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United Nations  
Economic Commission  
for Africa

# 5 years after Beijing:

What efforts in favour of African Women?



Assessing Women and Health

September 2001

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## Assessing Women and Health

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## Preface

Africa has made progress in the area of health since the Cairo International Conference on Population and Development (ICPD) and the Beijing Conference on Women. There is now greater awareness in the continent on the importance of women's health care issues and most African countries have reassessed and given higher priority to their health sector. Forty-four countries have included the sector in their national plans of action and many have made new institutional arrangements to intensify their implementation of the Dakar and Beijing Platforms for Action and the Cairo Programme of Action. One Central African country even organized a national health forum following the Beijing Conference.

However, these positive initiatives are taking place against the backdrop of the prevailing constraints to women's advancement, including their health care. These constraints are lack of human and natural resources, inadequate health policies, promotion of other major infrastructure to the detriment of health centres, the brain drain in the health sector, lack of maintenance personnel for health infrastructure, increasing poverty and decreasing external aid for health. What is more, the provision of community health services in several African countries has been left mainly to civil society organizations.

The fact that many countries have yet to address the issue of women's health is reflected in the continent's infant mortality rate which is the highest in the world, and continues to rise. The reproductive health of adolescents and the AIDS pandemic remain major causes for concern. Although most countries have prioritized health in general, women's health has not been given the required attention both in terms of advocacy programmes and in terms of resource allocation.

The issue of women and health is conceptually limited to maternal health, to the detriment of basic health care.

It is difficult to assess the actual progress made in the implementation of the Platforms' recommendations on women and health and in the involvement of women in health policies and strategies for two main reasons. The first is that only a few African countries have gender-specific policies relating to women's health. The second is that gender analysis is not applied in the sector owing to lack of training in this approach.

The African Centre for Women (ACW), entrusted with fostering the integration of gender analysis in the formulation and implementation of national development policies and strategies, expects the conclusions of this report to spur national, regional, subregional and international organizations to speed up implementation of the Dakar and Beijing Platforms for Action.

## 1. Introduction

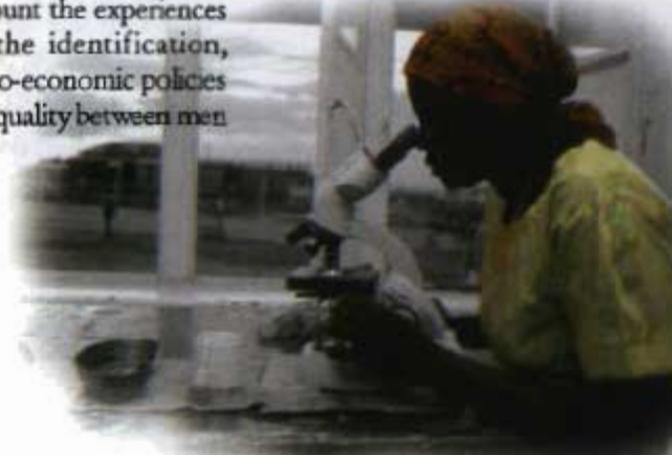
The objective of the Sixth African Regional Conference on Women, held in November 1999, in Addis Ababa, was to conduct a mid-decade review of the implementation of the Dakar and Beijing Platforms for Actions in line with the mandate of the Economic Commission for Africa (ECA). Thus, like the other United Nations Regional Commissions, ECA undertook the evaluation in preparation for the Beijing + 5 global review held in June 2000 in New York.

The present report therefore aims to evaluate the progress made by African countries in implementing the recommendations on women's health, family planning and development. It identifies the constraints to women's health priorities.

The report is substantially enriched by contributions from the workshop organized on the health theme during the Sixth African Regional Conference on Women.

That workshop was concerned about the increase in maternal mortality and about African countries' lack of political will to address the AIDS pandemic. It therefore stressed the need for sensitization campaigns against HIV/AIDS and other sexually transmitted diseases (STDs) and the need to give greater attention to the reproductive health of adolescents. It recommended that these issues should be made part of family planning bearing in mind the socio-economic conditions in African countries; that measures should be taken to improve community health which should be taken into account in allocating resources for community development. It also recommended that traditional medical practices should be involved more in national health systems which should avail more of the potentials of local methods of therapy.

Drawing on the Dakar and Beijing Platforms, African women requested that development programmes and, in particular, health policies and programmes for women, should be drawn up from a gender perspective. The importance of this approach, particularly gender analysis, lies in the fact that it fully takes into account the experiences and concerns of both men and women in the identification, implementation, follow-up and monitoring of socio-economic policies and programmes. Its final objective is to achieve equality between men and women.



Together with the gender approach, a multidisciplinary approach to women's health was recommended. It should involve training in the techniques of gender-disaggregated data collection and analysis at the national level in order to facilitate integration of women's needs and concerns in policies and programmes at that level.

## 2. Women's health: objectives and measures

The five critical areas of concern on women's health defined in the Dakar and Beijing Platforms are as follows:

- (a) To increase women's access to affordable quality health care, relevant information and appropriate related services throughout their lives;
- (b) To strengthen prevention programmes aimed at improving women's health;
- (c) To take initiatives, in favour of women, to combat sexually transmitted diseases, including HIV/AIDS, and address other health issues relating to sexuality and reproduction;
- (d) To promote research and disseminate information on women's health;
- (e) To allocate more resources to women's health care and provide follow-up and monitoring in this regard.

The Dakar and Beijing Platforms specifically recommended that more financial and other support should be given to preventive, biomedical, behavioural and epidemiological research on women's health problems, their causes and their socio-economic and political impact. Such support should cover studies on women's health care, on gender and age inequality and on chronic and non-transmittable illnesses, including cardio-vascular diseases, cancer, genital mutilation problems, HIV/AIDS and other STDs, population-related diseases and tropical diseases.

The Platforms also made recommendations on violence against women and on illnesses related to ageing.

The Beijing recommendations drew on those of the Cairo Conference on reproductive health and women's rights and the 1993 Human Rights Conference, but further stressed that women have the right to control their health and sexual life. Like the others, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) specified women's right to health care.

### 3. The African woman's health situation

Africa's strong representation at the Beijing Conference symbolized its concern for the situation of a continent plagued by civil wars, expensive structural reforms and marginalization resulting from globalization. The mid-decade review was expected to reflect these constraints.

The Dakar Conference pointed out that the health and nutritional status of women and girls in Africa was one of the worst in the world. This was due to the high rate of illiteracy among women; absolute poverty; weak participation of women in decision-making concerning their fertility; and non-use of the gender approach in identifying, formulating, planning and implementing development programmes.

In 1992, the maternal mortality rate in Africa was estimated at 540 for every 100,000 women as against 1 for every 100,000 in Northern Europe. The continent's infant mortality rate was also one of the highest in the world with 103 deaths for every 1000 live births. Abortion accounted for 30 per cent of the maternal mortality in some African countries. The region's high fertility rate was put at 6-7 children per woman. The average rate of use of contraceptives in the entire region was 1 per cent. Life expectancy was the lowest in the world - 49 years for men and 52 years for women. The pregnancy rate for young girls aged 15-19 years was 18 per cent as against 8 per cent in South America which ranked second.

The high maternal morbidity rate in Africa owed to inadequate access to health care, inadequate information and the prevalence of such chronic diseases as malaria and malnutrition. STDs and HIV/AIDS were the most serious threats to the health and lives of women. Female genital mutilation (FGM), widely practised in sub-Saharan Africa and Egypt, was identified as a traditional practice with devastating consequences for girls and women.

## 4. Institutions and follow-up mechanisms

### 4.1. Follow-up by the United Nations

The United Nations system-wide follow-up mechanism comprises the following bodies: The Commission on the Status of Women (CSW), the Committee on the Elimination of Discrimination against Women, the United Nations Development Fund for Women (UNIFEM), the International Research and Training Institute for the Advancement of Women (INSTRAW) and the Division for the Advancement of Women (DAW).

CSW, like the Committee on the Elimination of Discrimination against Women, meets once a year. During its 1998 session, CSW examined the issue of women's health exhaustively. An inter-agency task force was set up within the Administrative Committee on Coordination (ACC). Represented on the task force were the following United Nations agencies involved in the provision of social services: United Nations Population Fund (UNFPA) which was chairperson, International Labour Organization (ILO), Food and Agricultural Organization of the United Nations (FAO), World Trade Organization (WTO), United Nations Educational, Scientific and Cultural Organization (UNESCO), United Nations Industrial Development Organization (UNIDO), International Monetary Fund (IMF), the World Bank, United Nations Development Programme (UNDP), United Nations Children's Fund (UNICEF), World Food Programme (WFP), the Office of the United Nations High Commissioner for Refugees (UNHCR), United Nations Relief and Works Agency for Palestinian Refugees in the Near East (UNRWA), United Nations Centre for Human Settlements (UNCHS-HABITAT) and the Regional Commissions.

Health featured on the agenda of the ACC task force on basic social services for all. The task force provides country support to activities initiated to monitor implementation of the United Nations action programmes, particularly of the Cairo, Copenhagen and Beijing Conferences. It set up working groups particularly on primary health care, reproductive health and national capacity building to monitor maternal and infant mortality.

These working groups identified 15 general indicators for maternal and child health and drew up guidelines for dealing with specific health themes. They suggested essential actions to enable the network of resident coordinators to improve reproductive health. Also, WHO published a list of indicators for use at the local level and UNFPA selected a comprehensive range of programme indicators to be used primarily by national programme officers.

For its part, DAW organized jointly with UNFPA and WHO, and in consultation with the Commonwealth Secretariat, an expert group meeting on women and health, held in Tunis from 28 September to 2 October 1998.

The cross-cutting issues of traditional practices harmful to the health of women and girls were addressed under health, violence and the girl-child by CSW, WHO, UNICEF, UNFPA and the Committee on the Elimination of Discrimination against Women. These examined the relevant reports of the State parties in this regard.

#### 4.2. Follow-up at the regional level

The African Platform entrusted the coordination, monitoring and development of women's health care to the African Regional Coordinating Committee (ARCC) working in close cooperation with such intergovernmental organizations as the Preferential Trade Area for Eastern and Southern Africa (PTA), the Southern African Development Community (SADC), the Economic Community of West African States (ECOWAS), the joint OAU/ECA/ADB Secretariat, the relevant United Nations agencies such as UNIFEM, and in consultation with them as stipulated by the existing institutional arrangements. The Platform also recommended that these bodies should meet once a year and should submit a report to the ECA Conference of Ministers, the OAU Council of Ministers and the OUA Assembly of Heads of State and Government, every two years.

#### 4.3. At the national level

The Dakar and Beijing Platforms recommended that women's access to positions of responsibility should be monitored by the institutions established for that purpose.

As these institutions (ministries, directorates and affiliated non-governmental organizations (NGOs) acting as technical and advisory offices) may vary from country to country, monitoring of women's health at the country level was entrusted to the national preparatory committees of the Dakar and Beijing conferences. Moreover, several countries opted for inter-ministerial committees deciding on how their national plans should be implemented and on strategies for resource mobilization.

Although not many of these committees are seen to be active, except in Southern Africa and such countries as Senegal, Cameroon and Nigeria, the contents of national reports and the number of meetings held in countries show a post-Beijing period marked by greater awareness of the need to eliminate all forms of discrimination against women and to give greater attention to their needs and aspirations in programmes and projects.

## 5. Results and recommendations of the follow-up meetings and conferences

Since the Fourth World Conference on Women, the following meetings have reaffirmed the specific objectives and strategies contained in the Dakar and Beijing Platforms for Action:

- (a) The annual meetings of CSW;
- (b) The meetings of the Committee on the Elimination of Discrimination against Women;
- (c) The General Assemblies of WHO;
- (d) The Expert Group meeting on Integrating the Gender Approach into the Health Sector;
- (e) The International Conference on "African Women and Economic Development: Investing in our future" held to mark the fortieth Anniversary of ECA;

- (f) The subregional Follow-up meetings on the implementation of the Dakar and Beijing Platforms; and
- (g) The follow-up meeting on the Cairo Programme of Action, held five years after its adoption.

Generally, these various meetings, particularly the technical meetings organized by the relevant agencies concerned with health (WHO, the World Bank, UNICEF, UNDP, UNFPA, FAO, UNHCR, UNAIDS and WFP) and those organized by some donors (Germany, the Nordic countries, the Islamic Development Bank, ADB and IDB) have enabled the organizers to recall the strategic objectives stated in the Platform and to map out a systematic way of monitoring and coordinating the implementation of the Dakar and Beijing Platforms.

These meetings also recommended institutional, operational and strategic measures.

### 5.1. Institutional arrangements

These arrangements put emphasis on the role which each group of actors must play at each stage to maximize efforts at carrying out country activities.

Not only were Governments entrusted with leading the efforts by showing the highest level of political commitment, but were also given responsibility for guiding, coordinating, supervising and evaluating the activities.

The Beijing Platform for Action specifically identified the following players:

- (a) Governments in cooperation with non-governmental organizations, employers' associations, trade unions and international institutions. These are to secure women's increased access to affordable quality health care, information and appropriate related services throughout their lives;
- (b) Governments, in cooperation with non-governmental organizations, information agencies,

the private sector and the relevant international institutions, particularly the United Nations, which should intensify prevention programmes to improve women's health;

- (c) Governments, international organizations, especially the relevant United Nations bodies, bilateral and multilateral donors and NGOs, which should take measures to protect women against sexually-transmitted diseases, HIV/AIDS and other health problems concerning their sexuality and reproductive lives;
- (d) Governments and all administrative organs, in cooperation with NGOs particularly women and youth organizations, should mobilize more resources for women's health care and undertake review and appraisal of the situation.

Governments should show commitment and political will by establishing an appropriate legal framework to ensure the implementation and coordination of activities at the national level in partnership with civil society organizations. In this connection, Cameroon, Nigeria, Botswana and Zambia were requested to adopt appropriate legislation. Senegal, Rwanda and Uganda were requested to further define their democratic procedures.

Moreover, international institutions and regional and subregional organizations were requested to support initiatives taken with a view to a speedy attainment of the regional and global Platform objectives.

Finally, coordination of activities at every level was strongly recommended in order to avoid duplication of efforts and wastage of resources.

## 5.2. At the operational level

ACW has organized a series of post-Beijing subregional follow-up meetings:

- (a) To propose to member States how to draft a prototype action plan with targeted and measurable objectives, time frames, resource estimates and identified players;

- (b) To harmonize the presentation of action plans and evaluation reports in order to facilitate regional review and appraisal;
- (c) To recommended the specification of a time frame for achieving the strategic objectives, while stressing the need for coordinated action between Governments and NGOs on the one hand, and between NGOs and funding agencies on the other.

In that regard, ECA organized the Sixth African Regional Conference on Women in November 1999 to provide participants the opportunity to consult with one another and work together. The Conference requested the involvement of sector ministries in the implementation of the Platforms, especially to integrate the gender approach in their respective areas of responsibility, thus enabling them to cater for the needs and concerns of women. Such an involvement was all the more necessary as substantial resources were being allocated to these sectors where discriminatory practices continued to plague women's lives.

ECA has sent an Aide-Memoire to all African countries on the evaluation of national plans of action.

### 5.3. Strategic planning

The following two important lessons were drawn from the various national, subregional and regional meetings held after the Beijing conference:

- (a) Women's advancement has become a development issue and as such requires the mobilization of men and women over a long haul if sustainable results are to be achieved;
- (b) Women need to be educated about their status, rights and responsibilities in order to create the groundswell of empowerment which alone can change attitudes and behaviour.

In order to make the recommendations on health more explicit the post-Beijing meetings suggested that:

- (a) Women programme and project directors working in areas other than the advancement of women or social protection at every level should be involved in the formulation of strategies and action plans in their areas of responsibility;
- (b) Information, education and communication (IEC) programmes should be prepared to educate local communities about issues of public hygiene, family affairs, nutrition, reproductive health and a secure environment;
- (c) Regular meetings should be organized bringing together the various sectors of social development;
- (d) National meetings should be convened to popularize health issues;
- (e) Dialogue between the Government, NGOs and other partners should be intensified;
- (f) An on-going dialogue should be established among people from all segments of society on issues relating to gender disparities.

## 6. Resource allocation by the United Nations, Governments and various institutions

According to the 1998 World Health Report, health investment in Africa has practically stopped. The social sectors, including health, have been severely affected by worsening budget deficits. The share of the gross national product (GNP) allocated to health has been diminishing. Furthermore, the reported lack of reliable and verifiable data on health care financing and private sector health expenditure, in developing countries, does not help matters.

Additional resources for health development are provided by NGOs and bilateral and international donors to compensate for the dwindling public sector health resources and the inadequate private sector health

input, the economic recession and cutbacks in official development assistance. Consequently, some essential health care development activities, including those conducted to combat maternal and infant mortality and to promote vaccination campaigns, have become dependent on external funding.

In Africa, coordinating such aid is also a problem. Few are the countries in which the present state of financial resource allocation between health promotion and health care services are satisfactory.

As to the issue of human resources, the poor performance of health institutions and the inefficiency of health officials remain a cause for concern. The brain drain continues to the extent that the public sector has become less able to respond to present needs. The unemployment of young graduates is particularly felt in the health sector (World Health Report, 1998).

The good news, however, is that such African countries as Ghana and Cameroon have produced statistics that, although not exhaustive, show Governments' will to lead the efforts to improve women's health.

Virtually all African countries are aware of the need to rectify the situation as a matter of urgency. But this would entail decentralizing health services which, itself, would require that local governments have adequate administrative and management capacity and a machinery for guaranteeing transparency and popular participation. One disadvantage, however, is that health officials are not sufficiently attracted to primary health care owing to the lack of incentives and the possibility of being posted to remote areas.

Discouraging also is the fact that many African countries have placed, at the centre of their health policies, infrastructural development in which hospitals absorb the bulk of the health budget, often at the expense of health centres. Health facilities and equipment are generally poorly maintained for lack of financial resources and for cultural reasons. In many cases, the existing equipment could only be maintained with external assistance.

In order to address this situation, African countries are working hard to improve the quality of their health care by working out and replicating best practices and making optimum use of the existing resources.

Community participation has become necessary to revitalize the 'health for all' strategy. It involves cost-sharing for the purchase of medical

equipment and the meeting of building maintenance and other recurrent costs aimed at making medicines available and affordable.

## 7. Progress achieved

Having acknowledged that women have the right to enjoy the highest attainable standard of physical and mental health and that the exercise of this right is of crucial importance for their life and well-being as well as for their participation in all public and private activities, African Governments made the commitment, during the regional meetings of WHO, OAU and subregional organizations, to take appropriate measures to implement the above-mentioned recommendations.

Such measures were to enable them to address the needs of men and women of all age groups and to secure women's participation in the design, planning, decision-making, management, implementation, organization and evaluation of health services.

### 7.1. Identifying health as a priority

Even with the financial and other constraints, including high illiteracy rate, during the past five years, reflecting the widespread poverty of individuals and Governments alike, 34 African countries have prioritized health in their action plans. Several have reviewed or reformulated their health policies, programmes and activities to meet the objectives of the Regional and Global Platforms, as shown in box 1 and other boxes.

#### Box 1 Prioritizing health in national plans of action

The health action plans of African countries pursuant to the Dakar and Beijing Platforms are:

- (a) To reduce maternal and infant mortality;
- (b) To improve health care services (Morocco, Guinea, Uganda, Madagascar, the Gambia, Ghana, Botswana, Rwanda, Mali);
- (c) To reduce HIV/AIDS and other STDs (Botswana, Nigeria, Egypt, Côte d'Ivoire, Burkina Faso, Ethiopia, Uganda);
- (d) To improve family planning services and access to these services (Egypt, Ghana, SADC member States, Tunisia, Nigeria, Senegal, Cameroon, Kenya, Lesotho);
- (e) To expand social security services (Senegal, Tunisia, Algeria).

In spite of the commitments made by Governments at the Conferences, including the sessions of CSW and the Committee on the Elimination of All Forms of Discrimination against Women and WHO meetings, it should be emphasized that women's access to health services remains very limited in most African countries. Women's health conditions have even deteriorated in some countries. Consequently, Governments and NGOs need to take urgent measures to correct this situation by integrating health as a cross-cutting issue in sectoral programmes.

On a positive note, the mid-decade review of the implementation of the recommendations of the Cairo conference and information obtained on some countries' experiences indicate that some progress has been made. With regard to reproductive health and reproductive rights, 39 countries have taken measures to improve the quality of health care by organizing training programmes for health personnel, including traditional birth attendants. Among these countries are Nigeria, Guinea, Rwanda, Uganda, Zambia, Côte d'Ivoire, Ethiopia, Senegal and Cameroon.

Other countries such as Botswana, Algeria, the Niger, Burkina Faso and Malawi have improved and expanded the coverage of their health infrastructure. Still others like Uganda, Botswana, Morocco, Tunisia, Rwanda, Seychelles and Madagascar have revised their health protocols and procedures. Finally, almost all African countries have monitored and evaluated their health services. The use of female contraceptives is being tested following the success of the pilot project undertaken in several countries, including Botswana, Uganda, Kenya and Nigeria.

It is important to mention that some countries among which Burkina Faso, Côte d'Ivoire, Zambia and Madagascar have prioritized reproductive health issues concerning adolescents, with 34 countries, including Ghana, Benin, Cameroon, the Republic of the Congo, Seychelles, Uganda and South Africa, adopting national policies on youths and taking relevant measures. Some East African and Southern African countries have launched projects involving youths in advocacy and IEC awareness campaigns meant for them.

In 26 West African, East African and Southern African countries, civil society organizations have been playing an important role in providing reproductive health services to communities in general and to adolescents in particular.

Also, such countries as Botswana, Uganda, Kenya and Ghana have initiated new programmes or expanded existing ones aimed at increasing the responsibility of men in reproductive health through sensitization campaigns or targeted activities.

Some countries have embarked on socio-cultural surveys aimed at identifying and meeting men's needs with regard to reproduction. Positive developments like the establishment of associations to combat violence against women in such countries as Senegal, Mali, Nigeria, Malawi, Lesotho, Ethiopia and Kenya deserve mention.

On the negative side, initiatives to promote gender equality are still inadequate, and Africa is the only continent where maternal mortality continues to rise even though the causes are known. The authorities should strengthen their political will, establish emergency obstetric services and adopt new strategies to reduce maternal mortality. Although most countries have prioritized health in general, women's health has not been given the required attention both in terms of advocacy programmes and in terms of resource allocation.

Furthermore, the concept of promoting health care for women throughout their lives has neither fully materialized nor been implemented. This explains the inadequate attention given to the health of elderly women and the nutritional status of young girls and breast-feeding mothers.

Women's health is sometimes confused with maternal health which tends to exclude women above the child-bearing age. Women's sexuality as a concept and as a legitimate concern remains ignored.

Although several activities have been launched to combat violence against women, women are still subject to ill-treatment and danger. The initiatives taken should be institutionalized as health programmes. It is disturbing to note that, despite being a major area of concern, combating female genital mutilation and other harmful practices is still largely left to the initiatives and activities of NGOs, even after such practices have been proscribed by Governments.

Another area of concern is women and tobacco-related diseases in Africa. With the increasing restriction on tobacco smoking in foreign countries, the industry is targeting women and young people in Africa.

Finally, the HIV/AIDS pandemic has been characterized a most devastating health concern for African women in particular. Not only are women vulnerable to this disease but they are also the main providers of sustained care to AIDS victims, families and communities.

## 7.2 Examples of progress achieved

As the participants at the Sixth African Regional Conference on women came from various backgrounds - Governments, non-governmental organizations, youth organizations, the private sector and parliaments - the conference provided an opportunity for exchange of experiences gained over the last five years in the implementation of the Beijing Platform. Given the multiplicity and diversity of the objectives and strategies proposed by the Platform and the variety of environments (some of which unstable) in which they are implemented, examining a few selected case studies of the implementation would give lessons which could be adapted to other similar conditions.

### 7.2.1. Algeria

With a population of 29,472,000 inhabitants, 57 per cent of which live in urban areas, a literacy rate of 61.6 per cent and a fertility rate of 3.8 per cent (World Health Report, 1998), Algeria is one of the few African countries with a social security system. Its health insurance, for example, covers about 80 per cent of the population.

However, maternal mortality remains a major cause for concern in Algeria. Hospital statistics for 1996 show a rate of 176 deaths per 100,000 pregnancies. In April 1998, abortion was authorized for women victims of sexual assault and terrorist acts in order to secure their physical and mental health. Abortion used to be allowed only in life-threatening cases. National solidarity has been demonstrated in the free distribution of 73 drugs used in the treatment of eight chronic diseases.

All workers, irrespective of sector, and their dependants (80 per cent of the people) are covered by social security. The five types of coverage are: health and maternity insurance; accident and death insurance; family allowances; occupational accident and health insurance; and early retirement and unemployment insurance.



**Box 2**  
**Algeria aims at providing social security for the entire population**

Algeria is one of the five African countries that have met the three targets of the "health for all in 2000" policy, alongside South Africa, Cape Verde, Tunisia and Mauritius. Gender unbiased health services are available to 98 per cent of the population. Infant mortality is 58 per cent for boys and 54.8 per cent for girls. Diagnosis and treatment of STD/AIDS have been made part of reproductive health care. A unit for induced child birth has been established for the treatment of infertility and the diagnosis of genital cancers. Disabled women, both employed and unemployed, are given material and financial support which includes allowances, free or subsidized transportation and social security benefits. As for the health care personnel, 53 per cent of the posts are held by women and women are increasingly moving up into management positions.

### 7.2.2 Cameroon

This Central Africa country is classified as a middle-income country. It has a population of 13,937,000 inhabitants and a literacy rate estimated at 63.4 per cent in 1995. Cameroon has embarked on projects in the areas of education, responsible parenthood, education for life and love, nutrition, eradication of Guinea worm and diagnosis of breast cancer.

**Box 3**  
**Progress made by Cameroon in maternal and child health**

In fulfillment of the commitments made by Cameroon in Beijing, it has promulgated a law on the protection of women and children and set up mother and child health care and family planning programmes. It has also embarked on programmes on breast-feeding mothers, iodine deficiency disorders, reproductive health and AIDS.

These measures have helped to reduce the maternal mortality rate from 125 per cent to 90 per cent during the period 1990-1997, and have led to the establishment of a fertility induction unit in the Yaounde specialist hospital. In March 1997, a national forum was held on health. The operating budget of the Ministry of Health was considerably increased, iodine was introduced in kitchen salt enabling 86 per cent of households to now consume iodized salt. The number of suckling children has increased. Many more women have opted for the medical profession with women now accounting for 46.15 per cent of the pharmacists, 47.93 per cent of the nurses, 28.13 per cent of the para-medical technicians and 31.64 per cent of the dental surgeons.

### 7.2.3. Botswana

Botswana is considered one of the countries most affected by HIV/AIDS. According to WHO, the prevalence rate in 1994 was the highest in the world. This rate continued to rise with the disease affecting 31.7 per cent of the sexually active people in 1996.

Recent studies have shown that life expectancy dropped from 67 years in 1996 to 52 years in 1998 and may further drop to 33 years if the current trend is not checked. Consequently, a medium-term plan to combat HIV/AIDS has been extended to cover the period 1997-2003. With a greater incidence of the disease reported among young people in the 15-25 years age range, considerable sensitization efforts have been targeted at adolescents to educate them on the harmful consequences of unprotected sexual relations. Twenty per cent of pregnant women in this country fall within this age category.

A sample survey conducted on family health in 1996 showed a steady decline in the fertility rate, from 6.5 per cent in 1984 to 5 per cent in 1988 and then 4.2 per cent in 1996.

The use of contraception by women of child-bearing age rose from 32 per cent in 1988 to 42 per cent in 1996. The oral contraceptive is the most widespread form used (17.7 per cent in 1996) followed by female sterilization (11 per cent) and condoms (5.7 per cent).

Infant mortality steadily declined from 91 per cent of live births in 1971 to 71 per cent in 1981 and 41 per cent in 1995. However, the incidence of HIV/AIDS has made UNDP to forecast an alarming infant mortality rate of 148 per cent by 2010. With maternal mortality estimated at 200-300 per 100,000 live births, the Government decided to establish a project entitled "Safe Motherhood" to reduce the level to 50 per cent by the year 2000. The project's focus was on training for midwives, doctors and nurses.

With regard to infrastructure, Botswana has two government specialist hospitals with 374 and 560 beds, respectively; a private specialist hospital; a government mental hospital with 170 beds; six district hospitals; three hospitals in the mining areas; fourteen primary health care centres; two hospitals under construction; three hospitals run by missionaries; 220 clinics, 80 of which have maternity units; 330 health posts; and 740 mobile clinics. Health accounts for 12 per cent of the country's budget.

The reforms undertaken to improve the quality of health services include:

- (a) Introduction of quality total management methods with the participation of all stakeholders and beneficiaries;
- (b) Establishment of a performance management team responsible for increasing the productivity of the public health services and the establishment of a performance management system;
- (c) Improvement of services by adopting a quality service approach; and
- (e) Marketing of drugs. The Government of Botswana markets all drugs meant for health care and family planning.

## 8. Major constraints

The major constraints to the implementation of the Dakar and Beijing Platforms are:

- (a) Lack of trained personnel particularly in health care services in rural areas;
- (b) The brain drain to developed countries which offer a better professional environment and higher salaries;
- (c) Prioritizing curative medicine over preventive medicine;
- (d) Inadequate cooperation between the Government, NGOs, other civil society organizations and the private sector;
- (e) Non-implementation of WHO recommendations urging member States to allocate 10 per cent of their budget to health;
- (f) Restrictions which affect the use of contraceptives in several countries;
- (g) Wars and armed conflicts which destroy health systems and infrastructure;

- (h) Lack of the political will to support reproductive health services for adolescents;
- (i) Lack of reliable data on the most important aspects of women's health, particularly maternal morbidity and mortality; and lack of confidence in the conclusions of programme evaluations, making the publication of success stories difficult;
- (j) Non-existence of insurance systems, particularly for women in the informal sector, and high cost of drugs;
- (k) Non-inclusion of the subject of sterility in gender issues;
- (l) Non-inclusion of the problems of disabled women, like the blind, the deaf and the dumb, in health programmes, resulting in double discrimination against these women;
- (m) Trade globalization, privatization of health system and the external debt burden which have considerably reduced resources needed by women for access to health care.

## 9. Conclusions

The evaluation of the implementation of the Dakar and Beijing Platforms reaffirmed the need:

- (a) To focus health and population programmes on the needs of women and men irrespective of age; and
- (b) To ensure that these programmes facilitate women's equal participation with men in health care management, planning, monitoring and evaluation.

Governments, NGOs, the United Nations and other development aid organizations should take concrete measures to involve women at all levels of population and health matters which should be made to feature prominently in global human development strategies - and from the perspective of gender equality

ICPD recognized, in particular, every individual's right to optimum physical and mental health. Appropriate measures should therefore be taken to provide free access to health care, including reproductive health involving family planning and the sexual health of men and women.

Population programmes should be geared to promoting gender equality and equity, improving women's quality of life, granting them control over their sexuality, helping them to plan their fertility and enabling them to participate fully at all levels of implementation of population and development programmes.

Meeting these needs which will improve the lives of present and future generations requires designing population and family planning policies, programmes and strategies based on integrating gender equality in health care and reproductive health. This recommendation should also be respected at all stages of resource allocation, management and evaluation.

This measure which is central to development planning will promote social justice, poverty reduction and sustainable economic growth. Women are often among the poorest of the poor in spite of being vital actors in the development process. Hence the need to eliminate all forms of discrimination against them as a way of reducing poverty and speeding up sustainable human development.

Research on medical practices and traditional pharmacopoeia should be developed and the results disseminated for use in health programmes.

The health of women being a crucial issue, society as a whole should be mobilized for the reduction of maternal mortality which is now a major concern in Africa. Also vital is improving antenatal and post-natal consultation services as well as the nutritional status of adolescents, pregnant women and lactating mothers.

With regard to HIV/AIDS, Africa's Heads of State and Government need to implement the HIV/AIDS Declaration, adopted in July 1992, in which they decided:

- (a) To sensitize 95 per cent of the adults and young people on HIV/AIDS and its transmission, to ensure personal protection and the protection of others; and to ensure that each ministry draws up an anti-AIDS plan;

- (b) To formulate a regional AIDS plan for Africa;
- (c) To sensitize women to their right to refuse sexual relations where there are no necessary precautions; and
- (d) To encourage, within families and partners, dialogue to promote protection against HIV/AIDS and to provide support to members of the family suffering from AIDS.

Significant is the fact that Africa still has much to do in fulfilling its health commitments owing to the major confusion still plaguing the sector and the inadequacy of skills in the methods of integrating the gender approach in the formulation of policies and programmes.

Given the dwindling and paucity of material and financial resources in the continent, concepts should be clarified to identify the real problems and pinpoint efficient and long-lasting solutions.

Prejudices in health practice is an area still crying for research. The bulk of research resources are allocated to biomedical, clinical and epidemiological investigations which are, themselves, still stereotyped to the strict biomedical traditions which assume that, apart from the differences in their reproductive systems, men and women are similar.

Improving health indicators in Africa demands increasing women's participation in health research, collecting gender specific information on women's health, compiling gender-disaggregated data and applying other social science research methodologies in health research.

Intersectoral cooperation involving education, agriculture, industry, transport, finance, planning, the environment and social affairs is needed for a systematic implementation of the health recommendations made by the Beijing Platform, ICPD, CEDAW and other international conferences.

South-South cooperation is needed, including in the sharing of experiences on how to bring about change in the situation of women's health. Indeed, sustainable progress in women's health requires the political will of countries to implement coherent and realistic action plans.

True, African countries have made remarkable progress in women's health, but much remains to be done to efficiently implement the Beijing Platform. In the first place, the hidden challenges must be identified and the disparities between policies, programmes, resources and institutional arrangements closed. Secondly, non-discriminatory policies and practices should be emphasized and multi-sectoral programmes developed in favour of women's health, rights, equality with men and full participation in the formulation of community health care strategies.

Five years on, the African continent needs to design specific strategies for meeting the Beijing recommendations. Such strategies are all the more vital as the continent's maternal mortality rate and HIV/AIDS-related deaths continue to rise. This scourge, if unchecked, will only slow down Africa's progress. Consequently, all serious threats to women's health should be high on Africa's development agenda.

## 10. Recommendations

In view of the foregoing, the mid-decade review made the following recommendations:

### 10.1. HIV/AIDS

1. Adopting non-discriminatory policies against HIV-infected persons.
2. Providing support and medical assistance.
3. Adopting a multi-sectoral approach in designing anti-AIDS programmes and providing resources for the programmes.

### 10.2. Reproductive health

1. Educating men more on reproductive health and family planning.
2. Including sexual education, family planning, STDs and HIV/AIDS in awareness campaigns for both rural and urban populations.

3. Establishing programmes for groups with special needs, such as disabled persons, refugees and the elderly, and providing support to them.

### 10.3. Maternal mortality

Drawing up an African strategy specifically aimed at reducing the increasing rate of maternal mortality, and setting up regional, subregional and national mechanisms for comparing the number of deaths arising from maternal mortality and those from other causes.

### 10.4. Other recommendations

1. Adopting a comprehensive and integrated approach to health issues.
2. Standardizing methods of collecting and disseminating women-only data.
3. Adopting policies to protect individuals from the harmful effects of tobacco.
4. Increasing the availability and coverage of social security programmes, particularly through health insurance.
5. Putting an end to traditional practices harmful to women and girls.
6. Encouraging cooperation among NGOs, Governments and international organizations.
7. Promulgating laws against domestic violence.
8. Strengthening the commitment of Governments to implement the objectives of the Dakar Platform on health, increasing resource availability to stem the brain drain among senior professionals and expanding current programmes.

9. Establishing a mechanism for reducing the external debt of African countries in order to increase resource allocation to basic health care; and reducing the effect of trade globalization on the economies of African countries.
10. Requesting Governments to ratify the international conventions on health, seeing to it that they respect their health commitments, and taking measures to make the conventions on women reference points.
11. Increasing resource allocation to field activities and ensuring the coordination and evaluation of such activities and the financing of meetings.
12. Promoting the involvement of opinion leaders, elected officials and religious leaders in the care of HIV/AIDS victims and in prevention programmes.
13. Increasing the involvement of NGOs and other grassroots organizations that have proven themselves in the implementation of health programmes.