planning of 1.0 % followed by Chad with 2.8%. In Burundi, Angola, Eritrea less than 1 in 10 women are using a method of contraception. Mauritius has the highest rates of women using modern methods of family planning (75.9%) followed by South Africa (56.3%). Statistics indicate that countries with high percentages of women using modern methods have low maternal mortality rates for example in South Africa with 230 and Mauritius with 24 deaths per 100,000 live births.

Countries with low uptake of modern contraceptive rates like Mali, Angola and Guinea Bissau have high Total Fertility Rates of over 6 children per woman and high infant mortality rates of over 100 infant deaths per 1000 live births. Countries with low unmet need for family planning are likely to also have low fertility.

There is a high Unmet need for family planning: For the countries where data was available the

percent of women with an unmet need for family planning in Sub-Saharan Africa ranges from 41% in Uganda and Togo to 13% in Zimbabwe and 15% in South Africa. About 63 per cent of women have an unmet need for effective contraception and, consequently, a high proportion of unintended pregnancies.⁵⁰

Using contraceptives can prevent 20 to 35 per cent of maternal deaths but limited family planning supplies and services, as well as social norms, often bar women from using them.⁵¹

There is a higher unmet need for spacing than for limiting: The unmet need for spacing is close to twice the unmet need for limiting of births. Programmatic and budgetary decisions should be guided by patterns of method preference (by region, gender, place of residence, etc.).

Ensuring that women and men can access the contraceptive method that best suits their particular circumstances and fertility preferences contributes to increased contraceptive use, continuation and safety for the user.

Poor, uneducated, rural women are often more likely to have a high unmet need for family planning: Unmet need is highest among wealthier, educated urban women in the Central African Republic, and in Rwanda, the

49 Ross, John and William Winfrey. 2002. "Unmet Need for Contraception in the Developing World and the Former Soviet Union: An Updated Estimate." *International Family Planning Perspectives* 28(3): 138-143.

50 UNICEF, 2009. *The State of the World's Children 2009: Maternal and Newborn Health*, UNICEF, New York, 2009, pp. 19.

51 Population Action International. 2007. *A Measure of survival: Calculating Women's Sexual and Reproductive Risk*, PAI Report Card 2007.

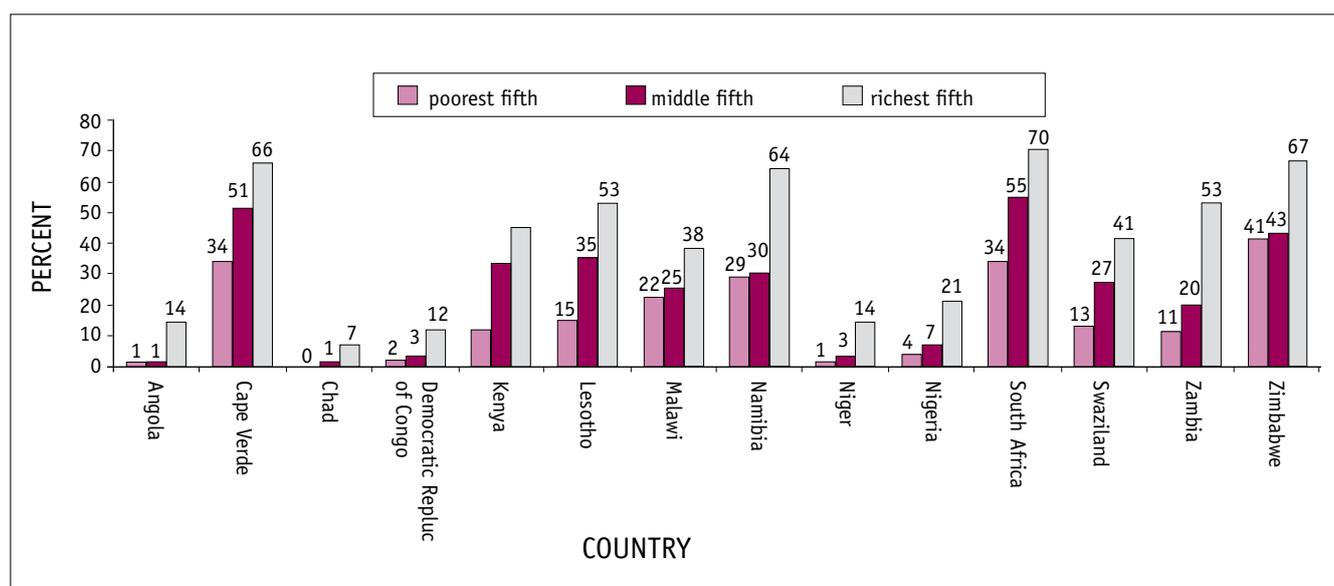


need is roughly equitable across differentials.⁵² As such, programs need to identify and focus on populations with the greatest need in each particular country.

Meeting the demands for family planning can prevent many, if not most, deaths from unsafe abortion. Around 137 million women who

want to space or limit their childbearing use no contraceptive method at all, while another 64 million use only traditional methods.⁵³ When a pregnant woman has not fully recovered from a previous birth, the new baby is more likely to die in infancy or contract infectious diseases during childhood.

Fig. 4: Percent of Married Women Using Modern Contraceptives by Wealth Status



52 Sedgh G, et al. 2007. "Women with an Unmet Need for Contraception in Developing Countries and Their Reasons for Not Using a Method." Occasional Report No. 37. New York: Guttmacher Institute.

53 Conde-Agudelo A and Belizan JM. 2000. "Maternal morbidity and mortality associated with interpregnancy interval: cross sectional study." British Medical Journal 321: 1255-59.

5

Unsafe Abortion: The Forgotten Epidemic

Globally it is estimated that over 70 million abortions occur annually.⁵⁴ An estimated 70 000 maternal deaths are due to unsafe abortion world wide. Of these almost all (97%) occur in the developing world. Africa accounts for 45% of all unsafe abortions which translates to 24 per 1000 unsafe abortions among women aged 15-44 years.⁵⁵ Unsafe abortion remains one of the leading causes of maternal morbidity and mortality in the region where an estimated 50% pregnancy related mortality is attributed to it. In Eastern Africa, nearly 14% of all pregnancies end in abortion, which translates to about 39 abortions per 1000 women of reproductive age every year. Abortion is one of the most common reasons for admission in Kenyan hospitals accounting for as many as half of all gynaecological admissions.⁵⁶

Several reasons are given by women who seek abortion services. The lack of access to family planning results in some 76 million unintended pregnancies every year in the developing world alone.⁵⁷ Many women who seek abortions are usually poor and struggling to provide for children they already have.

Magnitude of unsafe abortion in SSA: According to WHO an estimated 4.2 million unsafe abortions occur throughout Africa each year. Additionally one in every 150 abortions leads to death compared to one in every 85,000 procedures in the developed world. Hundreds of thousands more end up with chronic health problems.⁵⁸ Unsafe abortion is one of the main reasons women and girls seek emergency care and post-abortion care takes up one fifth to half of all gynaecological beds, in facilities across.

The risk of unsafe abortion is highest in sub Saharan Africa and South –Central Asia. There are variations between and within regions and countries in SSA. The risk of unsafe abortion is highest in Eastern, Central and Western Africa.

The number of unsafe abortion-related deaths per 100,000 live births is also highest in these regions with estimates of between 90-140 unsafe abortions per 100,000 live births. In Eastern Africa WHO estimates an abortion rate of 39 per 1000 women of reproductive age every year.⁵⁹

The age pattern of unsafe abortions varies markedly between countries and regions within the African continent. The proportion of women aged 15 to 19 who have an unsafe abortion is highest in Africa, and in some urban areas unmarried adolescents represent the majority of all abortion seekers. Understanding the age patterns of unsafe abortion is essential to identifying its causes and designing appropriate programmatic interventions to prevent it.

The magnitude of unsafe abortion among adolescents is high: Currently 40 percent of all unsafe abortions among adolescents in developing countries occur in sub-Saharan Africa. Data from seven countries revealed that 39 to 79 per cent of those treated for abortion related complications were adolescents.⁶⁰ In Nigeria adolescents make up half of the estimated 20,000 abortion related deaths annually.⁶¹

54 Grimes A David et al (2006). Unsafe abortion: The preventable pandemic. The Lancet Sexual and Reproductive Health Series, October 2006.

55 International Women Health Coalition: Access to Safe Abortion is a Human Right. January 2008

56 Rogo K, Bohmer L. and Ombaka C. (1999). *Community Level Dynamics of Unsafe Abortion in Western Kenya and Opportunities for prevention*. Pacific Institute for Women's Health and Centre for the Study of Adolescence, Nairobi

57 Singh, S., et al. 2004. Adding it Up: The Benefits of Investing in Sexual and Reproductive Health Care. Washington, D.C., and New York: The Alan Guttmacher Institute and UNFPA

58 http://www.ipas.org/Countries/Africa_Alliance.aspx

59 WHO. 2004. Unsafe Abortion: Global and Regional Estimates of Unsafe Abortion and Associated Mortality in 2000, 4th Edition. Geneva: World Health Organization.

60 UN Millennium Project. 2005b. Who's Got the Power: Transforming Health Systems for Women and Children. Task Force on Child Health and Maternal Health. London and Sterling, Virginia: Earthscan

61 Raufu, A. 2002. "Unsafe Abortions Cause 20,000 Deaths a Year in Nigeria." British Medical Journal 325(7371): 988. Cited in: de Bruyn and Packer 2004, p. 10).



In various countries, including Kenya, Malawi, Uganda and Zambia, adolescents make up a significant portion of hospital admissions related to unsafe abortion. Both adolescents and older women encounter similar challenges and often delay seeking life-saving treatment fearing exposure and judgmental attitudes from providers. Stigma and the poor quality of services also act as deterrents to adolescents seeking RH services.⁶²

An estimated 40 percent of all unsafe abortion among adolescents occurs in Sub Saharan Africa. In Nigeria where 10,000 women die from abortion complications each year, about half of the victims are adolescents

62 UNFPA, State of the World Report, 2005.

Consequences of unsafe abortion are severe:

Unsafe abortion remains one of the leading causes of maternal morbidity and mortality in the East African region where an estimated 50% pregnancy related mortality (nearly 1 in 5 deaths) are attributed to unsafe abortion.⁶³

The most common causes of death from unsafe abortion include severe bleeding, internal infection, tearing of the uterus and blood poisoning. The WHO estimates that 2 percent of women of reproductive age become infertile as a result of unsafe abortion, and 5 percent have chronic infections. Unsafe abortion also increases the risk of ectopic pregnancy, premature delivery and spontaneous abortion in future pregnancies.

63 WHO Estimates of the incidences of unsafe abortion and associated mortality – WHO. 2007

Cost of Unsafe abortion is unacceptable high:

Unsafe abortion has many costs. Unsafe abortion results in loss of life, contributes to increased disease burden and loss of opportunity and earnings. In addition to monetary, other costs can include time off from work, travel, long term health problems, social stigma and infertility. African governments spend millions of dollars very year treating complications from an otherwise preventable condition but are unprepared to take bold steps to put an end to this situation. The most vulnerable groups are adolescents, poor and rural women who are unlikely to afford safe abortion services.

In many developing countries, the consequences of unsafe abortion impose an additional burden on already-scarce hospital resources.⁶⁴ Unsafe abortion can also be reflective of the overall quality of health care systems. Even where the procedure is legal, often health system shortages, poverty and misconceptions about the laws keep abortion unsafe. Where abortion is legal, it must be safe and accessible. Where abortion is heavily restricted, laws and policies should be eased or lifted on the grounds that doing so is necessary to bring down the high rate of maternal death. Women's health and lives are less at risk where abortion is legal.

Law reform combined with comprehensive access to family planning can contribute to reduced demand for unsafe abortion: There is evidence that legalization combined with strong family planning efforts and community education, can lead to lower maternal deaths in a span of a few years. The experiences of Romania and South Africa are good examples. Romania's maternal mortality rate fell by almost 73 percent between 1990 and 2002, while deaths from abortion complications decreased by 91 percent in South Africa from 1994 to 2001.⁶⁵ Life-saving post-abortion care (PAC) should be accessible in all health facilities, regardless of the legal status of abortion.

64 WHO Estimates of the incidences of unsafe abortion and associated mortality – WHO. 2007

65 Population Action International, 2007. A Measure of Survival: Calculating Women's Sexual and Reproductive Risk, 2007 Report Card. 2007. Washington DC.

Some countries in the region have strengthened PAC services in both the public and private sectors. Emergency obstetric care reduces the risk of death from unsafe abortion, and voluntary family planning services have been shown to help prevent unintended pregnancies and reduce abortion rates.

Policy and legislative environment in regard to abortion

In Many African countries' abortion laws stem from antiquated colonial legal codes. Most African countries allow abortion in only one circumstance: when the woman's life is endangered. While the former colonial powers have reviewed their laws, African countries have been slow in embracing change with the rise in conservative elements opposed to liberalising abortion laws in various countries.

Restrictive laws driving up demand for unsafe abortion: In Kenya, where abortion is legal only to save a woman's life, complications from unsafe procedures can account for up to 20,000 hospitalizations in the public health-care system alone annually. In Uganda, where the law is similar to that of Kenya, almost 300,000 women and girls have unsafe abortions each year with about 85,000 seeking medical treatment for resulting complications.⁶⁶

Some countries have liberalized their laws: Over the last two decades there has been some liberalization of abortion laws motivated primarily by health concerns. In Africa a few countries like Cape Verde, Ethiopia, South Africa and Tunisia have reformed their laws to allow abortion for a broad array of circumstances during the first trimester. Other countries, including Benin, Burkina Faso, Chad, Guinea, Mali and Togo, have reformed their national laws to loosen restrictions on legal abortion.

Restrictive abortion policies mainly affect the poor who rely on the public sector for all their health needs; women who have the means can usually obtain abortions clandestinely from the private sector.

66 http://www.ipas.org/Countries/Africa_Alliance.aspx; Accessed on November 24, 2008)

A Good law does not always mean good services: Having liberal laws do not always lead to availability of services. Zambia and Ghana are good examples where despite the existence of a liberal law, services are still elusive for the majority of women.⁶⁷ Challenges to access include inadequate health care personnel and limited government spending as well as the sheer lack of knowledge among women.

In addition, the low status of women also affects decision making and health seeking behaviour. These obstacles compound the risk of unsafe abortion, particularly among adolescents and young women, who are especially vulnerable to unwanted pregnancy and who typically have less access to health information and services than adults. They may also not have the resources especially where services are not free.

The lack of knowledge of the law as well as procedures also locks out many people especially adolescents from accessing services:

In Kenya for example, many young people are under the false impression that the law prohibits abortion. Young women below 20 years account for about 16 percent of the over 20,000 abortion-related complications annually in Kenya's public hospitals.⁶⁸ A study of Kenya secondary school students showed that almost a third (29%) believed, incorrectly, that abortion was never permitted in Kenya, and another 14% did not know whether it was ever legal or not.⁶⁹

In Kenya many young people either believe incorrectly that abortion is illegal or do not know the legal status of abortion subsequently making it difficult for them to access services even in circumstances where the law permits it

In Mozambique, liberal interpretation of the restrictive law has allowed for the provision of hospital-based abortions to save women's lives and health. But as in other countries where progress has been made in ensuring access to safe abortion care, many Mozambican women are still likely to undergo procedures without receiving contraceptive counselling and services to prevent future pregnancies. In addition, frequent contraceptive commodity stock outs raise the possibility of repeat abortion. In some countries, the lack of protocols on treatment of abortion complications is an added hindrance.⁷⁰

What can be done to reduce unsafe abortion and related consequences?

There is an urgent need to reduce demand for unsafe abortion: Reducing demand for unsafe abortion by expanding access to contraceptives is critical if SSA is to stem the tide of abortion related mortality and meet the related MDG targets.

Make services legal and safe: Keeping abortion illegal has not reduced demand. Instead it is fuelling unsafe abortion. Countries in SSA with very strict abortion laws also have high rates of unsafe abortion and subsequently high maternal mortality rates. **Implement sexuality education programmes for young people:** There is ample evidence that comprehensive sexuality education have a positive impact on the choices young people make regarding their sexuality.

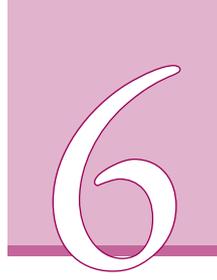
Implement the law: Where the law allows abortion even under limited circumstances, it should be implemented to the best extent possible.

67 http://www.ipas.org/Countries/Africa_Alliance.aspx; Accessed on November 24, 2008)

68 Gebreselassie, H., Gallo, M., Monyo, A. and Johnson, B. (2004) The magnitude of abortion complications in Kenya. BJOG: An International Journal of Obstetrics and Gynecology, 111, 1-7. Gebreselassie et al. 2004.

69 Mitchell, E., Halpern, C., Farhat, T., Muthuuri Kamathi, E. and Steibelt, E. (2003) Teen Web Nairobi: Results of a web-based project to survey and educate students about health (Chapel Hill, NC: Ipas). Mitchell et al. 2003.

70 http://www.ipas.org/Countries/Africa_Alliance.aspx; Accessed on November 24, 2008



Reproductive Tract Infections (RTIs) and Sexually Transmitted Infections (STIs)

Sexually transmitted infections (STIs) and reproductive tract infections are among the most common causes of illness worldwide, yet they are practically ignored in public health research, interventions, and services.⁷¹

Non-HIV STIs constitute the second major cause of disease burden (after maternity-related causes) in young adult women in developing countries. Untreated STIs are thought to account for 10–15 percent of foetal wastage and 30–50 percent of antenatal infections and are linked to cervical cancer and ectopic pregnancy. Furthermore, untreated STIs are associated with a significant increase in the rate of HIV infection—by as much as three to five times.

Sexually transmitted infections (STIs)

Assessing the global prevalence of STIs is hindered by the limited data on sexually transmitted infections. Surveillance is largely under funded despite the contribution of STIs to SRH disease burden especially in sub Saharan Africa.

However, the best available estimates indicate that more than 340 million new cases of the common bacterial and protozoal STIs (i.e. syphilis, gonorrhoea, chlamydial genital infections and trichomoniasis) occur every year throughout the world in men and women aged 15 to 49.⁷²

The prevalence of STIs is high in sub Saharan Africa and South and South East Asia: The largest number of new infections occurs in South and Southeast Asia but the highest rate of new infections is in sub Saharan Africa has the highest rate of new infections.

Prevalence varies between regions and by residence: Prevalence and incidence of STIs varies within countries and between countries in the same region, as well as between rural and

urban populations and even in similar population groups.⁷³ In general, STI prevalence tends to be higher among urban residents, unmarried individuals and young adults. It is estimated that at least a third of the 340 million new annual STI cases are among people under age 25.⁷⁴

STIs can have severe consequences: In adults, STIs can lead to pelvic inflammatory disease and potentially fatal ectopic pregnancy or chronic illness. STIs are also the leading preventable cause of infertility, which affects more than 180 million couples in developing countries.⁷⁵ While infertility affects both men and women, women typically suffer the greater social consequences from their partners and their communities especially in societies that place a high premium on childbearing.

In developing countries, STIs and their complications are among the top five disease categories for which adults seek health care. STIs (excluding HIV) are second only to maternal

71 Population Action International 2007. Measure of Survival :Calculating Women's Sexual and Reproductive Risk. PAI Report Card 2007. Washington DC.

72 WHO. 2001. Global Perspectives and incident of selected curable Sexually Transmitted Infections: Overview and estimates, Geneva, WHO.

73 WHO. 2001. Global Perspectives and incident of selected curable Sexually Transmitted Infections: Overview and estimates, Geneva, WHO.

74 Rustein SO and Shah IH. 2004. "Infecundity, Infertility, and Childlessness in developing Countries. DHS Comparative Reports , No.9 Calverton, MD ORC Macro and Geneva: WHO

75 Rustein SO and Shah IH. 2004. "Infecundity, Infertility, and Childlessness in developing Countries. DHS Comparative Reports , No.9 Calverton, MD ORC Macro and Geneva: WHO

factors as causes of disease, death and healthy life lost among women of reproductive age.

STIs increase risk of HIV Infection: Untreated STIs can also increase the risk of both acquisition and transmission of HIV. Improvement in the management of STIs can reduce the incidence of HIV infection in the general population. In unborn and newborn children, STIs can cause stillbirths, low birth weight and pneumonia.

In Africa, where the primary mode of HIV transmission is heterosexual intercourse, the presence of certain STIs (particularly genital ulcers and infections which cause genital discharge) is thought to increase significantly the likelihood of sexual transmission of HIV. A number of studies have indicated at least a two to nine-fold increased risk of HIV transmission among persons who have other STIs.

Women are more vulnerable to Infection: Women are more susceptible to infection than men due to various reasons including socio-cultural and physiological reasons and often suffer severe consequences, including cervical cancer and infertility.

In SSA STIs receive little attention: Only 14 per cent of people with STIs in sub-Saharan Africa had access to treatment in 2003.⁷⁶ Data on the global prevalence of sexually transmitted infections (STIs) are limited because STI surveillance has been largely neglected and under funded.

Despite the widespread prevalence and serious consequences, STIs receive little political or financial support. For example, in sub-Saharan Africa, it is estimated that 1,640,000 pregnant women have undiagnosed syphilis every year.⁷⁷ Untreated syphilis results in a stillbirth rate of 25 percent and a perinatal mortality of about 20 percent.

Screening and treatment programs for syphilis have roughly the same potential to prevent fetal deaths

as PMTCT programs (an estimated half a million foetal deaths averted per year) yet syphilis receives far less attention and funding.⁷⁸ Countries such as Kenya have policies that require mandatory testing and treatment of syphilis during pregnancy but few women receive this service.

STIs can be prevented: Condom use, STI testing and treatment, and adolescent education and counselling can prevent death, disability and infertility arising from STIs.

Preventing and treating STIs can therefore be an effective means of reducing reproductive morbidity and can be expected to make a major contribution in reducing HIV infection.

Condom use remains low significantly hindering efforts aimed at preventing the spread of STIs. Data from the Demographic Health Surveys in countries where they are available show that condom use remains low in most countries. According to the WHO statistics among the countries where data is available several countries such as Mali, Chad, Benin, Madagascar condom use among those at highest risk is less than 20% among females. The condom prevalence rate at highest risk sex is much higher for males than females in most of the countries.

Among married couples and regular partners, condom use is uncommon.⁷⁹ Condoms are still associated with infidelity and casual or commercial sex and are less likely to be used in these relationships.

It is important to expand screening, scale up testing and treatment and strengthen integration of STI treatment with other health problems. Improving data collection is also critical if countries are to plan and respond effectively to the disease burden arising from STIs.

76 Global HIV Prevention Working Group. 2003. Access to HIV Prevention: Closing the Gap. Menlo Park, California: Kaiser Family Foundation and the Bill & Melinda Gates Foundation.

77 UNAIDS.2005.AIDS Epidemic Update 2005. Geneva: UNAIDS

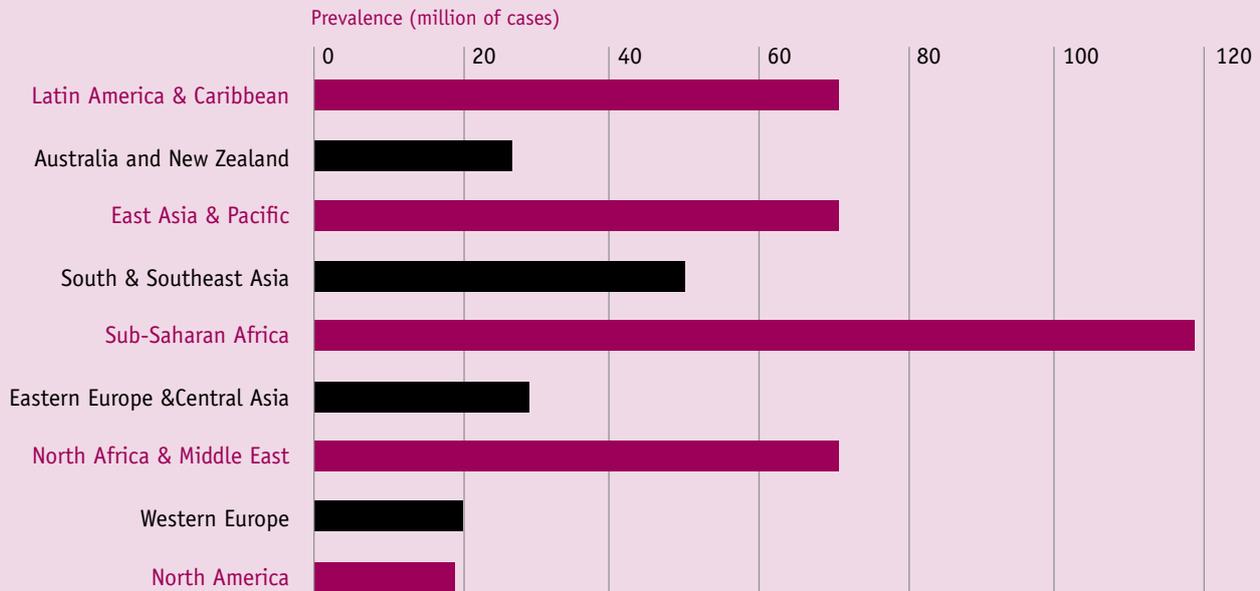
78 Population Action International, A Measure of Survival: Calculating Women's Sexual reproductive Risk. 2007 Report Card. Washington DC, 2007

79 Population Action International 2007. Measure of Survival: Calculating Women's Sexual and Reproductive Health Risk. PAI Report Card 2007. Washington DC

Fig. 5: Global STI prevalence rates by region

STI prevalence by region per 1000 people

More than 340 million new cases of curable STIs occur every year worldwide. The highest rate of new infections occurs in sub-Sahara Africa, followed by Latin America and the Caribbean.



Source: WHO, 2001. Global Prevalence and Incidence of Selected Curable Sexually Transmitted Infections Overview and Estimates. Geneva: WHO.

Source: PAI, 2007. Measure of Survival: Calculating Women’s Reproductive Risk. PAI Report Card 2007

RH Needs of People with Disability

About 10 percent of the world’s population – i.e. 650 million people - live with a disability and but possibly represent as high as 20 percent of the poor. Their sexual and reproductive health has been neglected.

Persons with disabilities are as likely as persons without disabilities to be sexually active. However, they are at increased risk of HIV and AIDS and are up to three times more likely to be victims of physical and sexual abuse and rape and have less access to physical, psychological and judicial interventions.

80 percent of Persons with disabilities (PwDs) live in developing countries. They face risks of violations of their reproductive rights, including forced sterilization and infringements on their rights to marry and form a family. Disabled adolescent girls and women are at particularly high risk of sexual abuse and have limited autonomy and access to education and employment. Poverty and limited access to resources further erodes their economic and social rights, while patriarchal traditions present obstacles to decision-making and community participation.

People with disabilities face exclusion from social services including reproductive health services: The vast majority of Africans with disabilities are excluded from schools and opportunities to work, virtually guaranteeing that they will live out their lives as the poorest of the poor. School enrolment for the disabled is estimated at no more that 5-10 percent. Only 1 percent of disabled women living in developing countries are literate.



HIV/AIDS and Women in sub-Saharan Africa

The impact of HIV/AIDS has been more severe in sub Saharan Africa where twelve of the most affected countries are found. SSA accounts for almost a third (32%) of all new HIV infections and AIDS-related deaths globally, with national adult HIV prevalence exceeding 15% in Botswana, Lesotho, Namibia, South Africa and Swaziland.⁸⁰ Within the region, trends vary considerably with Southern Africa being the most affected. In Central and Western Africa prevalence rates are below 5 percent except in Gabon (5%) and Central African Republic (6.3 percent).⁸¹

Southern Africa most affected: In the southern African region estimates show that the percent of adult HIV infection is highest in Swaziland (26.1%) followed Botswana (23.9%) and lowest in South Africa at 18.1% a figure which is still much higher than for any of the countries in the other sub regions. Botswana's epidemic remains severe with almost 1 in 4 adults (15-49) living with HIV.⁸²

The Eastern sub region is the second highest in HIV adult prevalence. HIV prevalence in the sub region varies greatly. In Zimbabwe, Zambia, Mozambique and Mauritius prevalence is over 10 %. In the Comoros, Madagascar and Somalia have prevalence rates of less than 1 percent. In East Africa, adult HIV prevalence is either stable or declining slightly.⁸³

Prevalence is low in Western and Central Africa: In the Western and Central African sub regions the average HIV prevalence is 2.5% which is much lower than that of the Southern and Eastern sub regions. Nigeria still has the largest epidemic in this sub region. Almost 3 million [1.7 million–4.2 million] Nigerians are living

with HIV second in number globally only to South Africa.⁸⁴

The epidemics in West Africa are stable overall, with the exception of Burkina Faso, Côte d'Ivoire and Mali, where HIV prevalence is declining.⁸⁵

HIV and Women in sub Saharan Africa

About 60 percent of all people living with HIV in sub-Saharan Africa are women, with young women facing the highest risks:⁸⁶ Women are more vulnerable to the infection than men, for biological, socio-cultural and economic reasons, but adolescent girls and young women face additional risks Harmful practices, such as child marriage and female genital mutilation/cutting with non-sterilized instruments, expose them to additional dangers.⁸⁷

Young women face highest risk of HIV/AIDS infection: Women between 15 and 24 are 1.6 times more likely than young men to be HIV-positive. In sub-Saharan Africa, young women living with HIV outnumber HIV-positive young men 3.6 to 1. In South Africa among the 15-24

80 UNAIDS & WHO, 2007, Sub-Saharan Africa AIDS epidemic update. Regional Summary

81 UNAIDS & WHO, 2007, Sub-Saharan Africa AIDS epidemic update. Regional Summary UNAIDS and WHO

82 UNAIDS & WHO, 2007, Sub-Saharan Africa AIDS epidemic update. Regional Summary UNAIDS and WHO

83 UNAIDS & WHO, 2007, Sub-Saharan Africa AIDS epidemic update. Regional Summary UNAIDS and WHO

84 UNAIDS & WHO, 2007, Sub-Saharan Africa AIDS epidemic update. Regional Summary

85 UNAIDS & WHO, 2007, Sub-Saharan Africa AIDS epidemic update. Regional Summary

86 UNAIDS, UNFPA, and UNIFEM. 2004. Women and HIV/AIDS: Confronting the Crisis. New York and Geneva: UNAIDS, UNFPA, and UNIFEM).

87 UNFPA, State of the world report, 2005).

year olds, women account for about 90% of new infections.⁸⁸

The highest female infection rates are in countries where the epidemic has become generalized and where transmission is primarily heterosexual, often in the context of marriage. Integrating reproductive health and HIV/AIDS services is cost-effective, reduces stigma and increases access to services for the poor.

Gender discrimination, poverty and violence contribute to the increase in spread of the AIDS epidemic: Physiologically, women are at least twice as likely as men to become infected with HIV during sex. Women and girls are often ill informed about sexual and reproductive health matters and are more likely than men to be illiterate. They often lack negotiating power and social support for insisting on safer sex or rejecting sexual advances. Gender based violence is a major risk factor for contracting HIV. In addition, poverty forces many women into subsistence sex work or transactional relationships that preclude negotiating condom use.⁸⁹

HIV can contribute negatively to women's health. HIV and AIDS contribute to the high maternal mortality ratio in sub-Saharan Africa. Among pregnant women living in major cities, 13.5 per cent are estimated to be infected.⁹⁰

AIDS, too, is placing a heavy burden on health systems in the countries where it has reached epidemic proportions, leaving children destitute, increasing levels of poverty and reducing productivity.

Access to antiretroviral treatment can help safeguard a woman's well-being and prevent the tragedy of HIV transmission to her children. Yet most HIV-positive women in developing countries have no access to antiretroviral treatment - neither for themselves nor to prevent transmission to their children.

Some people believe that HIV-positive women should not have sexual relations and should not have children. As a result, these women are often denied information and services to prevent pregnancy and mother-to-child HIV transmission, as well as access to quality prenatal and obstetric care. Protecting the reproductive rights of HIV-positive women, including preventing coerced abortions or sterilization, is a critical human rights issue.

Access to treatment is limited: In Africa, only 5 per cent of pregnant women are offered HIV prevention services. Among HIV-infected pregnant women in the region, coverage of antiretroviral prophylaxis for preventing mother-to-child transmission increased from 11 per cent in 2004 to 31 per cent in 2006.⁹¹

88 Rehle TM et al. (2007). National HIV incidence measures – new insights into the South African epidemic. *South African Medical Journal*.

89 UNAIDS, 2004a. "Fact Sheet: Women and AIDS: Geneva: UNAIDS.

90 United Nations Children's Fund, Joint United Nations Programme on HIV/AIDS and World Health Organization 2008, *Children and AIDS: Second stocktaking report*, UNICEF, New York,

91 United Nations Children's Fund, Joint United Nations Programme on HIV/AIDS and World Health Organization, *Children and AIDS: Second stocktaking report*, UNICEF, New York, April 2008, p.5.

Text Box 6: HIV Among married Women in sub-Saharan Africa

Women now account for half of the 33 million people living with HIV around the world. In sub-Saharan Africa, home to two-thirds of the world's people living with HIV, women are even harder hit, making up 60 percent of those infected. Not only are women biologically more susceptible than men to HIV, many behavioral and social factors play into women's vulnerability. If a young woman is uninfected with HIV at the time of her marriage, traditional wisdom says that she has avoided the disease altogether. More and more, however, research shows that marriage is not enough to protect people from HIV, either women or men.

Sex and HIV within Marriage: In about one out of ten married couples in Kenya, at least one partner is living with HIV. Among married people who are living with HIV, 45 percent have a partner who is uninfected. This is not unique to Kenya—in a study of five African countries, two thirds of HIV-infected couples are sero-discordant (one partner is HIV-negative, while the other is HIV-positive).⁹²

In Rwanda and Zambia, it is estimated that over half of new infections occur within marriage or in cohabitating relationships, and just under half in Uganda.^{3,4} While risk of transmission in discordant couples can be drastically reduced, this can only happen when partners are tested, disclose their results, and use condoms. However, the number of people who do so in many affected countries remains low, contributing to infection within marriage. Condom use is infrequent among married couples for multiple reasons, including the desire for children and the widespread association of condoms with infidelity and lack of trust. In Kenya, 97 percent of people in married or cohabitating relationships reported that they did not use a condom the last time they had sex.

Extramarital Sex: New research suggests that having multiple concurrent sexual partners (having more than one partner during the same time period) plays a major role in fuelling the HIV epidemic, particularly in sub-Saharan Africa. This has important implications for married couples, as married men consistently report higher numbers of extramarital partners than their wives. For example, in Kenya, 11 percent of married men reported having an extramarital partner in the past year, as opposed to just over two percent of women. Polygamy is also associated with increased risk of HIV. In Kenya, among currently married people, seven percent of those in monogamous relationships are HIV-positive, but the rate reaches 11 percent among those in polygamous relationships.⁹³

Violence within Marriage and HIV: Gender-based violence plays an overlooked but significant role in women's vulnerability to HIV. Forced sex obliterates women's ability to negotiate condom use, and the threat of physical violence is a strong deterrent to requesting condom use, particularly with a husband who may view the request as an admission or accusation of infidelity. In many parts of Africa and around the world, married women have little legal protection from violence. In 2006, Kenya passed the Sexual Offences Act, which strengthened existing sexual violence laws. However, before its passage, parliamentarians removed a clause criminalizing marital rape. In Kenya, 43 percent of ever-married women report physical or sexual violence from their husband and 28 percent experienced violence within the past year.⁹⁴

Many steps can be taken to reduce the vulnerability of married women and men to HIV infection, including stronger policies, better prevention strategies, and changes in harmful social norms. Educating men and women about social norms and how those norms negatively impact men and women's health is a critical first step.

Source: Adapted from PAI Fact Sheet on HIV in Marriage.

⁹² Government of Kenya, 2008, Kenya AIDS Indicator Survey, 2007, Nairobi

⁹³ Government of Kenya, 2008, Kenya AIDS Indicator Survey, 2007, Nairobi

⁹⁴ See Kenya Demographic and Health Survey, 2003



Adolescent Sexual & Reproductive Health

An estimated 25% of the world's population is made up of young people between the ages of 10-24, most of whom live in the developing world. In many parts of the developing world, adolescents face serious challenges associated growing up. In sub-Saharan Africa the combination of poverty and conflict further compounds the situation. Some of the most critical problems facing young people are those related to sexuality and reproduction

Why focus on young people

Young women face higher reproductive risks due to biological, cultural and economic reasons. Pregnancy is the leading cause of death for young women aged 15 to 19 worldwide with complications of childbirth and unsafe abortion being the major risk factors.⁹⁵ Girls aged 15 to 19 are twice as likely to die in childbirth as those in their 20s, and girls under 15 are five times as likely to die as those in their 20s.⁹⁶ In almost all countries in sub-Saharan Africa, HIV/AIDS prevalence is higher among girls aged 15 to 24 than among boys of the same age.

Sexual activity begins early and is often unprotected: In sub-Saharan Africa, young people are sexually active by their late teens. The high level of sexual activity among adolescents is associated with risks such as HIV/AIDS, pregnancy and unsafe abortion, economic hardship and school dropouts. There are variations however based on residence, level of education and socio-economic status. Young people must be provided with the information and skills that will enable them postpone their sexual debut.

Childbearing begins early: In sub-Saharan Africa alone, more than half of the women give birth before the age of 20 as compared with one-third for Latin America and the Caribbean. Sexual activity at a very early age, and low use of contraceptive are some of the factors contributing to this.⁹⁷

Early and forced marriage is also common: The percentage of adolescents getting married before the age of 18 years ranges from 75% in Mali and Niger to around 15% in Botswana, Namibia and Rwanda. Early marriage is higher in rural areas and those areas reporting lower levels of education. Marrying at younger ages means that young people start child bearing early before they are physiologically mature.⁹⁸

The plight of young people is further compounded by the lack of clear government policies on Adolescent Reproductive Health in many countries in the region. This creates uncertainty and hinders provision of information and services. The need for supportive policies is critical if countries in this region are to deal effectively with adolescent reproductive health and related issues.

Sub Saharan Africa has very high teenage pregnancy rates: The range of unplanned pregnancies among adolescent girls ranges from high to very high in some sub-Saharan African countries where up to 50 percent of adolescent mothers reported that their pregnancies were unplanned. Overall, adolescent fertility rates are highest in Central and Western Africa.⁹⁹

Adolescents face higher reproductive risks than older women: For biological, cultural and economic reasons, sexual and reproductive risk is higher among adolescent women. Pregnancy is the leading cause of death for young women aged 15 to 19 worldwide with complications of childbirth and unsafe abortion being the major risk factors.

95 WHO. 2007. Adolescent pregnancy—unmet needs and undone deeds: A review of the literature and programmes. Geneva: WHO.

96 2004. Maternal Mortality Update 2004: Delivering Into Good Hands. Geneva: WHO.

97 2004. Maternal Mortality Update 2004: Delivering Into Good Hands. Geneva: WHO.

98 UNICEF 2008. Progress for Children. A Report Card on Maternal Mortality. Number 7, September 2008.

99 WHO. 2007. Adolescent pregnancy—Unmet needs and undone deeds: A review of the literature and programmes. Geneva: WHO.

Teenage girls who are not physically mature are at greater risk of obstructed labour, pregnancy-induced hypertension and obstetric fistula, Girls aged 15 to 19 are twice as likely to die in childbirth as those in their 20s, and girls under 15 are five times as likely to die as those in their 20s.

Death and injury rates are higher among infants born to young mothers. Young mothers are less likely to get prenatal care, and babies born to very young mothers are more likely to be premature or underweight. The risk of dying in the first year of life is typically greater by 30 percent or more among babies whose mothers are aged 15 to 19 than among those born to mothers aged 20 to 29. In general, young mothers are less likely to have the means to safeguard the health of their infants.

In almost all countries in sub-Saharan Africa, HIV/AIDS prevalence is higher among girls aged 15 to 24 than among boys of the same age.

Relationships with older men increase young women's vulnerabilities: Studies on informal transactional sex in sub-Saharan Africa found that between 7 and 38 percent of unmarried adolescent girls surveyed report receiving money, gifts or favours within the last year in exchange for sex.¹⁰⁰

Conflict complicates life for young women in SSA: Conflict and displacement of families disrupts the transition to adulthood and complicates the lives of young people in Africa even further. It predisposes them to violence, abuse and related consequences such as unwanted pregnancy, unsafe abortion and injury.

Text Box 7: High Fertility and Teenage Pregnancy in Uganda

Uganda has an estimated population of 29.2 million people half of whom are estimated to be young people below the ages of 30. With its population growing at a rate of 3.2% per annum, Uganda has one of the highest growth rates in the world and higher than the Sub Saharan Africa average of 2.4%. About 12.3 % of the populations have no education.¹⁰¹ Only 5 percent of males and 3 percent of females have completed secondary or higher education.

Sexual activity begins early for both men and women: Both Ugandan women and men begin having sexual intercourse before they marry. Median age at first sex among women is 16.6 years, over one year before marriage.

Reproductive health challenges facing young people in Uganda include lower uptake of contraceptive use. The need for spacing (25 percent) is higher than the need for limiting (16 percent). Currently only 37 percent of the demand for family planning is being met and 46 percent of last births were either unwanted or wanted later. At current fertility levels, a Ugandan woman will have an average of 6.7 children in her lifetime. There has been almost no decline in the fertility rate since 1995. Half of women have had their first birth by the age of 19.

Uganda has a high fertility and birth rate among adolescents and youth with indications that 61% of females below 20 years having at least one child. While deaths rates have fallen, fertility and birth rates remain at high levels resulting in rapid population growth. The fertility rate has been attributed to low levels of education, low incomes and social status, early marriages, low contraceptive use, religious and cultural beliefs as well as the need for old-age security. Contraceptive use is as low as two in five currently married women (41 percent) in Uganda have unmet need for family planning.¹⁰²

There is a low level of gender equality in Uganda: Living in poverty and confronted with peer pressure, young women often turn to sex in exchange for gifts. Only around half of the sexually active youth aged 15-24 use condoms. Young women constitute nearly half of all maternal deaths, due to an increased risk of complications in pregnancy and birth, which in turn often leads to obstetric fistula. HIV/AIDS related fear and stigma remain widespread although political commitment has considerably raised awareness on the topic.

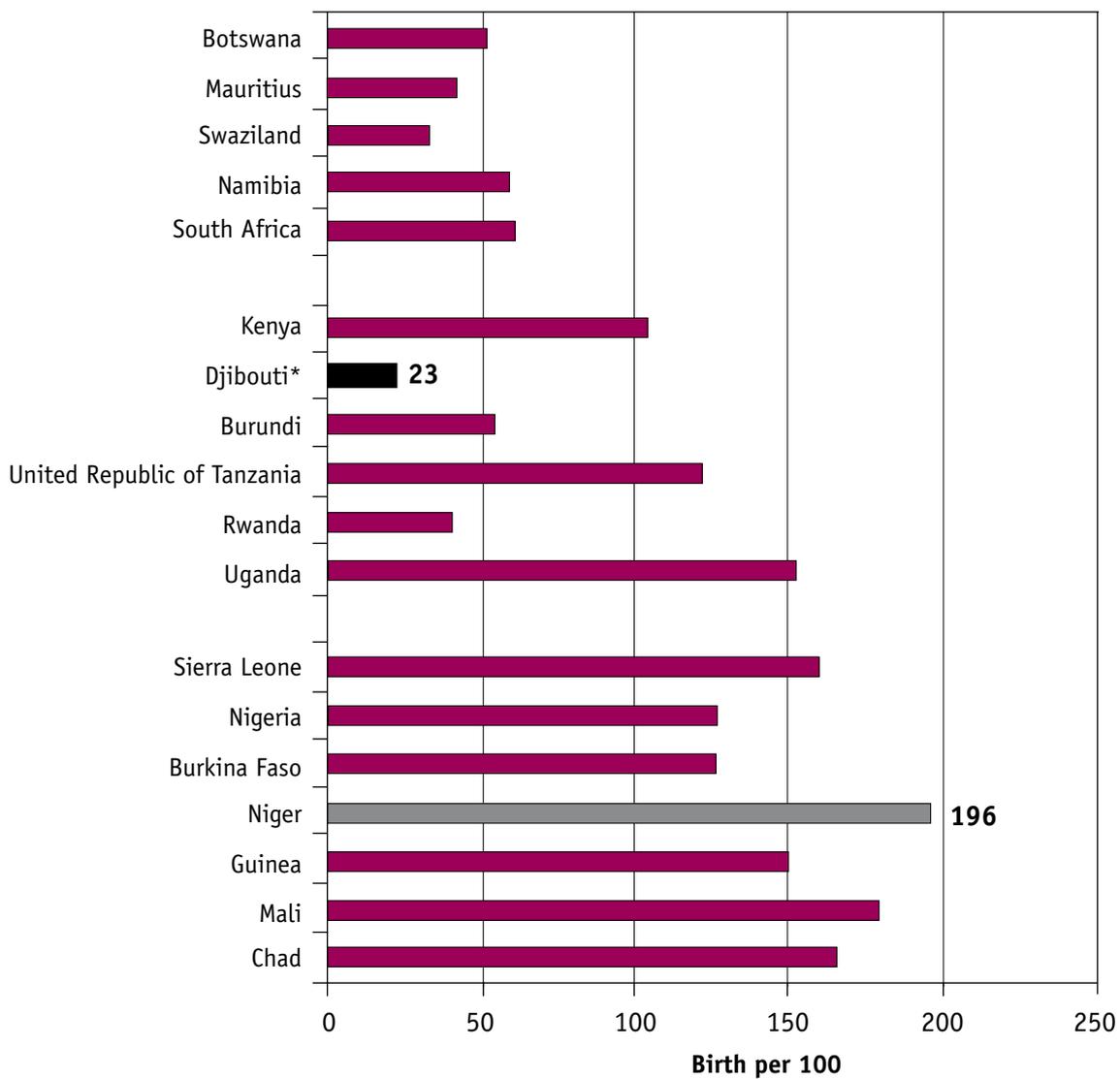
Unsafe abortion rates increasing: Due to unplanned childbearing abortion is becoming increasingly common in Uganda, even though national law permits abortion only to save a woman's life. The other social factor that has an impact on sexual behavior in Uganda is education.

100 Population Action International, 2007. Calculating Women's Sexual and Reproductive Risk. 2007 Report Card. PAI, Washington DC

101 Government of Uganda & Uganda AIDS Commission. UNGASS Country Progress Report Uganda report, 2008

102 Government of Uganda & Uganda AIDS Commission. UNGASS Country Progress Report Uganda report, 2008

Fig. 6: Adolescent Fertility Selected SSA Countries



Source: WHO, UNFPA, UNICEF Data from various publications



Education can be a Powerful Tool in Improving Maternal Health in sub-Saharan Africa

Education is a potentially powerful tool for elevating women's status and improving their health and general well being. Better educated women are more likely to use maternal health services, including antenatal care and skilled delivery care. Education can influence factors such as consistent condom use, contribute to increase in contraceptive use and a reduction in sexual partners there by contributing to lower reproductive risk. Educated women also tend to develop a better understanding of formal institutions, including those related to health care provision, which in turn encourages health-seeking behaviours and are also more likely to claim rights and participation more in social development.¹⁰³

Sub-Saharan Africa has made some progress in improving access to education. SSA's total net enrolment ratio in primary education increased from 54 to 58 per cent between 1991 and 2000, and then accelerated to 71 per cent in 2006. The number of girls attending school is also on the increase with the gender parity index rising from 83 per cent in 1991 to 85 per cent in 2000 and 89 per cent in 2006. Despite these improvements, many school age children are not attending school and drop out rates among girls remain high.¹⁰⁴

Education is key to improving maternal and neonatal health, reducing the incidence of harmful practices such as early marriage and Female Genital Mutilation (FGM) – practices which have adverse effects on maternal health. It contributes to reducing child marriage – with its largely inevitable consequences of premature pregnancy and motherhood, eliminating extreme poverty and hunger, and enhancing knowledge of health risks and life skills.

Educating girls and young women is one of the most powerful ways of breaking the poverty trap and creating a supportive environment for maternal and newborn health.

Children of educated mothers are 50 per cent more likely to survive until the age of five and beyond than those whose mothers did not receive or complete schooling.

There is evidence that young people who complete primary school are less likely to be infected by HIV than those who never managed to graduate from primary school. Educated girls are also more likely to delay marriage and less likely to get pregnant while very young, reducing the risk of dying in childbirth. Better knowledge of health-care practices, expanded use of health services during pregnancy and birth, improved nutrition and increased spacing between births – all factors that are fostered by girls' education – reduces maternal mortality.¹⁰⁵

Education therefore improves reproductive health. Educated women are more likely to seek adequate prenatal care, skilled attendance during childbirth and to use contraception. They tend to initiate sexual activity, marry and begin childbearing later and have fewer children than uneducated women. Every three years of additional education correlates with up to one child fewer per woman.¹⁰⁶

¹⁰³ Population Action International (PAI) 2007. A measure of survival. Calculating Women's Sexual and Reproductive Risk: PAI Report Card 2007.

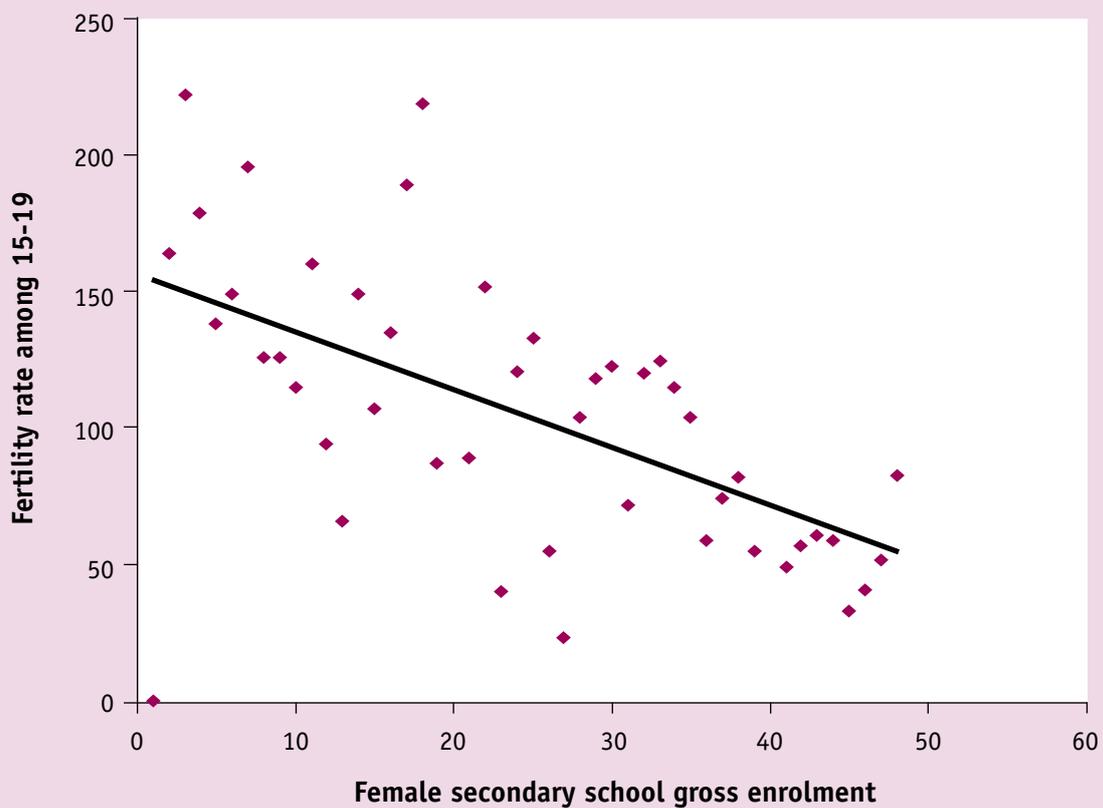
¹⁰⁴ See MDG Report 2008. High-level Event on the Millennium Development Goals, United Nations Headquarters, New York, 25 September 2008

¹⁰⁵ The World Bank 2001; Smith, L. C., and L. Haddad. 2000. Explaining Child Malnutrition in Developing Countries: A Cross Country Analysis. Research Report. No. 111. Washington, D.C.: International Food Policy Research Institute; and Schultz 1993

¹⁰⁶ UNFPA 2005. State of the World Population. The promise of Equality, Gender, Equity, Reproductive Health and the millennium Development Goals. UNFPA.



Fig. 7: Adolescent fertility and secondary education





Harmful Practices: Violating the Rights of Girls and Women

Culturally accepted norms and practices often limit a woman's ability to safeguard her own sexual and reproductive health and survival. In many countries, the law remains silent about harmful traditional practices such as FGM, child marriage and sex-selective abortion. In cases where protective legislation does exist, statutory laws can be undermined by customary laws. Moreover, often there are limitations to the opportunities available to women—in terms of access to jobs, unequal pay scales, discriminatory inheritance laws, and unequal access to education and political participation. No where is this more true than in SSA where FGM and early marriage are common and systematic discrimination on the basis of culture is the norm rather than the exception.

Too Young to wed: Early and forced marriage in sub Saharan Africa

In the next 10 years, 100 million young women will marry before they turn 18.¹⁰⁷ The rate of marriage among girls younger than age 18 is greater than 40 percent in South Asia and Africa, and it exceeds 60 percent in parts of East and West Africa.¹⁰⁸

There is a strong association between early marriage and early childbearing. Once young girls get married, they is often pressure to prove their fertility a factor which puts them at increased risk of pregnancy related mortality and morbidity. Very young and first-time mothers disproportionately suffer from prolonged and obstructed labor, which can result in obstetric fistula.

Marriage increases risk of HIV infection among girls: They may also be at a higher risk of contracting HIV than their unmarried, sexually active counterparts.¹⁰⁹ Studies in Kenya and Zambia report that HIV infection rates among married girls are 48 to 65 percent higher than among sexually active unmarried girls.¹¹⁰

Early marriage can also mark the end of a girl's education depriving her of associated benefits. Young married girls are also more likely to experience domestic violence and sexual abuse. They also face high risk of forced sex. A study in South Africa found that 30 percent of pregnant adolescent girls reported forced sexual initiation, in most cases by their boyfriends.¹¹¹

Several countries especially those that have ratified the UN Convention on the Rights of the Child (UNCRC) have outlawed early marriage, enforcement remains weak and unco-ordinated.

FGM is still commonly practiced in SSA

Around 70 million girls and women aged 15–49 in 27 countries of Africa and the Middle East are estimated to have undergone this practice. In recent years, there has been a slight decline in prevalence; however, FGM is still very commonly practiced among many communities in sub-Saharan Africa.¹¹² FGM is usually carried out before a girl reaches 14 years of age and is seen by some communities as enabling girls to become “clean” before they enter adulthood. The severest form of FGM involves the removal of the genitalia is carried out, without anesthesia.¹¹³

107 Population Action International. 2007. A Measure of Survival. Calculating Women's Sexual and Reproductive Risk. PAI Report Card 2007

108 Population Action International. 2007. A Measure of Survival. Calculating Women's Sexual and Reproductive Risk. PAI Report Card 2007

109 WHO. 2007. Adolescent pregnancy—Unmet needs and undone deeds: A review of the literature and programmes. Geneva: WHO.

110 Ronsmans, Carine, and Wendy J Graham. 2006. “Maternal mortality: Who, when, where and why.” *The Lancet* 368: 1189-1199.

111 WHO. 2007. Adolescent pregnancy—Unmet needs and undone deeds: A review of the literature and programmes. Geneva: WHO.

112 United Nations Children's Fund, Progress for Children: A World Fit for Children Statistical Review, Number 6, UNICEF, New York, 2007, p. 44

113 Njoh, A. 2006. Tradition, Culture and Development in Africa, p. 97. Hampshire: Burlington. Ashgate Publishing Company.

The prevalence of FGM/C in SSA varies by country and region. In Guinea-Bissau, for example, a recent survey (2006) showed that FGM/C is still widely practiced: 44.5 per cent of girls and women aged 15 to 49 years are affected by the practice.

FGM has numerous physical health risks including trauma and bleeding, and in later life difficult childbearing and heightened risk of sexually transmitted infections including HIV.¹¹⁴ It can also contribute to increased risk of such adverse events as prolonged or obstructed labor and post-partum hemorrhage. The risk of FGM related complications for both mother and baby increases with the severity of the mutilation.

FGM not only affects the reproductive health of women, it also affects their newborns. It is harmful to babies and leads to an extra one to two perinatal deaths per 100 deliveries¹¹⁵

Female genital mutilation and cutting violates girls' and women's human rights, denying them their physical and mental integrity, their right to freedom from violence and discrimination and, in the most extreme cases, their lives. FGM/C is a reflection of gender inequality and discrimination, a form of violence against girls.

Responding to the Challenge: What can be done?

Abandoning female genital mutilation and cutting is critical to ensuring safe motherhood and reducing neonatal deaths. Successful initiatives in Senegal and other countries where FGM is widespread show that community education and open dialogue can have positive results.

Enforcement of legislation in countries where the practice is banned would go a long way in ensuring that the rights of women are protected.

Alternative Rites of Passage: Some countries like Kenya have introduced alternative rites of passage for the girls and some offer housing for the girls to keep them from getting circumcised. For the Intervention programmes to work well male involvement is vital.

Education of communities on the dangers: Community education on the consequences of FGM and the dangers that girls who go through the practice face can accelerate change in reducing prevalence in some areas.

Investing in girl's education: Educated girls are less likely undergo FGM. Educated women are also less likely to subject their daughters to FGM.

114 UNICEF. 2008. Progress for children. A report card on maternal mortality. No 7, September 2008.

115 World Health Organization, Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries, WHO, Geneva, 2006, p. 6.



Sexual and Gender Based Violence: The New Epidemic

Violence kills and disables as many women between the ages of 15 and 44 as cancer. And its toll on women's health surpasses that of traffic accidents and malaria combined.¹¹⁶

Violence against women and girls is a problem of pandemic proportions. At least one out of every three women around the world has been beaten, coerced into sex, or otherwise abused in her life time. VAW is the most pervasive human rights violation today. It devastates lives, fractures future communities, and stalls development. For women aged 15-44 violence is a major cause of death and disability. Among the ten selected risk factors facing women in this age group, rape and domestic violence rated higher than cancer, motor vehicle accidents, war and malaria. Studies have also revealed increasing links between VAW and HIV/AIDS. Women who have experienced violence are at higher risk of HIV infection.

In many parts of the world, Sexual and Gender Based Violence (SGBV) is on the rise. Gender-based violence knows no boundaries— economic, social or geographic and takes many forms, from the domestic confrontations that leave millions of women living in fear to sexual abuse and rape, to harmful practices ranging from female genital mutilation/cutting and dowry-related violence.

Women are often the overwhelming victims of gender-based violence (GBV), which is often perpetrated by men. Gender-based violence both reflects and reinforces gender inequity. In recent years, trafficking and enslavement of women and children has also increased resulting in millions of women and children being subjected to dangerous practices and prompting the intervention of the United Nations.¹¹⁷

The action plans from the 1994 ICPD and the 1995 Fourth World Conference on Women (Beijing) recognized the elimination of gender-based violence as central to gender equality and the empowerment of women.

The consequences of gender-based violence are devastating. It is estimated that death and disability from violence affecting women between 15 and 44 years is the same as that resulting from cancer. The toll on women's health as a result of GBV surpasses that of traffic accidents and malaria combined.

Gender Based violence is very common in sub Saharan Africa

In sub Saharan Africa socio-economic and political challenges reinforced by gender inequity provides an environment where violence against women goes on unabated. Fuelled by conflict, poverty and socio-cultural practices that condone discrimination against women, SGBV has escalated in Africa to unacceptable levels. The use of rape as a weapon of war has also increased in recent years with the Democratic Republic of Congo experiencing very high levels.

Under Assault: Adolescent Girls and Young Women

Data from various countries show that while young men also experience violence, younger women and adolescent girls are especially vulnerable to gender-based violence. In Mali, the United Republic of Tanzania and Zimbabwe between 20 and 30 per cent

¹¹⁷ In 2000, the UN General Assembly voted to adopt a protocol to the UN Convention against Trans-national Organized Crime to protect women and children

¹¹⁶ UN Millennium Project, 2005

of adolescent girls had experienced sexual violence. In Burundi, 88 per cent of the women seeking care from UNFPA-supported NGO centres offering support for victims of sexual violence in 2004 were young women.¹¹⁸ In Kenya, 40-60 percent of all reported cases of violence affect girls below the age of 16 years.¹¹⁹

Violence against girls has serious medical, social, economic and psychological consequences. Violence can have life long effects on the life of a girl and can affect relationships and decision making regarding sexuality and related issues.

Violence against women compromises reproductive health and pregnancy outcomes.

Consequences of GBV include unwanted pregnancy, unsafe abortion and maternal mortality; miscarriage and stillbirth; delayed antenatal care; premature labour and childbirth; foetal injury and low birth weight.

Data suggest that unwanted pregnancies carry a greater risk than those that are wanted and that women with unwanted pregnancies are less likely to receive early antenatal care or give birth under skilled attendance. Such pregnancies may also carry a greater risk of unsafe abortion – a significant cause of maternal death in sub-Saharan Africa. Violence before or during pregnancy can lead to multiple health risks for the mother and child, including miscarriage, preterm labour and foetal distress and low birth weight.¹²⁰

Violence increases risk of HIV infection

among women and girls: Abused women also face higher risks of contracting HIV and other sexually transmitted infections. Exposure increases directly with rape and indirectly through fear of negotiating condom use. The fact that violent men tend to have more partners outside of marriage adds to the risks.¹²¹

118 Organized Crime: Adopted and opened for signature, ratification and accession by General Assembly Resolution 55/25 of 15 November 2000." Geneva: Office of the United Nations High Commissioner for Human Rights.

119 Centre for the Study of Adolescence. 2007. Adolescence in Kenya: The Facts, CSA Nairobi.

120 Population Action International. 2007. A Measure of Survival. Calculating Women's Sexual and Reproductive Risk. PAI Report Card 2007

121 de Bruyn, M., and S. Packer. 2004. Adolescents, Unwanted Pregnancy and Abortion: Policies, Counseling and Clinical Care. Chapel Hill, North Carolina: Ipas

During the 1991-2001 conflict in Sierra Leone, young girls were specifically singled out for rape and many, particularly the very young, did not survive. An estimated 70 to 90 per cent of rape victims contracted STIs. Millions of women have been raped and sexually tortured during conflicts. Rape camps, sexual slavery, and forced impregnation or intentional infection with HIV have all occurred in recent conflicts.¹²²

Even when women fleeing conflict find their way to refugee camps, they are not necessarily safe. In one Tanzanian camp, 26 per cent of women refugees from Burundi were raped.¹²³

Mortality from violence is under-estimated:

Increasing evidence suggests that infants and young children are also at risk from violence, and that deaths from physical violence are underestimated.

Weak policy and institutional framework a major factor in the rise of GBV in SSA:

Few countries have laws and policies against GBV although in recent years there has been an increase in the number of countries adopting legislative measures. But even where laws exist enforcement and legal systems may not be supportive and sometimes may re-victimize women. Such laws often lack budgetary appropriations, leaving critical gaps between intention and reality.

Responding to the challenge: What can governments do?

In sub-Saharan Africa where gender-based violence is so widely tolerated, governments must adopt comprehensive approaches including: strengthening legal systems; investing in the safety, education, reproductive health and rights, and economic empowerment of women; gender-sensitive education from an early age; public health systems that provide appropriate care and support for victims; mobilizing communities, opinion and religious leaders, and the media; and engaging young and adult men to take a strong stand on the issue.¹²⁴

122 Adrian-Paul, A. 2004. "HIV/AIDS." Inclusive Security, Sustainable Peace: A Toolkit for Advocacy and Action. Washington, D.C., and London

123 Adrian-Paul, A. 2004. "HIV/AIDS." Inclusive Security, Sustainable Peace: A Toolkit for Advocacy and Action. Washington, D.C., and London

124 United Nations Children's Fund, The State of the World's Children 2009: Maternal and Newborn Health UNICEF, New York, 2009, pp. 35-37



Improving access to education for girls is key to reducing GBV: Although gender-based violence affects women of all classes, poverty and lack of education are additional risk factors. Increasing educational levels can help prevent violence by empowering young women.

Educational programmes can also serve as a vehicle for sensitizing young men to respect women's rights and mobilizing them to support anti-violence activities.

Integration of appropriate services into the primary health care systems: At the 1995 Beijing Conference, governments promised to "integrate mental health services into primary health care systems and train primary health

workers to recognize and care for girls and women of all ages who have experienced any form of violence.¹²⁵

Expanding access to Comprehensive Post Rape Care is an important first step: Governments are also increasingly making emergency contraception available as a component of post-rape care. Increasing the availability of health facilities offering on-site screening and care for abused women is critical. Expanding these services to rural areas is just as important if women are to receive the care when they need it.

¹²⁵ Center for Reproductive Rights. 2005. "Governments in Action: Legal and Policy Developments Affecting Reproductive Rights." Briefing Paper. New York: Center for Reproductive Rights

Text Box 8: The Role of Men: Bringing Men And Boys Back To Reproductive Health

A growing body of international research and interventions are demonstrating significant potential in encouraging men and boy's positive roles in building gender equality and improving men's, women's and children's health. These developments reflect the recognition that, as key decision-makers, men and boys are essential partners in addressing today's public health challenges, and in building more equitable and prosperous societies. The necessity of this active engagement is reinforced by an increasing number of international declarations, and is now recognised as key to meeting the Millennium Development Goals (MDGs).¹²⁶

While biological and socio-economic factors contribute significantly to early sexual activity and related consequences, socialization too plays an important role in shaping the attitudes of adolescents towards key aspects of Reproductive Health (RH). It leads to stereotyping, which in turn affects the planning, and implementation of reproductive health, family planning and HIV/AIDS prevention programs. For instance, most RH programmes target women, and focus almost exclusively on family planning, a warped social attitude has emerged where family planning is treated as solely a female responsibility.

In many countries, risk taking behaviour by men such as having sex with many women is a measure of a young man's virility. Such behaviour which is very common in sub Saharan Africa, not only puts the men at risk but also endangers the lives of their partners.

Gender-based expectations can keep men from enriching the lives of their children and their own lives as well. Many societies tacitly condone male risk-taking and use of violence to exert authority. While young men are often perpetrators of violence, they are also its primary victims. Reproductive health and contraception remain primarily women's responsibility. A large percentage of married men aged 25 to 39, particularly in sub- Saharan Africa; report that they have not discussed family planning with their partners.

What programmes exist: In recent years, there has been an increase in the number of programmes aimed at leveraging the positive involvement of men in the struggle for equality and reproductive health. While some encourage joint participation in decisions about contraception, emergency plans for pregnancy and labour and voluntary HIV testing others emphasize men as agents of positive change and encourage them to question gender norms more broadly. Some also target adolescent boys at a formative and potentially risky time in their lives. Despite these efforts, most initiatives are small in scale and are able to reach only a small number of men.

Programmes that emphasize the role of men as agents of positive change and involves them more fully in promoting gender equality and social change offer significant opportunities to help men understand how gender inequities harm their partners and themselves. The Men as Partners programme, initiated by Engender Health in South Africa, seeks to curb the transmission of HIV through workshops, radio and Internet dialogues, involving frank discussions between men and women about gender norms and relationships. Workshops are often facilitated by men motivated by their own exposure to domestic violence and AIDS, and convinced of the need for change.

Approaches are limited to increasing male uptake of SRH services: Programme approaches remain narrow with most initiatives still focusing on serving men as clients. For male involvement programmes to succeed, they need to go beyond working directly with men to promote a positive shift in gender norms, away from attitudes and behaviors that undermine women's and men's own health and general well being. Programmes must therefore adopt approaches that combine service delivery, community education, outreach and advocacy.

There is limited capacity to design and implement Male involvement interventions in the region: A survey of two African countries, Uganda and Lesotho, revealed that the documentation of process and experience in setting up programmes which could affect the scaling up and replication of existing interventions is weak. The study found that in both countries programs targeting men started with limited diagnostic studies or baselines to identify priority issues and design the interventions appropriately.

¹²⁶ See IPPF, 2009, Study on Uganda and Lesotho.

Strengthening Health Systems is critical to improving maternal health

“It will be impossible to achieve national and international goals – including the Millennium Development Goals (MDGs) – without greater and more effective investment in health systems and services”.¹²⁷

Health systems refer to all resources, organizations and actors that are involved in the regulation, financing, and provision of actions whose primary intent is to protect, promote or improve health. WHO defines six building blocks to a well functioning health system namely: service delivery; health workforce; information; medical products, vaccines and technologies; financing; and leadership and governance.¹²⁸

Health systems in sub-Saharan African countries face various problems such as shortages of trained staff, essential supplies and equipment, adequate facilities, and management skills. Other problems include creating demand for available services and overcoming the stigmatization that prevent people from accessing services. The cost of health care continues to be a significant barrier to service access and use. For example, country studies have found that user fees introduced by health sector reforms led to significant drops in the use of maternal health services. Studies in Kenya and Zimbabwe found that the introduction of user fees resulted in a 50 and 30 per cent drop, respectively, in the use of maternal health services.¹²⁹

In addition, health systems in many sub Saharan African countries cannot deliver essential interventions well enough to reduce mortality due

to contextual challenges, such as armed conflict, natural disasters, high HIV burdens and low adult female literacy rates which combined contribute to stagnating or deteriorating coverage.

A good evidence base is essential for planning monitoring progress: In many SSA countries the evidence base for maternal health is weak. In some countries data for key indicators is not available and it is difficult to establish the level of achievements in those areas. A strong knowledge base is an essential component of a well functioning health system and forms the foundation for policies, programmes and partnerships and is an essential component for health systems.

Human resources are fundamental to a functioning health system and are in many developing countries a major constraint to scaling up health interventions. Human resources for health must be adequate in number and well-trained. In SSA, there are only 2 physicians per 10 000 compared with 32 per 10 000 in the European Region.¹³⁰

The shortage of skilled professionals is a paramount concern. In African countries, a ratio of one doctor for every 10,000 people is not uncommon. This compares to 1 doctor per 500 people in the United States. Stemming the “brain drain” of qualified medical personnel seeking better salaries and working conditions abroad is another priority. Sub-Saharan Africa will need an estimated one million more health workers in order to reach the health-related MDGs.

127 World Health Organization 2007 Everybody business: strengthening health systems to improve health outcomes: WHO's framework for action. World health Organization

128 World Health Organization 2007 Everybody business: strengthening health systems to improve health outcomes: WHO's framework for action. World health Organization

129 UN Millennium Project. 2005c. Who's Got the Power: Transforming Health Systems for Women and Children. Task Force on Child Health and Maternal Health. London and Sterling, Virginia: Earthscan).

130 WHO 2009: World Health Statistics 2009.



Demand creation should be an integral part of efforts to reduce maternal mortality and morbidity. One of the ways of reducing maternal and neonatal deaths is the early recognition of preventable risks as this enables families to take timely action to prevent mortality and morbidity. It is also important to focus on entrenched cultural attitudes and beliefs around pregnancy and childbirth that contribute to increased risk. Yet few countries have community health strategies while adopting facility based approaches which fail to take into account the factors at play in the lives of women.

Ensuring equitable and sustainable financing: Funding remains a challenge for both rich and

poor nations. Support for family planning and reproductive health is even more problematic as most countries fail to meet the required financial targets necessary to ensure equitable and sustained access to services.

Strengthening infrastructure, transportation, logistics, supplies and the referral system: To improve maternal health, it is essential to invest in sectors that support basic health care. In addition to improving information systems, ensuring equitable and sustainable financing governments must also focus on developing infrastructure, strengthening logistics and the referral process.

A Measure of Government Commitment: Health Care financing in sub Saharan Africa: A grim scenario

One of the biggest challenges for maternal and neonatal health is the shortage of skilled health personnel. A 2006 World Health Organization survey reveals that while Africa accounts for more than 24 per cent of the global disease burden, it has only 3 per cent of the world's health workers and spends less than 1 per cent of total global resources dedicated to health, even after loans and grants from abroad are taken into account.

Limited spending on maternal Health: Across Africa, spending on health remains limited. Sub-Saharan countries are spending less than \$2 per person for maternal health while most experts estimate at least a minimum of \$8 per person. To see a fully functioning health system, governments would need to spend \$40–50 dollars per person, not taking into account anti-retroviral drugs.¹³¹

Current funding levels are inadequate for meeting MDGs: "To reach the Millennium Development Goals (MDGs), it is estimated that the proportion of government spending on health would need to increase nearly six-fold and that more than 12 percent of GDP would have to be spent on health. Yet the current regional average is 4.7%¹³²

Most countries do not meet the WHO recommended levels of per capita funding. Few countries in sub-Saharan Africa meet the WHO recommendation of \$34 minimum per capita and so far only 5 countries have achieved this. Assuming all African countries meet Abuja target of 15%, an

almost impossible feat judging by current trends, most countries in sub-Saharan Africa will still not meet the minimum per capita target by 2020.

Main challenges faced by African governments in increasing spending on health include: limited fiscal space, low domestic resource mobilization capacity, and constrained economic growth.

Sources of funding for health in the African region

The belief that additional resources for health must come from outside Africa is worrying. African governments insist that improving the efficiency and effectiveness of existing spending should be given more priority and should take precedence over efforts to meet Abuja and WHO targets. At the same time, they acknowledge the need to increase overall health financing and insist that additional aid flows should come from external sources.

In 2008, eighteen countries received about 11 percent of their total health expenditure from external sources; 9 countries received between 11–20%; 7 countries received 21–30%; 6 countries received 31–40%; and the remaining 6 countries received 41–60% of their total health expenditure from external sources. Countries could create additional resources for health by reprioritizing government expenditure most significantly, redirecting resources from military expenditure.¹³³

131 Investing in the health of Africa's mothers, Africa Renewal, Vol.21 #4 (January 2008), page 8

132 GovenderV, McIntyre D, Loewenson, R (2008) 'Progress towards the Abuja target for government spending on health care in East and Southern Africa,' EQUINET Discussion Paper Series 57. EQUINET: Harare.

133 Joses Muthuri Kirigia Alimata J Diarra-Nama(2008) Can countries of the WHO African Region wean themselves off donor funding for health? Bulletin of the World Health Organisation, Volume 86 No. 11 November, 817-908 <http://www.who.int/bulletin/volumes/86/11/08-054932/en/index.html>



Human Resource management: Investing in People: Staff Training

Although the countries with the largest shortages of health workers in absolute terms are found in Asia – notably in Bangladesh, India and Indonesia – the largest relative need is in sub-Saharan Africa.¹³⁴

Shortages of skilled health workers arise from many factors, including under-investment in training and recruitment, weak incentives for health-care workers and low remuneration among others.

The sub-Saharan Africa region would need to increase its numbers of health workers by 140 per cent to reach the requisite density. An earlier WHO estimate calculated that 334,000 skilled birth attendants would need to be trained

worldwide in the coming years to cover 73 per cent of births.

Migration of Health workers causing a major problem: Heavy migration of skilled health workers from developing countries to industrialized nations – spurred by the burgeoning demand for health workers in industrialized countries with ageing populations – has taken a very heavy toll on health systems in SSA.

A survey of 10 African countries showed that the number of locally trained doctors now working in eight Organization for Economic Co-operation and Development countries was equivalent to 23 per cent of the doctors still domestically employed in those countries.

¹³⁴ World Health Organization, World Health Report 2006: Working together for health, WHO, Geneva, 2006, pp. 8–12, 24, 99–101

Broken Promises and Misplaced Priorities

In recent years a growing number of sub-Saharan African countries have embraced democratic practices opening up space for public discourse on social development issues. People have become more informed and citizen participation has increased. But as human rights take centre stage, reproductive rights remain largely ignored.

Governments in the region have signed most international and regional instruments governing reproductive health such as the International Conference on Population and Development, ICPD POA, 1994; the Beijing Platform for Action, 1995; the Millennium Development Goals (MDGs) endorsed by the international community in 2000, the Safe Motherhood Initiative (SMI) launched in Nairobi in 1987 or even the Partnership for Maternal and Newborn Health launched in 2005 and the recent Maputo Protocol.

However few countries make provisions for implementation. The result is an uncoordinated approach to implementation and the inability to meet global and regional targets. Additionally there is limited understanding of the critical linkages between reproductive rights and the broader human rights. Civic and political rights are seen as more important, yet the failure to meet reproductive rights is a clear violation of human rights.

A look at policy documents clearly show that African governments understand the need to improve maternal health yet in terms of financial commitment RH is not treated as a priority and is often left to outside donors to fund.

Supporting and empowering women through education and eradicating harmful practices that

perpetuate inequity and undermine women's health is equally important.

Promises made both locally and internationally are not kept. The Abuja targets have not been met by many countries, eight years since its signing. The Maputo Protocol that guarantees the reproductive rights of African women has not been ratified by all the countries that signed it a few years ago. Yet the protocol is in line with other global commitments these countries have already made.

A review conducted in 2006 revealed that only one third (33 percent) of countries had allocated at least 10% of their national budget to health while one country had attained the target of 15%. In recent years the number of countries allocating at least 15 percent of national budgets to health has risen to five -Malawi Rwanda, Lesotho, Burkina Faso and Liberia. In some countries the proportion of the national budget allocated to health has shrunk since Abuja.¹³⁵

Countries still spend more on defence than on health. The East African countries, Kenya, Uganda and Tanzania allocated more funds to defence than health in their 2009/2010 budgets. In fact in Kenya, the allocation for defence and internal security was almost four times more than that for the Ministry of Public Health under which reproductive health falls. Yet Kenya remains a relatively peaceful country.

Corruption and mismanagement are also hindering countries from meeting their obligations. There is a high level of leakage of even the limited resources allocated to health sectors.

¹³⁵ Health Financing in Africa: Challenges and Opportunities for Expanding Access to Quality Health Care –AU Paper, 2009 [http://www.africa-union.org/root/ua/conferences/2009/mai/sa/04-08mai/camh-exp 13a\(iv\)](http://www.africa-union.org/root/ua/conferences/2009/mai/sa/04-08mai/camh-exp%2013a(iv))

There seems to be a clear link between the level of corruption and a country's ability to provide social services. A comparison of the RRI index for sub-Saharan Africa with the recent corruption index launched by Transparency International confirms that those countries with low levels of corruption such as Mauritius, Cape Verde, Namibia and Botswana to name just a few, also have better health outcomes than those countries at similar levels of development but with high levels of corruption.

There is increasing evidence that investing in maternal health has far reaching benefits for communities. While additional resources are clearly needed, the more urgent requirement is

to shore up political support for these issues. Where there is political will to reduce maternal mortality significant progress has been made. And it has little to do with a country's size or wealth. If that were the case, Nigeria would be doing significantly better than it currently is.

Contrary to popular belief it is clear from the rankings that a country's wealth is not the most important determinant of maternal health outcomes. What matters is the country's commitment to improving the maternal health status of its women. Countries at similar levels of development have invested differently in reproductive health across the continent.

"The AU Abuja 15 percent pledge is one of the most important commitments African leaders have made to health development and financing, and our Heads of State should strive to meet this pledge without further delay. The continued loss of millions of African lives annually which can be prevented is unacceptable and unsustainable. Our leaders know what they have to do. They have already pledged to do it. All they have to do now is actually do it. This is all we ask of them.

While global health is a global responsibility, African leaders also have a moral responsibility to our people. Just as we expect the international community to honour their commitments to global health, we also expect African leaders to honour African commitments". -Archbishop Desmond Tutu, April 2008

Call To Action

Take Steps to Ensure The Survival of Millions of African Women and Children

What's Your Number and How Do You Improve It?

A Measure of commitment is an invaluable tool for advocates, decision-makers, donors and the media to assess the state of women's lives and health in sub-Saharan African countries. That so little progress has been in reducing maternal deaths in SSA should serve as a wake-up call to African governments. Fifteen years after the International Conference on Population and Development and eight years after the Millennium Declaration, African women are still dying from largely preventable causes.

The Reproductive Risk Index is designed to assist advocates in galvanizing political support for reproductive health. It should be use to make the case for increased funding and strong policies for sexual and reproductive health and rights. Most importantly, it should be used to advance women's equality, without which none of the recommendations below are achievable.

Invest in education of both boys and girls

Education makes a significant difference in the lives of women and has tremendous impact on maternal health outcomes. Evidence from the 47 countries included in this report clearly show that positive relationship between education and health seeking behaviour. Countries that have higher literacy rates among women have higher contraceptive prevalence rates and lower fertility than those with low literacy levels among women and girls.

Reach youth with information and services

Comprehensive, age-appropriate sexual and reproductive health education for both in- and out-of-school youth is imperative, in every society. Equally important is the provision of youth-friendly services that are confidential, easy to get to, and accessible in places and times that are convenient to youth. Policymakers should redouble efforts to invest in quality education for girls and all young people. The transition from adolescence to adulthood should be supported and enriched through public policy that values girls' and boys' rights, cherishes their potential and espouses gender equity.

End harmful practices that discriminate against women

Very early marriage and childbearing, intimate partner violence, female genital mutilation/cutting and other harmful traditional practices violate women's rights and are detrimental to their health and lives. To effect lasting change, laws and policies to ban harmful practices must accompany locally-driven educational efforts to end such practices and honour the rights of girls and women. But it will take time, steadfast leadership, and consistent activism and education at the local and national levels.

Reposition Family Planning

Family planning efforts have declined in the recent past with funding decreasing and political support diminishing. Efforts to satisfy the unmet need for family planning are an urgent regional priority as high fertility is one of the major drivers of maternal mortality. Countries with a high unmet need also have lower maternal deaths. Reposition family planning is therefore a priority and countries should ensure that family planning is accessible and available to all those who require the services. Countries ensure a broad mix of contraceptives—including emergency contraception (EC), as well as male and female condoms—and provide high-quality care that empowers women, men and young people to make informed decisions.

Expand Access to emergency obstetric care services in rural areas

Increasing women's access to life-saving reproductive health care is a smart investment; maternal health interventions are among the most cost-effective interventions for women of reproductive age. Scaling up emergency obstetric care, combined with recruiting and training health professionals, is paramount. These efforts will fundamentally save the lives of women and their babies.

Make abortion safe, legal and accessible

Health professionals need a supportive policy and regulatory environment that provides training, furnishes necessary resources and ensures that abortion is accessible in a range of health care settings—not just hospitals. Post-abortion care (PAC) is a core component of reproductive health care and should be fully funded and accessible. Where abortion is legal, efforts should be made to ensure that it is safe and accessible.

Involve communities

The mix of factors that contribute to poor reproductive health varies from one community to another. Therefore, efforts to reach women, men and youth with comprehensive sexual and reproductive health information and services must be locally led and implemented. Community-based reproductive health workers were once the backbone of primary health care in many rural areas, but declining funding for family planning, combined with onerous policy restrictions, have taken their toll. It's imperative to rebuild and sustain networks of community health workers to provide health information and supplies.

Support Integration of sexual and reproductive health with HIV/AIDS efforts

Voluntary family planning is a key HIV-prevention strategy and must be closely coordinated with HIV/AIDS efforts. Funding, policies and programs must work together to achieve maximum impact. For instance, family planning services must be offered within PMTCT programs, and HIV-positive women, men and youth must have access to sexual and reproductive health information and care.

Increase investment for reproductive health supplies

Government and donor support for reproductive health supplies must increase significantly. Inconsistent financing and weak distribution systems hinder supplies from getting to where they are needed, resulting in frequent shortages and stock-outs of key health supplies. Improving the health of women and young people depends upon a sufficient and reliable supply of contraceptives (including female and male condoms), safe delivery kits, and immunizations, drugs to treat STIs and malaria, and other basic supplies, reaching their communities on a regular basis. Countries should strive to meet the recommended minimum for maternal health.

Improve health information system to generate timely quality data for quicker decision making

Maternal health data remain weak in many countries with data on key indicators missing making it difficult to assess progress and plan interventions. A well functioning health information system is one that ensures the production, analysis, and use of reliable and timely information on health determinants, health system performance and health status of a country's population.

Improve research of sexual and reproductive health

Better information and measurement of sexual and reproductive health is crucial for evidenced-based programming at the local level, as well as better monitoring of progress, evaluation of programs and policy-setting at the national level. Improved research and data-collection will highlight where changes in programming and strategy are needed.

Implement regional and global agreements

Countries often sign but fail to implement regional and global agreements related to reproductive health and rights. It is imperative that these instruments are implemented to ensure that reproductive rights are mainstreamed into the broader human rights agenda of countries. Countries that signed onto both the Abuja Declaration and the Maputo Protocol need to honour these commitments

Measuring Reproductive Risk in sub-Saharan Africa

Highest Risk Category

There are 11 countries in this category. All the countries have high maternal mortality ranging from 700 in Burkina Faso to 2100 in Sierra Leone. Less than half the women deliver without skilled care in almost all the countries. Two countries have skilled attendance at delivery of less than 20 percent. There is a high unmet need for Family Planning with 5 out of the 11 countries having unmet need for contraceptives of over 90 percent. Only one country has ANC coverage of over 50%. In 4 countries ANC coverage is less than 20 percent. The two countries with the lowest ANC coverage in this category also have the lowest skilled care at delivery and the lowest CPR.

Rank	Country	HIV Prevalence Among Adults 15-49	Adolescents Fertility	Female Secondary School Enrolment (Gross)	Female Illiteracy Rate	Ante Natal Care Coverage At Least 4 Visits
		(%)	Births per 1000 women aged 15-19 years		(%)	(%)
47	Chad	4.2	164	8	87	13
46	Democratic Republic of the Congo		222	16	46	
45	Mali	1.8	179	21	84	30
44	Angola	2.5	138	16	46	
43	Guinea	2	149	24	82	48
42	Niger	0.5	196	9	91	11
41	Burkina Faso	1.7	126	12	85	18
40	Nigeria	3.8	126	29	40	47
39	Central African Republic	8	115		66	
38	Sierra Leone	2	160	26	76	68
37	Ethiopia	2.4	94	24	77	10

	Contraceptive Prevalence Rate (ALL methods)	Births Attended by Skilled Attended Health Personnel	Grounds on Which Abortion is Permitted*	Maternal Mortality Rate (MMR)	Infant Mortality Rate (IMR)	Reproductive Risk Index (RRI)
	(%)	(%)		Maternal Deaths per 100000 Live births	infant deaths per 1000 live births 2005	
	3	15	i	1500	119	74.7
	21	61		1100	113	73.6
	8	41	i	970	128	72.6
	6	45		1400	131	68.0
	9	38	ii	910	102	66.8
	11	16	i	1800	109	65.5
	14	38	ii	700	104	63.4
	13	35	i	1100	109	63.1
	19	44	i	980	96	62.5
	5	42	iii	2100	160	60.8
	15	6	ii	720	86	60.7

Very High Risk Category

Most countries in SSA fall in this category. In the 21 countries in this category skilled care during pregnancy and childbirth is limited but there are variations with some countries. Maternal and infant mortality is very high. Unmet need for contraception is highest in the Western African countries. Very early marriage is common and adolescent fertility is generally high. Access to ANC is limited in many countries.

Rank	Country	HIV Prevalence Among Adults 15-49	Adolescent Fertility	Female Secondary School Enrolment (Gross)	Female Illiteracy Rate	Ante Natal Care Coverage At Least 4 Visits
		(%)	Births per 1000 women aged 15-19 years	(%)	(%)	(%)
36	Somalia	3	66			32
35	Mozambique	14.9	149	13	75	41
34	Côte d'Ivoire	4.7	107	18	61	35
33	Malawi	13.5	135	27	46	55
32	Guinea-Bissau	2.2	189	13	52	62
31	Liberia	2.1	219	27	54	84
30	Senegal	1.2	87	21	71	64
29	Sao Tome and Principe			33		
28	Togo	3.9	89	27	61	46
27	Uganda	6.6	152	16	41	40
26	Rwanda	3.2	40	13	40	10
25	United Republic of Tanzania	7.6	121	6	38	69
24	Madagascar	0.1	133	23	35	38
23	Burundi	2.4	55	12	48	79
22	Djibouti*	3.7	23	18		
21	Kenya	7.8	104	49	30	52
20	Cameroon	6.3	118	21	40	52
19	Equatorial Guinea*	4.1	123	23		37
18	Eritrea	1.5	72	23		49
17	Benin	1.6	120	23	77	96
16	Zambia	18	125	27	40	71

Contraceptive prevalence Rate (ALL methods)	Births Attended by Skilled Health Personnel	Grounds on Which Abortion is Permitted*	Maternal Mortality Rate (MMR)	Infant Mortality Rate (IMR)	Reproductive Risk Index (RRI)
(%)	(%)		Maternal Deaths per 100000 Live births	infant deaths per 1000 live births 2005	
15	25	i	1400	115	59.7
17	48	ii	520	95	59.4
13	63	i	810	116	58.7
42	56	i	1100	88	58.4
10	35	i	1100	112	57.4
6	51		1200	131	55.6
12	52	i	980	65	54.4
29	79	iii		77	55.3
17	49	i	510	88	54.4
24	39	i	550	76	54.3
17	39	ii	1300	112	54.0
26	46	i	950	71	52.6
27	51	i	510	65	52.1
20	25	ii	1100	99	51.1
18	61		650	84	49.3
39	42	i	560	64	49.0
26	62	ii	1000	87	47.9
	65		680	91	47.8
8	28	ii	450	55	47.3
17	89	ii	840	97	46.6
34	43	iv	830	92	46.2

Moderate Risk Category

HIV prevalence ranges from very low to very high. Performance on various indicators is fairly mixed. Contraceptive Prevalence is generally high with Zimbabwe, Mauritius and South Africa registering CPR of 60 or above. Ghana and Sudan are the only countries with CPR below 20% – 17% and 8% – respectively. ANC coverage is generally high with between 6 out of 10 to 9 out of 10 women making at least 4 visits. Adolescent fertility is high in the Congo and the Gambia. Most women deliver with skilled care except in Ghana where less than half the women deliver without skilled care.

Rank	Country	HIV Prevalence Among Adults 15-49	Adolescent Fertility	Female Secondary School Enrolment (Gross)	Female Illiteracy Rate	Ante Natal Care Coverage At least 4 Visits
		(%)	Births per 1000 women aged 15-19 years		(%)	(%) most recent year available
15	Congo	4.2	115	39	21	
14	Gambia	1	104	43		
13	Zimbabwe	18.7	59	14	14	64
12	Lesotho	27.1	74	42	10	88
11	Gabon	7.1	82	46	21	63
10	Ghana	2.3	55	46	50	69
9	Seychelles			93		
8	Comoros*	0.1	49	30		
7	Sudan	1.7	57	33	48	75
6	South Africa	21.8	61	98	19	72
5	Namibia	18.6	59	61	16	69
4	Swaziland	32.1	33	47	22	
3	Mauritius	1	41	88	19	
2	Botswana	28.9	52	78	18	97

Contraceptive Prevalence Rate	Births Attended by Skilled health Personnel	Grounds on which Abortion is Permitted*	Maternal Mortality Rate (MMR)	Infant Mortality Rate (IMR)	Reproductive Risk Index (RRI)
(%)	(%)most recent year available		Maternal Deaths per 100000 Live births	infant deaths per 1000 live births 2005	
44	83	i	740	70	43.5
18	55		690	74	42.1
60	80	ii	880	57	41.7
37	55	i	960	64	40.2
33	86	i	520	53	39.1
17	47	iii	560	56	38.7
		iii	810	11	36.4
26	62		400	48	35.8
8	57	i	450	64	34.7
60	92	v	400	45	33.6
44	76	iii	210	41	33.4
46	70	iii	390	70	32.3
76	99	i	15	14	29.8
44	99	iii	380	46	21.4

Low Risk Category

Only one country in sub Saharan Africa fall under this category. There is a high contraceptive prevalence and almost all births – 9 out of 10 - are delivered with skilled care. Maternal mortality is low. There is good political will towards improving health targets. Cape Verde is one of the few countries that have met the 15% Abuja target and is also expected to meet the Millennium Development Goals.

Rank	Country	HIV Prevalence Among Adults 15-49	Adolescent Fertility	Female Secondary School Enrolment (Gross)	Female Illiteracy Rate	Ante Natal Care Coverage at least 4 Visits
		(%)	Births per 1000 women aged 15-19 years		(%)	(%)
1	Cape Verde*		83	86		99

Countries With Missing Data

Rank	Country	No of Variables Missing
46	Democratic Republic of the Congo	3
39	Central African Republic	2
36	Somalia	2
29	Sao Tome and Principe	5
22	Djibouti*	3
19	Equatorial Guinea*	3
18	Eritrea	1
14	Gambia	3
9	Seychelles	6
8	Comoros*	3
4	Swaziland	1
3	Mauritius	1
1	Cape Verde*	1

Countries With More Than 3 Data Points Missing Should Be Ignored

Contraceptive Prevalence Rate (ALL methods)	Births Attended by Skilled Health Personnel	Grounds on which Abortion is Permitted*	Maternal Mortality Rate (MMR)	Infant Mortality rate (IMR)	Reproductive Risk Index (RRI)
(%)	(%)		Maternal Deaths per 100000 Live births	infant deaths per 1000 live births 2005	
61	89		210	24	11.0

* Grounds on which abortion is permitted, ranging from the most to the least restrictive:

- i To save the woman's life or prohibited altogether;
- ii To preserve physical health (also to save the woman's life);
- iii To preserve mental health (also to save the woman's life and physical health);
- iv Socioeconomic grounds (also to save the woman's life, physical health and mental health);
- v Without restriction as to reason.

Bibliography

Adrian-Paul, A. 2004. "HIV/AIDS." Inclusive Security, Sustainable Peace: A Toolkit for Advocacy and Action. Washington, D.C., and London

Central Bureau of Statistics, Kenya Service Provision Assessment 2005. Central Bureau of Statistics, Nairobi

Centre for the Study of Adolescence 2007. Adolescence in Kenya: The Facts, CSA Nairobi

Centre for Reproductive Rights. 2005. Governments in Action: Legal and Policy Developments Affecting Reproductive Rights. Briefing Paper. New York: Centre for Reproductive Rights.

De Bruyn, M., and S. Packer. 2004. Adolescents, Unwanted Pregnancy and Abortion: Policies, Counselling and Clinical Care. Chapel Hill, North Carolina: Ipas).

De Krug, E., et al. (eds.). 2002. World Report on Violence and Health. Geneva: WHO.

Geneva Centre for the Democratic Control of Armed Forces, Geneva, 2005

Department of Health, Medical Research Council, Orc Macro. 2007. South Africa. Demographic and Health Survey 2003. Pretoria: Department of Health key findings of the survey)

Gebreselassie, H. et al 2004. The magnitude of abortion complications in Kenya. BJOG: An International Journal of Obstetrics and Gynecology, 111, 1–7.

Govender V....et al 2008 'Progress towards the Abuja target for government spending on health care in East and Southern Africa,' EQUINET Discussion Paper Series 57. EQUINET: Harare.

Gray, Ron H, et al. 2005. "Increased risk of incident HIV during pregnancy I Rakai, Uganda: A Prospective Study" The Lancet 366:189-1188

Grimes A David et al (2006). Unsafe abortion: The preventable pandemic. The Lancet Sexual and Reproductive Health Series,

Guttmacher Institute.(2006. "Rates of Cesarean Delivery in Developing Countries Suggest Unequal Access." International Family Planning Perspectives 32(2): 105).

Joses Muthuri Kirigia and AlimataJ Diarra-Nama 2008. Can countries of the WHO African Region wean themselves off donor funding for health? Bulletin of the World Health Organisation, Volume 86 No. 11 November, 817-908

Lopez AD....et al,2006. "Global and regional burden of disease and risk factors, 2001: Systematic analysis of population health data." The Lancet 367: 1747-57.

UN Millennium Project 2007. Millennium Development Goals Mid-term Country Report. New York. 2007

Mitchell, E., et al. 2003. Teen Web Nairobi: Results of a web-based project to survey and educate students about health, Chapel Hill, NC: Ipas.

Njoh, A. 2006. Tradition, Culture and Development in Africa, p. 97. Hampshire: Burlington. Ashgate Publishing Company.

Population Action International. 2007. A Measure of Survival. Calculating Women's Sexual and Reproductive Risk. PAI Report Card 2007, Washington DC

PRB and African Population & Health Research Center (APHRC) 2008. Africa Population Data Sheet. Washington DC.

Ronsmans, Carine, and Wendy J Graham. 2006. "Maternal mortality: Who, when, where and why." The Lancet 368: 1189-1199.

UNFPA 2005 State of the World Population 2005: The promise of Equality, Gender Equity, Reproductive Health and the Millennium Development Goals, UNFPA, New York.

UNICEF 2007Progress for Children: A World Fit for Children Statistical Review, Number 6, UNICEF, New York, 2007, p. 44

UNICEF 2008 . Progress for Children: A report card on maternal mortality, Number 7, New York, September 2008

UNICEF 2009.The State of the World's Children 2009: Maternal and Newborn Health UNICEF, New York

UNAIDS 2005. AIDS Epidemic Update, 2005. Geneva

UN Millennium Project. 2005. Who's Got the Power: Transforming Health Systems for Women and Children. Task Force on Child Health and Maternal Health. London and Sterling, Virginia: Earthscan.

WHO. 2007. Adolescent pregnancy—Unmet needs and undone deeds: A review of the literature and programmes. Geneva: WHO.

Paxton A...et al.2006. Global Patterns in availability of emergency obstetrics care. International Journal of Gynecology and Obstetrics ; 93(3):300-07).

Ross, John and William Winfrey. 2002. "Unmet Need for Contraception in the Developing World and the Former Soviet Union: An Updated Estimate." International Family Planning Perspectives 28(3): 138-143.

Rustein SO and Shah IH. 2004. "Infecundity, Infertility, and Childlessness in developing Countries. DHS Comparative Reports , No.9 Calverton, MD ORC Macro and Geneva: WHO

Singh, S., et al. 2004. Adding it Up: The Benefits of Investing in Sexual and Reproductive Health Care. Washington, D.C., and New York: The Alan Guttmacher Institute and UNFPA

Vlassof M. et al 2004 "Assessing Costs and Benefits of sexual reproductive health interventions. Occassional Report Number 11. New York: Guttmacher Institute

WHO 2009: World Health Statistics 2009, Geneva

World Health Organization 2006. World Health Report 2006: Working together for health, WHO, Geneva

WHO. 2007.WHO Global database on births attended by skilled health personnel, Geneva, WHO).

World Health Organization. 2007.WHO Estimates of the incidences of unsafe abortion and associated mortality

World Health Organization 2007. Everybody business: strengthening health systems to improve health outcomes: WHO's framework for action. World health Organization

WHO, 2007.. Maternal Mortality and Morbidity: is pregnancy getting safer for Women? Reproductive health matters vol. 15: November 30 2007

World Health Organization, 2006 Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries, WHO, Geneva

WHO. 2004. Unsafe Abortion: Global and Regional Estimates of Unsafe Abortion and Associated Mortality in 2000, 4th Edition. Geneva: World Health Organization.



Centre for the Study of Adolescence

Mbaazi Avenue, Off Kingara Road, Lavington
P.O.Box 19329-00202, Nairobi, Kenya
Tel: +254-020-2398724
Tel/Fax: +254-020-2398723
Email: csa@csakenya.org
Website: www.csakenya.org



Population Action
INTERNATIONAL

1300 19th Street, NW Suite 200
Washington, DC 20036-1624 USA
Phone: +1 (202) 557-3400
Fax: +1 (202) 728-4177
www.populationaction.org
Email: pai@popact.org

ISBN: 9966-9845-3-4