



## 5. Health

“Women’s right to the enjoyment of the highest standard of health must be secured throughout the whole life cycle in equality with men. Women are affected by many of the same health conditions as men, but women experience them differently. The prevalence among women of poverty and economic dependence, their experience of violence, negative attitudes towards women and girls, racial and other forms of discrimination, the limited power many women have over their sexual and reproductive lives and lack of influence in decision-making are social realities which have an adverse impact on their health. ... The trend [for adolescent girls] towards early sexual experience, combined with a lack of information and services, increases the risk of unwanted and too early pregnancy, HIV infection and other sexually transmitted diseases, as well as unsafe abortions.”<sup>1</sup> [*Beijing Platform for Action*]

Access to quality health care is not only a human right. It is also important to enable participation in the economic, social and political life of the community by keeping people productive, preventing illnesses and saving lives. Given that women and girls often bear most of the burden of unpaid work including caring for sick members of the family, this works both directly by affecting the quality of life of individuals suffering from mortality and morbidity, and indirectly by affecting those who care for them when they are sick.

The Health component of the AGDI is part of the social block of both the GSI and the AWPS. It includes issues related to child and maternal health, access to family planning services, HIV, and unsafe abortions. The Health component consists of five indicators in the GSI; three on child health – under-five stunting, underweight and mortality, and two on HIV - prevalence rate for 15-24 year olds and access to antiretroviral therapy. The issues evaluated in the AWPS relate to 4 key areas of sexual and reproductive health of the Programme of Action of United Nations International Conference on Population and Development (ICPD) adopted in Cairo in 1994.

The Programme of Action of the ICPD recommended universal access to a full range of reproductive health-care services, including family planning by 2015<sup>2</sup>. The main objectives were to: provide affordable, acceptable and accessible family planning services to allow couples to choose the number, spacing and timing of the birth of their children, prevent unwanted pregnancies, reduce adolescent pregnancies and the incidence of high-risk pregnancies and reduce unsafe abortion<sup>3</sup>; prevent, reduce the incidence of, and provide treatment for, sexually transmitted diseases, including HIV/ AIDS<sup>4</sup>; and achieve a rapid and substantial reduction in maternal morbidity and mortality<sup>5</sup>. In the global review and appraisal of the implementation of the Programme in 1999 member States recommended key actions to speed up implementation. The key actions and targets for family planning, maternal mortality and HIV/AIDS are presented in Box 1.

#### **BOX 1 SELECTED KEY ACTIONS FOR THE IMPLEMENTATION OF THE PROGRAMME OF ACTION OF THE ICPD**

***Family planning services (paragraph 58):*** “Where there is a gap between contraceptive use and the proportion of individuals expressing a desire to space or limit their families, countries should attempt to close this gap by at least 50 per cent by 2005, 75 per cent by 2010 and 100 per cent by 2050.”

***Unsafe abortions (paragraph 63):*** “Governments should take appropriate steps to help women avoid abortion, which in no case should be promoted as a method of family planning, and in all cases provide for the humane treatment and counselling of women who have had recourse to abortion. ... [I]n circumstances where abortion is not against the law, health systems should train and equip health-service providers and should take other measures to ensure that such abortion is safe and accessible.

<sup>1</sup> United Nations (1995: paragraphs 92-93).

<sup>2</sup> United Nations (1996: paragraph 7.6).

<sup>3</sup> *Ibid.* at paragraphs 7.14 and 7.44.

<sup>4</sup> *Ibid.* at paragraph 7.29.

<sup>5</sup> *Ibid.* at paragraph 8.20.

**Maternal mortality and morbidity (paragraph 64):** “By 2005, where the maternal mortality rate is very high, at least 40 per cent of all births should be assisted by skilled attendants; by 2010 this figure should be at least 50 per cent and by 2015, at least 60 per cent. “

**HIV/AIDS (paragraph 70):** “Governments should use, as a benchmark indicator, HIV infection rates in persons 15 to 24 years of age.”

**Adolescents (paragraph 73(e):** “[E]nsure that adolescents, both in and out of school, receive the necessary information, including information on prevention, education, counselling and health services to enable them to make responsible and informed choices and decisions regarding their sexual and reproductive health needs, in order to, inter alia, reduce the number of adolescent pregnancies.”

**Source:** United Nations (1999).

The Millennium Declaration of 2000 included 4 Millennium Development Goals (MDGs) related to gender and health to be achieved by 2015. The aim of MDG1 was to halve the proportion of individuals suffering from hunger. MDG4 and MDG5 called for reductions by two thirds of under-five mortality and maternal mortality ratio respectively. MDG6 aimed to halt and begun to reverse the spread of HIV/AIDS, and achieve universal access to treatment for HIV/AIDS.

**Table 1: Gender-related health targets in Sustainable Development Goals and Agenda 2063**

Priority area	SDG target for 2030	Agenda 2063 target for 2023
<b>Malnutrition</b>	End all forms of malnutrition, including achieving by 2025 the internationally agreed targets on stunting and wasting in children under five years of age <sup>6</sup> , and address the nutritional needs of adolescent girls, pregnant and lactating women, and older persons (Target 2.2)	Reduce stunting in children to 10 percent and underweight to 5 percent (Goals 1, 3 and 5)
<b>Maternal mortality</b>	Reduce the global maternal mortality ratio to less than 70/100,000 live births and no country should have a maternal mortality ratio greater than 140/100 000 live births (Target 3.1)	Reduce 2013 maternal, neonatal and child mortality rates by at least 50 percent (Goal 3)
<b>Infant and child mortality</b>	End preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-five mortality to at least as low as 25 per 1,000 live births (Target 3.2)	Reduce 2013 maternal, neonatal and child mortality rates by at least 50 percent (Goal 3)
<b>HIV/AIDS</b>	End the epidemics of AIDS (Target 3.3)	Access to antiretroviral drugs is 100 percent (Goal 3)
<b>Sexual and reproductive health</b>	Ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes (Targets 3.7 and 5.6)	Increase 2013 levels of access to sexual and reproductive health services to women by at least 30 percent (Goal 2)
<b>Universal health coverage</b>	Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all (Target 3.8)	Increase 2013 levels of access to quality basic health care and services by at least 40 percent (Goal 3)

Building on the Programme of Action of the ICPD and the MDGs, Sustainable Development Goals 2, 3 and 5 sets a number of targets related to childhood malnutrition, sexual and reproductive health, maternal, newborn and child health, and HIV/AIDS to be met by 2030. The African Union’s Agenda 2063 set a number of related targets to be achieved by 2023. The targets for the SDGs and for the first 10 years of Agenda 2063 in priority areas in health are summarized in Table 1.

<sup>6</sup> World Health Assembly Resolution 65.6 (WHO, 2014a): Targets adopted by the World Health Organization in 2012: a 40 percent reduction in the number of children who are stunted; and reduce and maintain childhood wasting to less than 5 percent.

## Child health

State parties “shall take appropriate measures: to diminish infant and child mortality; to ensure the provision of necessary medical assistance and health care to all children ...; to combat disease and malnutrition ...; to ensure appropriate pre-natal and post-natal health care for mothers; ... to develop preventive health care, guidance for parents and family planning education and services”<sup>7</sup>. [*Convention on the Rights of the Child*]

The Child Health sub-component in the Gender Status Index consists of three indicators. These are the prevalence rates of under-five stunting, under-five underweight, and under-five mortality.

### Childhood malnutrition

Malnutrition impact negatively on children’s well-being and reflect social inequalities. Two of the main indicators of childhood malnutrition are stunting and underweight (see Box 2). In 2016, an estimated 155 million children under the age of 5 were stunted worldwide of whom 38 percent lived in Africa<sup>8</sup>. Although the proportion dropped from 38 percent in 2000 to 31 percent in 2016, the number of stunted African children under 5 years rose by 17 percent over that period to reach 59 million in 2016. An estimated 19 percent of children under 5 in sub-Saharan Africa were underweight in the period from 2000 to 2015<sup>9</sup>.

#### BOX 2 STUNTING AND UNDERWEIGHT: DEFINITIONS, CAUSES, CONSEQUENCES AND INTERVENTIONS

**Definitions.** Childhood stunting refers to being too short for one’s age. Underweight refers to a child who is too thin for his or her age. Stunting (underweight) is defined as a height (weight) that is more than 2 standard deviations below the median height-for-age (weight-for-age) of the WHO Child Growth Standards. A child who is below 2 standard deviations from the reference median for weight-for-height is considered wasted. Children can be underweight for their age because they are stunted, wasted, or both.

**Causes.** The main factors contributing to stunted growth and development are poor maternal health and nutrition, inadequate child feeding practices and infection in the first 1, 000 days of the child’s life. More specifically the main risk factors are: (a) poor maternal health and nutrition status before, during and after pregnancy; (b) short birth spacing; (c) adolescent pregnancy; (d) non-exclusive breastfeeding; (e) severe infectious diseases; and (f) infections from exposure to contaminated environments and poor hygiene. Household and socio-economic factors including household poverty and quality of care exacerbate these factors. The causes of underweight are similar to those for stunting.

**Consequences.** Both stunting and underweight have long-term effects on individuals and societies. These include: diminished cognitive and physical development, reduced educational outcomes, reduced productive capacity and poor health, and an increased risk of diseases in adulthood.

**Interventions.** The following interventions are recommended to reduce undernutrition and its effects.

- Improve identification, measurement of and understanding of undernutrition.
- Improve maternal nutrition, including nutrient supplementations, and health, starting with adolescent girls.
- Promotion of early and exclusive breastfeeding for 6 months and continued breastfeeding for up to 2 years of life.
- Nutritious and safe foods in early childhood.
- Improve water, sanitation and hygiene to protect children from infections and diseases.
- Manage acute malnutrition.
- Implement early childhood development programmes to limit the negative education and cognitive consequences of undernutrition.

<sup>7</sup> United Nations (1989: Article 24).

<sup>8</sup> UNICEF, WHO and World Bank Group (2017).

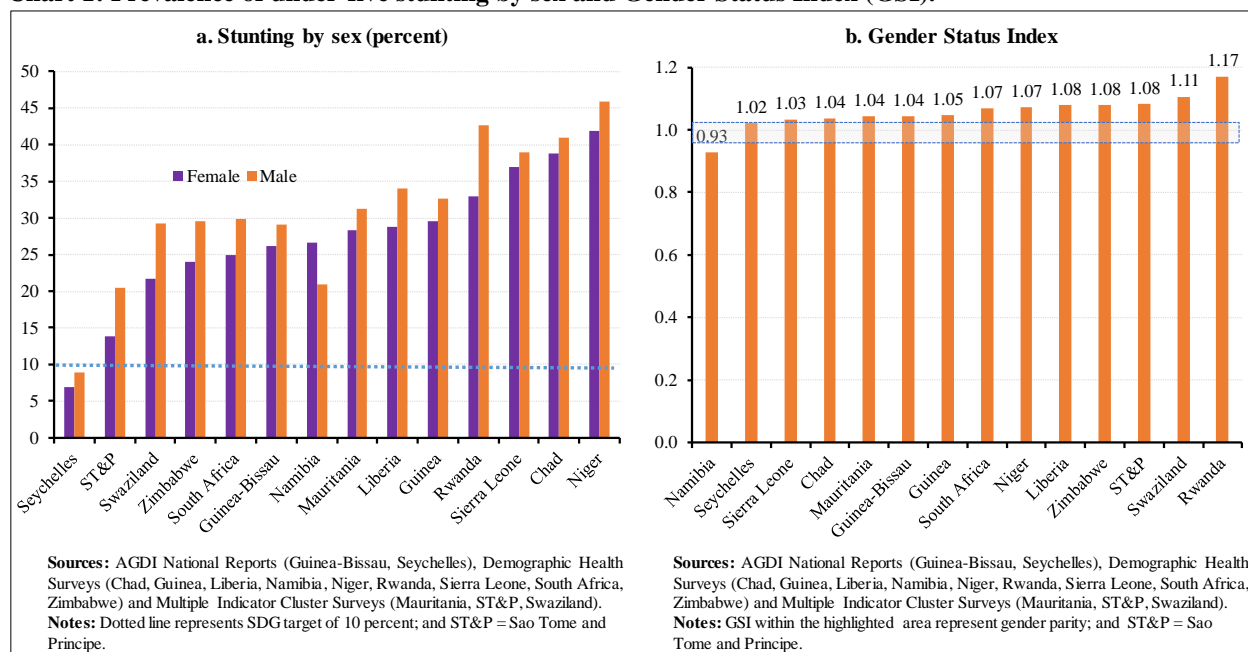
<sup>9</sup> UNICEF (2016).

- Institute policies to alleviate poverty, and improve food security, population health and access to health services.

**Sources:** Bhutta et al (2013), WHO (2014b) and UNICEF, WHO and World Bank Group (2017).

Rates of stunting among under-fives range from 7 percent for girls in **Seychelles** to 42 percent for girls in **Niger** (Chart 1a). There is gender parity for **Seychelles** and **Sierra Leone** with a GSI of between 0.97 and 1.03 (Chart 1b). Girls are at an advantage relative to boys for all other countries for which data is available except for **Namibia**. The advantage in favour of girls is especially significant for **Swaziland** (GSI=1.11) and **Rwanda** (GSI=1.17). **Seychelles** has achieved the target of 10 percent set in the SDGs for both sexes. The rates for other countries with data are significantly above target. Analysis of data from Demographic Health Surveys reports published after 2006 shows that stunting rates are lower for children: from the highest wealth quintiles relative to the lowest; living in urban areas compared to those living in rural areas except for **Sao Tome and Principe** where there is no difference; with mothers who were 18 years of age or older at the time of birth compared to those with mothers who were less than 18 years of age at the time of birth except in **Liberia** where there is no difference; and whose mothers have a higher education compared to those with no education<sup>10</sup>.

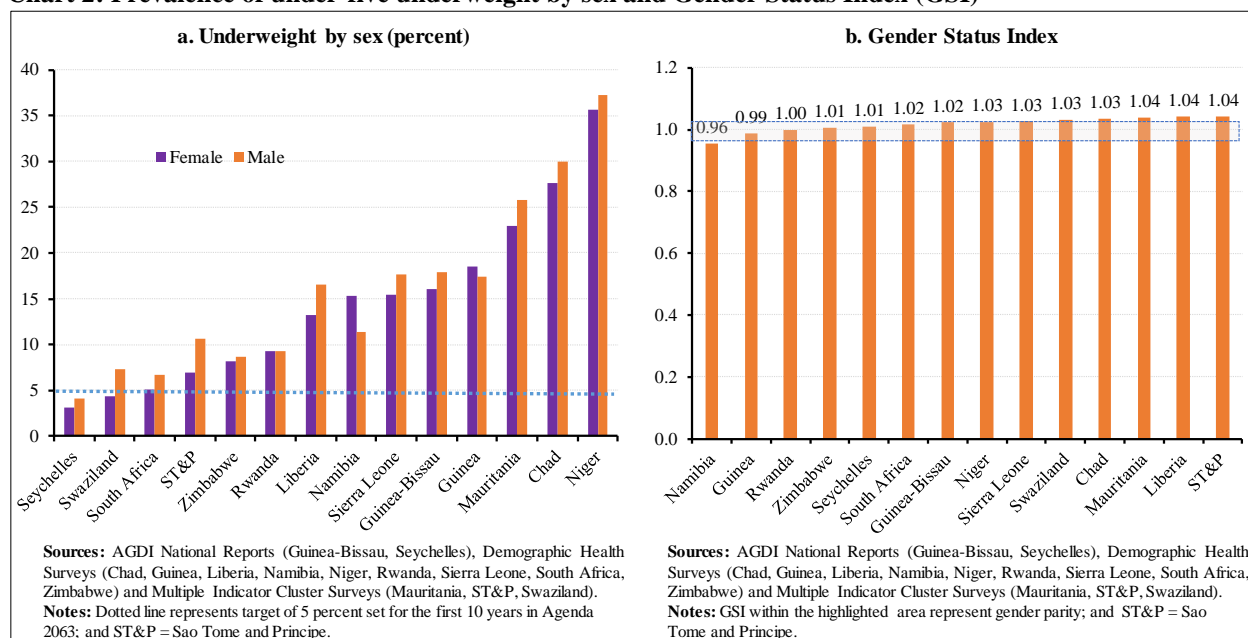
**Chart 1: Prevalence of under-five stunting by sex and Gender Status Index (GSI).**



The prevalence of under-fives who are underweight tend to be less than for stunting for both sexes (Chart 2a). All countries where data is available has broadly attained gender equality (Chart 2b). **Seychelles**, **South Africa** and **Swaziland** are performing very well relative to the target set for the first 10 years in Agenda 2063, with **Seychelles** having reached the target for both sexes, and **South Africa** and **Swaziland** having reached the target for females. The prevalence of underweight children is significant in **Chad** and **Niger** with rates above 25 percent for both girls and boys, and **Mauritania** with a rate above 25 percent for boys.

<sup>10</sup> International Food Policy Research Institute (2016) and National Department of Health [South Africa] et al. (2017). DHS data for the following countries were used in the analysis: Guinea (2014/15), Liberia (2013), Namibia (2014), Niger (2012), Rwanda (2014), Sao Tome and Principe (2008/09), Sierra Leone (2014), South Africa (2016), Swaziland (2008) and Zimbabwe (2015).

**Chart 2: Prevalence of under-five underweight by sex and Gender Status Index (GSI)**



## Child mortality

The world has made substantial progress in improving child survival with global under-five mortality rate dropping from 91 deaths per 1,000 live births in 1990 to 43 in 2015<sup>11</sup>. Northern Africa reduced under-five mortality rate from 73 in 1990 to 24 in 2015, and sub-Saharan Africa experienced a cut in its rate from 180 in 1990 to 83 in 2015. However, in spite of the progress Africa is the region with the highest under-five mortality rate and more than 3 million children in Africa died before they reach their fifth birthday in 2015. In sub-Saharan Africa, one out of every 3 deaths of under-fives is due to new-born deaths compared to a half in regions with low child mortality<sup>12</sup>.

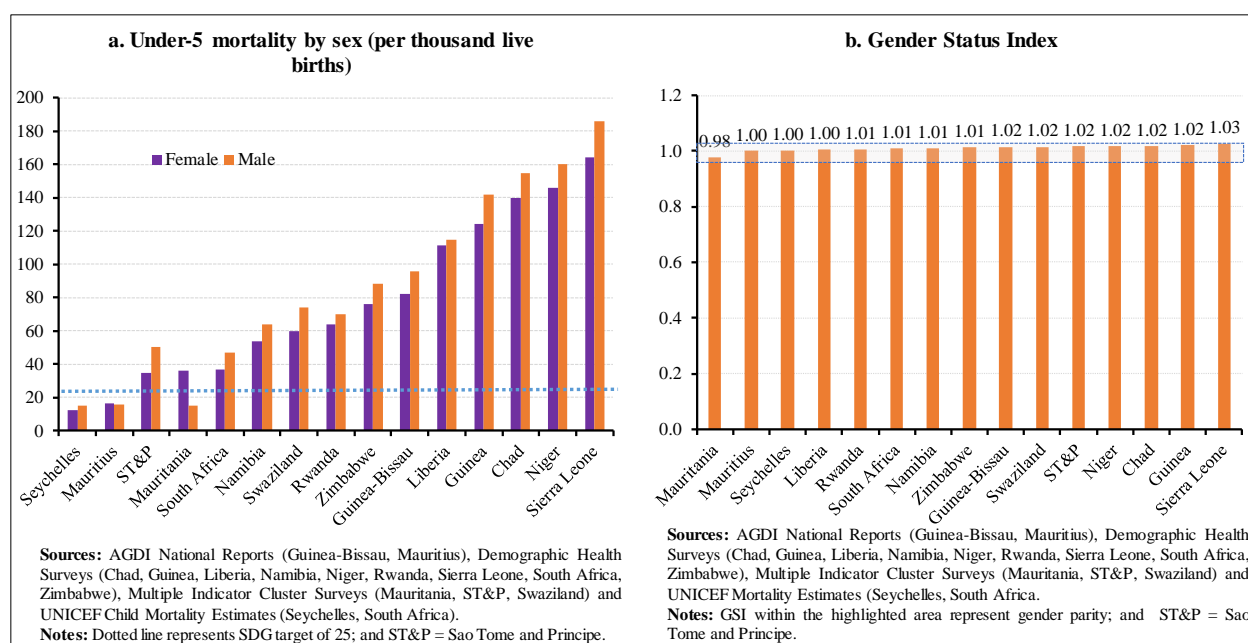
There is gender parity in terms of prevalence of under-five child mortality for all countries with data with GSI ranging from 0.98 in **Mauritania** and 1.03 in **Sierra Leone** (Chart 3b). **Mauritius** and **Seychelles** have met the SDG target of 25 for both sexes, and **Mauritania** has met the target for boys. However, mortality rates remain high for both sexes for the other countries where data is available (Chart 3a). They are especially high for **Chad, Guinea, Liberia, Niger** and **Sierra Leone** where the rates exceed 100 for both sexes. **Liberia, Niger** and **Rwanda** are among the 11 African countries to reduce under-five mortality by more than two thirds between 1990 and 2015 as was required by the fourth millennium development goal<sup>13</sup>.

**Chart 3: Under-five child mortality by sex and Gender Status Index (GSI).**

<sup>11</sup> UNICEF, WHO, World Bank Group and United Nations (2015).

<sup>12</sup> UNICEF (2016).

<sup>13</sup> UNICEF, WHO, World Bank Group and United Nations (2015). The other 8 African countries are Egypt, Ethiopia, Eritrea, Madagascar, Malawi, Mozambique, Uganda, and Tanzania.



Most deaths of children under the age of five are caused by undernutrition, infectious diseases and conditions such as pneumonia, diarrhoea, malaria, meningitis, tetanus, HIV and measles diseases, and complications before, during and just following birth<sup>14</sup>. Deaths caused by diseases are readily preventable or treatable with proven, cost-effective interventions. The most important of such interventions are increasing access to child care services - including antenatal care, care by a skilled birth attendant, giving birth in well-equipped health facilities, emergency obstetric care and immediate new-born care<sup>15</sup> -, increasing the coverage of interventions to ensure children survive these diseases, and better child nutrition. Box 3 highlights the application of these interventions in the case of **Niger**.

### BOX 3 INTERVENTIONS TO REDUCE UNDER-FIVE CHILD MORTALITY IN NIGER

The mortality rate in children younger than 5 years in Niger declined rapidly from 328 for each 1000 livebirths in 1990 to 96 in 2015 with an annual rate of decline of 4.9 percent. Niger achieved the fourth Millennium Development Goal – which is to reduce under-five mortality by two thirds by 2015 - in 2000. Three main categories of interventions have contributed to achieve these results (Table B1). Firstly, improving access to primary health care for women and children by: increasing coverage of interventions aimed at reducing deaths from malaria, pneumonia, diarrhoea and measles; increasing geographical access by building community health posts (*Case de Santé*) in rural and remote areas since 2000 and resourcing those with trained community health workers essential drugs and commodities; and abolishing use fees for pregnant women and children under 5 in 2006. Community health care workers (*Agents de Santé Communautaire*) are paid, have a minimum of secondary school education, and are selected by the community. The community health posts provide treatment and referral for malaria, pneumonia and diarrhea; screening and referral of acute malnutrition; promotion of good health, nutrition and hygiene practices; and promotion and distribution of family planning products and services. Secondly, mass campaigns were used to rapidly increase the coverage for insecticide-treated bednets, measles vaccination and Vitamin A supplementation. Thirdly, steps were taken to address child malnutrition.

**Table B1: Major policies and interventions related to child survival in Niger, 1998-2009**

Access to child healthcare services	Mass campaigns	Child nutrition
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<sup>14</sup> UNICEF, WHO, World Bank Group and United Nations (2015).

<sup>15</sup> UNICEF (2016).



<ul style="list-style-type: none"> <li>- National IMCI Policy 1996-98</li> <li>- 2000: Presidential declaration for rural development and improvement of access to basic services</li> <li>- 2000: Introduction of clinical ICMI training of 190 health workers</li> <li>- 2000: Construction of first community health posts in rural and remote communities</li> <li>- 2005: Malaria Policy Revision</li> <li>- 2006: Free health-care policy for children and pregnant women</li> <li>- 2007: 1, 700 community health posts created with 431 trained community health workers</li> <li>- 2008: Malaria and diarrhea policy</li> <li>- 2009: 1, 444 ICMI-trained health workers</li> <li>- 2009: Total of 1, 938 functioning health post with 2, 308 trained community health workers.</li> </ul>	<ul style="list-style-type: none"> <li>- 2000: National Vitamin A supplementation campaigns (twice a year through 2009)</li> <li>- 2004: National measles campaign</li> <li>- 2005: Mass distribution of 2.3 million insecticide-treated bednets</li> <li>- 2005-2009: Rollout of tetanus toxoid vaccine</li> <li>- 2008: National measles campaign</li> <li>- 2009: Mass distribution of 2.8 million insecticide-treated bednets</li> </ul>	<ul style="list-style-type: none"> <li>- 2005: Network of National Nutrition Rehabilitation centres established</li> <li>- 2006: Nutritional Policy - Management of malnutrition</li> <li>- 2009: Total of 39 inpatient and 671 outpatient nutrition centres</li> </ul>
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These interventions resulted in significant increases in take-up of vaccinations against childhood diseases and micronutrient supplementations, ownership of insecticide-treated bednets, antenatal care, and careseeking for childhood diseases. Amouzou et al. (2012) concluded that the increase of insecticide-treated bednet and nutritional interventions aimed at reducing stunting and wasting together contributed to about half of the total lives of under-5 children saved in 2009.

However, there are a number of challenges that may imperil the sustainability of the decline in under-5 mortality rates. These include: persistently high fertility rates; the influx of refugees from neighbouring countries which contributes to increased demand for health services; chronic food insecurity issues; heavy dependence of the health system on external donors; and the lack of progress in reducing newborn mortality.

**Sources:** Amouzou et al. (2012), Besada et al (2016), and UNICEF, WHO, World Bank Group and United Nations (2015).  
Note: IMCI = Integrated Management of Childhood Illness.

However, several socioeconomic and demographic factors work against the utilisation of these interventions and services and children surviving these diseases (Table 2). Mortality in urban areas is generally lower than in rural areas (except for **Sao Tome and Principe** and **Swaziland**), although the percentage disparity for **Chad** is relatively small. Mortality declines markedly as mother's education increases and as the wealth of the household increases. In general, mortality is relatively higher among children born to mothers under the age of 20 than among children born to mothers between 20-29 years with the exception of **Namibia**. A child born less than two years after a preceding birth is almost at least twice as likely to die before his or her fifth birthday as a child born four or more years after a preceding birth; the probability is at least 3 times in **Guinea** and **Liberia**.

These socioeconomic and demographic factors interact with other structural barriers to undermine children's survival. These structural barriers include delays in choosing and booking delivery facilities in advance, arriving at the facilities on time, seeking, and receiving adequate treatment once at the facilities<sup>16</sup>. Reasons for these include last-minute decisions about delivery facilities, expecting mothers and children having to travel long distances to receive care, poor transportation infrastructure, lack of information on

<sup>16</sup> Cohen et al. (2017) and Koffi et al. (2017).



when to seek care, cost considerations, and a lack of quality equipment and trained midwives, doctors or nurses to provide the care. In addition to these factors, a study undertaken in **Niger** in 2012 identified a lack of electricity and clean water, poor sanitation, and exposure to household air pollution as potential additional risk factors to child survival<sup>17</sup>.

**Table 2: Under-five mortality rates by background characteristics**

Background characteristics	Chad	Guinea	Liberia	Namibia	Niger	Rwanda	Sao Tome and Principe	Sierra Leone	Swaziland	Zimbabwe
<i>Residence</i>										
Rural	149	148	120	64	163	70	69	181	105	92
Urban	141	87	106	54	83	51	74	158	107	60
<i>Mother's education</i>										
No education	140	139	122	76	158	89	138	180	151	106
Secondary and higher	135*	66	97	55*	91	43	49	147	102*	26#
<i>Wealth quintile</i>										
Lowest	161	173	130	67	144	84	90	186	118	102
Fifth	138	68	99	31	114	40	28	144	101	52
<i>Mother's age at birth</i>										
Below 20 years' old	159	143	129	56	177	83	88	199	107	96
20-29 years' old	141	127	110	58	144	62	51	165	104	76
<i>Birth spacing</i>										
Less than 2 years	192	219	190	96	203	99	111	263	134	162
4 years and above	71	73	60	59	86	49	65	100	102	68

**Source:** Most recent Demographic and Health Surveys (various years) published since 2005.

**Notes:** \* secondary education only; and # more than secondary education only.

In order to reduce child mortality, governments will have to further focus interventions and services on the most disadvantaged children. These are children from poor households, those living in rural areas, and those whose mothers are uneducated and very young. Improving access to quality family planning information and services to enable women as well as adolescent girls to delay pregnancies and lengthen birth spacing is important. Furthermore, improving access to education up to secondary school for girls and promulgating and implementing laws that prevent child marriage will also be needed. Especially in countries where the prevalence of HIV is high, preventing mother-to-child transmission of HIV by expanding antiretroviral medicines for mothers living with HIV, both during and after their pregnancies as part of comprehensive maternal, newborn and child health services is important to improve child survival. Box 4 highlights how interventions to reduce child mortality in **Sierra Leone** benefitted the poor the most.

#### BOX 4 INTERVENTIONS TO REDUCE UNDER-FIVE MORTALITY IN SIERRA LEONE

In 2010, Sierra Leone introduced a package of basic services targeting the major killers of vulnerable children and women. These services included insecticide-treated nets, promotion of early and exclusive breastfeeding, immunization, and birth attendance. To support this effort, the government trained 15,000 community health workers between 2000 and 2015, and provided on-the-job training for primary health care workers at each of the country's 1,200 primary health care centres. Sierra Leone also conducted mass malaria prevention campaigns every two years, distributing insecticide-treated nets to pregnant women and children. In 2010, Sierra Leone launched the Free Health Care Initiative to improve access to health care for mothers and children. It is projected that the under-five mortality in Sierra Leone between 2008 and 2013 fell annually by an estimated 14 deaths per 1,000 live births among the poor, compared to 9 deaths per 1,000 live births among non-poor groups.

<sup>17</sup> Koffi et al. (2016).

Source: UNICEF (2017).

## Sexual and reproductive health

“Reproductive health care is the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, ... Men and women have the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.”<sup>18</sup> [*Programme of Action of the ICPD*]

The Programme of Action of the International Conference on Population and Development (ICPD) defined reproductive health to include sexual health (see quote above). The key reproductive and sexual health interventions are: provision of family planning services; improving maternal and newborn health; reducing sexually transmitted infections including HIV; eliminating unsafe abortion and providing post-abortion care; and promoting healthy sexuality, including adolescent health and reducing harmful practices<sup>19</sup>. Integration of services to achieve the above ends have the potential to address the multiple needs of patients, reduce service costs, enhance the effectiveness and sustainability of programmes, and generate wider health benefits<sup>20</sup>.

The following sections discuss the performance of the countries covered by the report in four areas of sexual and reproductive health, namely HIV/AIDS, maternal mortality, family planning and safe abortions. HIV is covered under both AWPS and GSI, while the other three are covered under the AWPS only.

### HIV/AIDS

States Parties shall ensure that women have “the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS; the right to be informed of one’s own health status and that of one’s partner, particularly infected with sexually transmitted diseases, including HIV/AIDS”<sup>21</sup> [*Protocol to the African Charter on Human and Peoples’ Rights of Women in Africa*]

HIV progressively weakens the immune system and peoples’ defense against infection. AIDS is the most advanced stage of HIV infection<sup>22</sup>. The first reported cases of AIDS were in 1981. Although many people infected with HIV now has access to life-saving antiretroviral therapy, HIV/AIDS is still a major threat to public health<sup>23</sup>.

### HIV prevalence

An estimated 1.4 million new HIV infections were recorded in central, eastern, southern and western Africa in 2015 bringing the total number of people living with HIV in those regions to almost 26 million<sup>24</sup>. Eastern and southern was the sub-region that experienced the largest reduction in new adult HIV infections between 2010 and 2015 of about 40 000 or a 4 percent decline<sup>25</sup>. In sub-Saharan Africa, adolescent girls and young

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<sup>18</sup> United Nations (1996; para. 7.2).

<sup>19</sup> United Nations Millennium Project (2006) reported that the World Health Organization outlined these interventions in 2004 as necessary for good sexual and reproductive health.

<sup>20</sup> UNAIDS and Lancet Commission (2015).

<sup>21</sup> African Union (2003: Article 14 (1)(d) and (e)).

<sup>22</sup> WHO (2016a).

<sup>23</sup> *Ibid.*

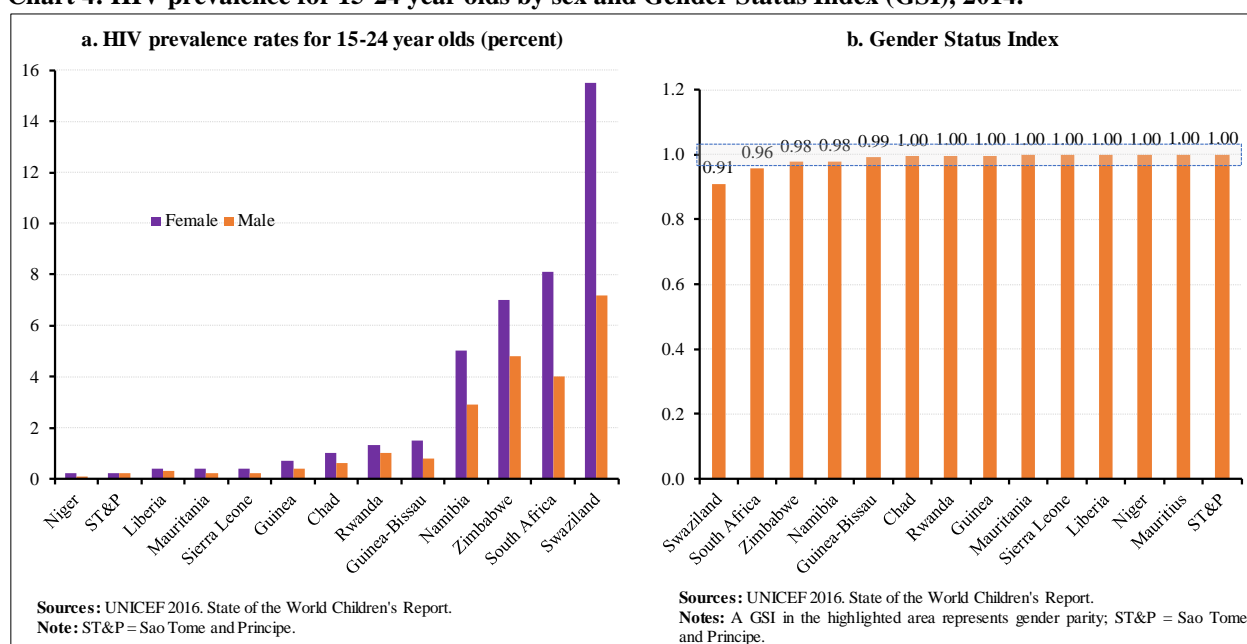
<sup>24</sup> UNAIDS (2016a).

<sup>25</sup> *Ibid.*

women accounted for 25 percent of new HIV infections among adults, and women accounted for 56 percent of new HIV infections among adults<sup>26</sup>.

There is gender parity for all countries with data with GSI between 0.97 and 1.03 for all countries except for **Swaziland** (GSI = 0.91) and **South Africa** (GSI = 0.96) in terms of prevalence of HIV infection of 15-24 year olds (Chart 4b). The prevalence of HIV infection in 2014 was 1 percent or less for both sexes in **Guinea, Liberia, Mauritania, Mauritius, Niger, Sao Tome and Principe** and **Sierra Leone**, and 1 percent or less for adolescent boys and young men in **Chad, Guinea** and **Rwanda** (Chart 4a). **Namibia, South Africa** and **Swaziland** have HIV prevalence rates of above 2 percent for both sexes, with rates of 7 percent, 8 percent and 16 percent for females in **South Africa, Swaziland** and **Zimbabwe** respectively. **Swaziland** had the highest reported adult prevalence of HIV infections in the world in 2015 with a rate estimated at 28.8 percent<sup>27</sup>.

**Chart 4: HIV prevalence for 15-24 year olds by sex and Gender Status Index (GSI), 2014.**



The prevalence of HIV infection for adolescent girls and young women between the ages of 15 and 24 was higher than for males in the same age group for all countries with data except for **Mauritius** where they are the same (Chart 4a). The prevalence of HIV infection for adolescent girls and young women in South Africa and **Swaziland** is at least twice that of their male counterparts. The *South African National HIV Prevalence, Incidence and Behaviour Survey 2012* published in 2014 reported that the estimated prevalence of HIV infection among females in the 15 to 19 years (5.6 percent) was eight times that of males in the same age group, while that of females between the ages of 20 and 24 years was estimated at 17.7 percent compared to 5.1 percent for their male counterparts<sup>28</sup>. Adolescent girls aged 15-19 in **Guinea** and **Swaziland** are more than 5 times more likely to be infected by HIV than boys<sup>29</sup>.

The main factors that increase the risk and susceptibility of adolescent girls and young women to HIV infection are prevalence of relationships between young women and older men, early sexual debut, intimate partner violence, unwanted and forced sexual activity, lack of access to information about HIV and health

<sup>26</sup> *Ibid.*

<sup>27</sup> <http://www.unaids.org/en/regionscountries/countries/swaziland>

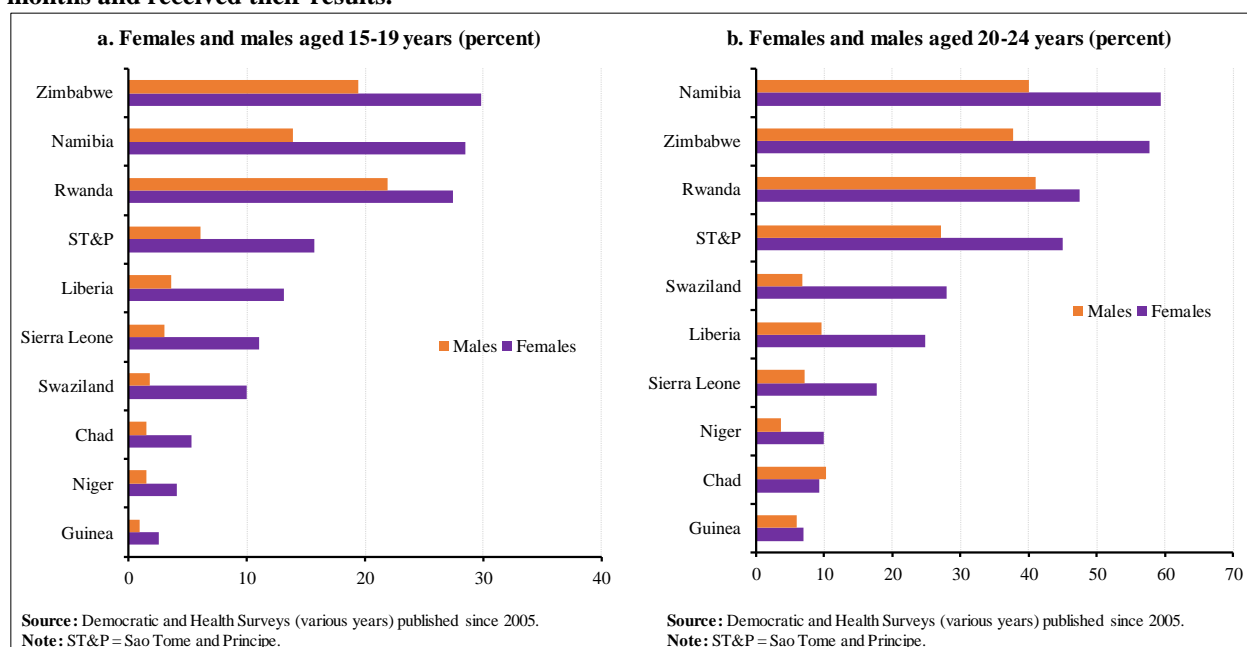
<sup>28</sup> Shisana et al. (2014).

<sup>29</sup> UNAIDS (2015).

services, limited access to and use of condoms, and biological makeup of females that exposes them to more infection than males<sup>30</sup>. The percentage of adolescent girls aged 15-19 who reported having sexual relationships in the previous 12 months with someone at least 10 years older in **Sierra Leone, Sao Tome and Principe, Chad, Niger, and Guinea** were 22 percent, 32 percent, 38 percent, 41 and 50 percent respectively<sup>31</sup>. Other reasons noted in AGDI country reports are: cultural beliefs that one man whether married or not can have sexual intercourses with several female partners; female economic dependence on males which can reduce women's ability to negotiate for the use of condoms when having sexual relations; limited awareness on existing legal measures in place protecting women's rights; and inadequacies of laws prohibiting gender-based violence.

Another factor that may explain the higher reported prevalence of HIV infection in young females is that more women than men present themselves for HIV tests. Data from Demographic and Health Surveys undertaken since 2005 show that, except for **Chad**, a greater percentage of adolescent and young females have tested for HIV and received their results than their male counterparts (Chart 5). This can partly be explained by the fact that pregnant women are having more opportunities for HIV testing as part of the integration of HIV services with antenatal care in many countries. Also, men are more likely to work outside the home and are therefore less likely to be targeted by HIV community outreach and sensitization campaigns. Other contributors to low rates of testing for both women and men are stigma associated with HIV testing, fear of testing and knowing one's HIV status, and a poor understanding of the risk to HIV infection<sup>32</sup>. As an example of the latter, research undertaken in **Swaziland** in 2015 found that those who report few sexual partners felt that they were not at risk of HIV infection given the perception that HIV is linked to prostitution<sup>33</sup>. Chart 5 also shows that a lower percentage of adolescents aged 15-19 have tested for HIV and received their results than young people aged 20-24 for both males and females for all countries with available data.

**Chart 5: Percentage of adolescents and young males and females who have been tested for HIV in the past 12 months and received their results.**



<sup>30</sup> Shisana et al. (2014) and Dellar et al. (2015).

<sup>31</sup> Demographic and Health Surveys (various years).

<sup>32</sup> UNAIDS and Lancet Commission (2015).

<sup>33</sup> Horter et al. (2017).

In addition to adolescent girls and young women, other specific populations are at higher risk of being infected with HIV. According to Demographic and Health Surveys undertaken after 2005 for **Chad, Guinea, Liberia, Namibia, Rwanda and Sierra Leone** the HIV prevalence among youth age 15-24 years is higher in urban areas than in rural areas for both sexes. In **Seychelles**, although the prevalence of HIV infection amongst the general population is low (0.87 percent), it is high among men who have sex with men (13.2 percent), people who inject drugs (5.8 percent) and female sex workers (4.6 percent)<sup>34</sup>. In 2015, the prevalence of HIV infection for people who inject drugs, female sex workers, men who have sex with men and prison inmates in **Mauritius** were 44 percent, 22 percent, 20 percent and 22 percent respectively<sup>35</sup>.

The prevalence of HIV infection among female sex workers was upwards of 30 percent in **Guinea-Bissau, Rwanda, South Africa, Swaziland and Zimbabwe**<sup>36</sup>, 9.8 percent in **Liberia** in 2013<sup>37</sup>, and 6.7 percent in **Sierra Leone** in 2015<sup>38</sup>. In **South Africa**, a survey undertaken in 2013 and 2014 estimated that HIV prevalence among female sex workers was 71.8 percent in Johannesburg, 39.7 percent in Cape Town, and 53.5 percent in Durban<sup>39</sup>. Although high risk behavior partly explains the higher prevalence of HIV infections for these population groups, the criminalization of commercial sex, violence against sex workers that goes unreported, stigma associated with sex work and discrimination contribute to ensure that sex workers do not have access to HIV services.

### *Access to antiretroviral therapy*

There is no cure for HIV infection. However, timely access to antiretroviral treatment (ART) substantially reduce mortality from HIV infections, prevents illness by reducing the risk of tuberculosis infection in people living with HIV, and allows working-age adults living with HIV to return to work earlier<sup>40</sup>. Strong adherence to ART also greatly reduce the risk of transmitting the virus to others by up to 96 percent<sup>41</sup>.

The eastern and southern Africa has seen ART coverage increased from 24 percent in 2010 to 54 percent in 2015<sup>42</sup>. In **South Africa** which has the largest treatment programme in the world<sup>43</sup>, 3.7 million people living with HIV had initiated ART treatment in 2017<sup>44</sup> compared to 1.3 million in 2008<sup>45</sup>. A total number of 133,574 adults and adolescents in **Rwanda** were receiving ART by June 2014 an increase of 60 percent compared to 2010<sup>46</sup>.

In all countries where data is available, a higher proportion of females has access to ART compared to men, except for **Mauritania and Mauritius**; both men and women have 100 percent to ART in **Seychelles** (Chart 6). Gender disparities in favour of females are significant in **Rwanda, Niger, Guinea-Bissau, Guinea, and South Africa** where the percentage of females with access to ART is at least 1.7 times those of their male counterparts. In **South Africa**, deaths due to HIV dropped from 681, 434 in 2006 to an estimated 150, 375 in 2016<sup>47</sup> partly as a result of expanded access to ART. Consequently, the median age at death rose from 41.7 years for females and 43.4 years for males in 2004 to 60 years for females and 52.1 years for males in 2015<sup>48</sup>.

<sup>34</sup> National AIDS Council [Seychelles] (2015).

<sup>35</sup> Ministry of Foreign Affairs, Regional Integration and International Trade [Mauritius] (2015).

<sup>36</sup> UNAIDS and Lancet Commission (2015) and UNAIDS (2016b).

<sup>37</sup> National AIDS Commission [Liberia] (2017).

<sup>38</sup> National HIV/AIDS Secretariat [Sierra Leone] (2015).

<sup>39</sup> University of California-San Francisco et al. (2015).

<sup>40</sup> UNAIDS (2013).

<sup>41</sup> *Ibid.*

<sup>42</sup> UNAIDS (2016a).

<sup>43</sup> *Ibid.*

<sup>44</sup> South African National AIDS Council (2017).

<sup>45</sup> UNAIDS and Lancet Commission (2015).

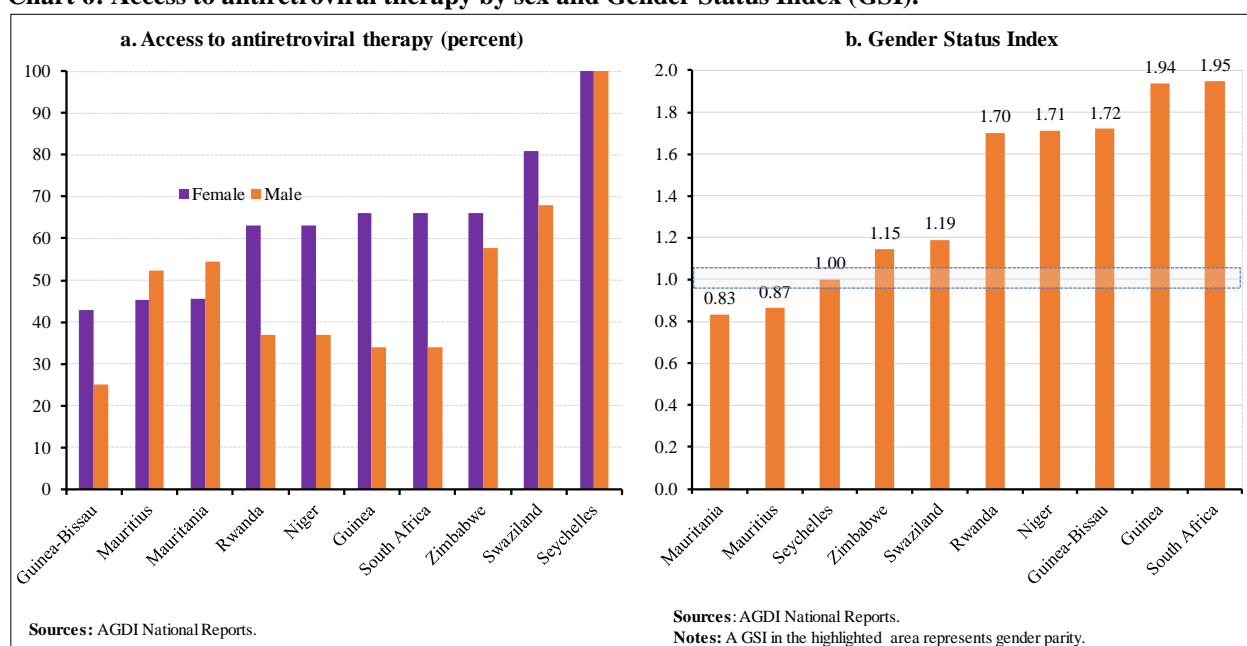
<sup>46</sup> Ministry of Health [Rwanda] (2014).

<sup>47</sup> South African National AIDS Council (2017).

<sup>48</sup> Statistics South Africa (2017).

As discussed above, women are more likely than men to undertake HIV testing. Consequently, women are more likely to know their HIV status and access ART. Further to this, males in tend to initiate ART a bit later than women. For example, in **Swaziland** 54 percent of women initiating ART whilst in stage 1 – the earliest stage of HIV infection - of HIV compared to 37 percent of men, and 31 percent of males initiating treatment in stages 3 and 4 compared to about 20 percent of women<sup>49</sup>. This state of affairs reduces the preventive effects of treatment and may lead to more AIDS-related deaths among men.

**Chart 6: Access to antiretroviral therapy by sex and Gender Status Index (GSI).**



### *Interventions for the prevention and treatment of HIV infections*

A growing set of interventions have been developed for the prevention and treatment of HIV infections. The main interventions include: prevention of mother-to-child-transmission programmes; condom promotion and distribution; expanding access to ART; voluntary male circumcision; and behaviour change programmes<sup>50</sup>. These have to underpinned and enabled by political commitment and advocacy, appropriate and effective laws, policies, plans and institutional mechanisms based on quality evidence base, and sensitisation campaigns. As much as possible, these HIV interventions have to be integrated with other health services. They should also target marginalised communities including adolescent girls and young women and those sub-populations which are most at risk of HIV infections such as sex workers, men who have sex with men, people who inject drugs, and prisoners.

Structural interventions are increasingly seen as important for successful HIV prevention and treatment<sup>51</sup>. These interventions include empowerment programmes that promote economic opportunities for women and laws, policies and programmes with the object to reduce gender-based violence and HIV-related discrimination and stigma. Other important structural interventions are social protection programmes that make it worth the while for girls to stay in or return to school and removal of laws and policies that make it mandatory for parental and/or spousal consent in accessing sexual and reproductive rights services.

<sup>49</sup> Ministry of Health [Swaziland] (2015).

<sup>50</sup> UNAIDS and Lancet Commission (2015).

<sup>51</sup> *Ibid.*



[To update] Table A1 measures how far governments have met the regional and global commitments to achieve universal access to HIV prevention, treatment, care and support. Countries scored themselves highly on policy commitment, having a plan, setting targets, involvement of civil society, information and dissemination, and monitoring and evaluation. Weak areas overall were having laws on HIV/AIDS, human resources and capacity enhancement. **Guinea, Mauritius and Seychelles** scored themselves very high on this issue, while Sierra Leone scored itself 50 percent.

Most national HIV/AIDS plans aim to meet UNAIDS 90-90-90 fast track targets by 2020 to diagnose 90 percent of all people living with HIV, to treat 90 percent of all people with an HIV diagnosis with sustained ART, and 90 percent of all people receiving ART to achieve viral suppression. In a synthesis undertaken in 2015 by UNAIDS and the World Bank in 18 countries in Eastern and Southern Africa found that **Mauritius, Namibia, Rwanda, South Africa, Swaziland and Zimbabwe** identified female sex workers in national AIDS plans or strategies as being essential to reach with effective programme implementation<sup>52</sup>. Box 5 summarises selected interventions planned by **South Africa** in the *National Strategic Plan on HIV, TB and STIs 2017 – 2022* towards HIV prevention and treatment.

#### BOX 5 PLANNED HIV PREVENTION AND TREATMENT INTERVENTIONS IN SOUTH AFRICA

In 2016, an estimated 270 000 people in South Africa became newly infected with HIV. About 40 percent of people living with HIV are still unaware of their status and the 3.7 million receiving ART represent a little over half of those who are eligible. It is estimated that a quarter of ART patients is lost to follow up within the first year.

Against this backdrop, the *South African National Strategic Plan on HIV, TB and STIs 2017 – 2022* was adopted in 2017 to direct and coordinate the national effort in responding to HIV, tuberculosis (TB) and sexually transmitted infections (STIs). The plan was based on wide consultations involving government at all levels, civil society sectors, development partners, and private sector organisations.

The plan focuses on:

- High impact and targeted prevention programmes combining biomedical prevention methods such as medical male circumcision, condom promotion and distribution and the preventive use of ART, and social and behaviour change communication that encourage people to reduce their risk of HIV infection.
- Achieving UNAIDS 90-90-90 targets by 2020: 90% of all people living with HIV will know their HIV status; 90% of all people with an HIV diagnosis will receive sustained antiretroviral therapy; and 90% of all people receiving antiretroviral therapy will achieve viral suppression.
- Providing targeted services to prevent mother-to-child transmission of HIV both before and after birth.
- Specific populations that are more severely affected by HIV than the general population to overcome the barriers of access to HIV prevention and treatment programmes. These include: sex workers; transgender people; men who have sex with men; people who use drugs; and inmates of correctional facilities
- Interventions to address social and structural factors that increase the risk of prevalence to HIV infection.
- Adolescent girls and young women by expanding national campaigns, such as *She Conquers*, retaining girls in school, and providing comprehensive sexuality education in schools and youth friendly sexual reproductive health and contraception services at clinics. The objectives of the *She Conquers* campaign are to: decrease new HIV infections in girls and young women; decrease teenage pregnancies; increase the retention of adolescent girls and young women in school; decrease sexual and gender based violence amongst adolescent girls and young women; and increase economic opportunities for young people, particularly for young women.

<sup>52</sup> UNAIDS and the World Bank Group (2016). The other 12 countries were: Angola, Botswana, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mozambique, South Sudan, Uganda, the United Republic of Tanzania, and Zambia.



- Increased access to justice and the reduction of stigma associated with HIV.
- Generation and use relevant, timely data to monitor progress on implementation and track the impact of interventions.
- Accelerating the Test and Treat approach to ART which introduces treatment for all people who test positive for HIV as soon as they are medically and emotionally ready to start. The Test and Treat model was adopted in September 2016.
- Reducing stigma of people living with HIV by conducting community education programmes.
- Establishing AIDS council structures at national, provincial and local level, and ensuring representation of all stakeholders including vulnerable and sub-populations at high risk of HIV prevention in decision-making structures at all levels.

**Source:** South African National AIDS Council (2017) and Department of Health [South Africa] (2016).

## Maternal mortality

“States Parties shall take all appropriate measures to establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breastfeeding”<sup>53</sup> [*Protocol to the African Charter on Human and Peoples’ Rights of Women in Africa*]

African women continue to face severe health risks associated with pregnancy and childbirth. These health risks may lead to temporary or permanent disability, and in far too many cases, death. Estimates for 2015 show that maternal mortality ratio for Northern Africa and sub-Saharan Africa were 546 and 70 per 100, 000 live births respectively, representing declines of 59 percent and 45 percent since 1990<sup>54</sup>. Africa accounted for 62 percent of all maternal deaths in 2015.

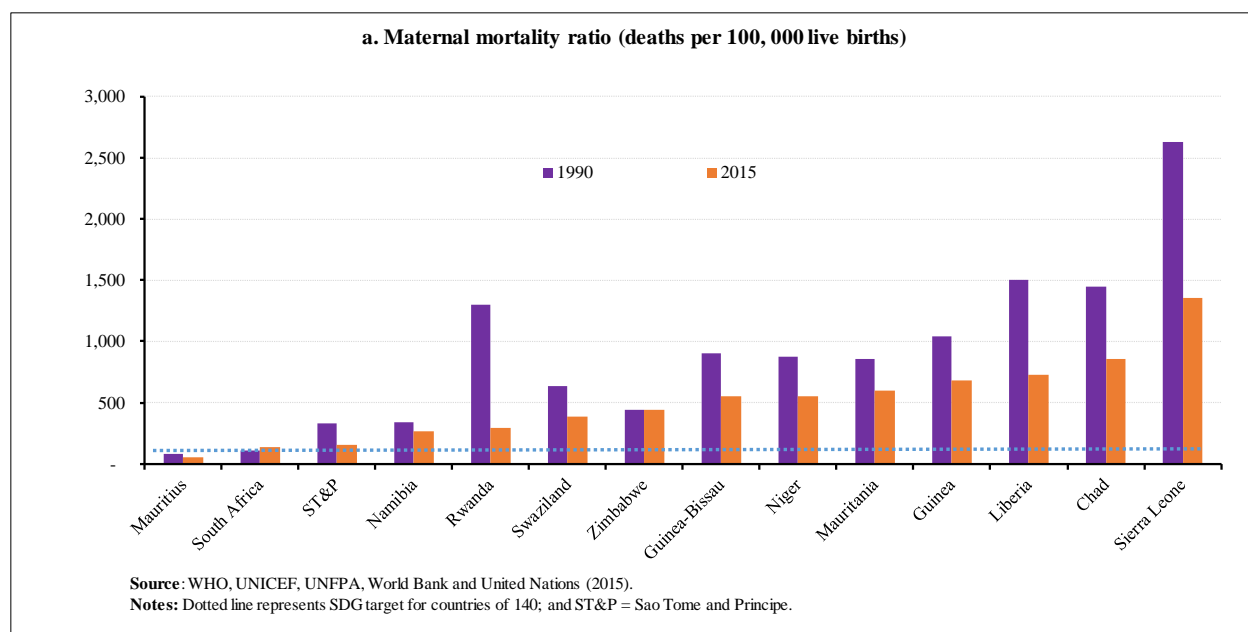
**Seychelles** registered only 4 cases of maternal death in the period 2006-2015. Chart 7 reports maternal mortality ratio for African countries covered by this report in 2000 and 2015. At 53 and 138 deaths per 100, 000 live births respectively, **Mauritius** and **South Africa** have met the target for maternal mortality in SDG3 although both countries recorded increases in ratios between 2000 and 2015. **Rwanda** met the MDG goal to reduce maternal mortality by 75 percent between 1990 and 2015 by reducing its ratio by 78 percent from 1, 300 in 1990 to 290 in 2015. Maternal mortality ratios for **Sierra Leone**, **Liberia** and **Sao Tome and Principe** fell by 48, 52 and 53 percent respectively over the same period. In addition to **Rwanda**, all the **Small Islands Developing States** and **countries from Southern Africa** under review with data have ratios below 500 deaths per 100, 000 live births. **Guinea Bissau**, **Niger**, **Mauritania**, **Guinea**, **Liberia**, **Chad** and **Sierra Leone** had maternal mortality ratios of above 500 in 2015. **Sierra Leone** had the highest maternal mortality ratio in the world in 2015 with a ratio of 1, 360<sup>55</sup>.

**Chart 7: Maternal mortality ratio, 1990 and 2015 (deaths per 100, 000 live births)**

<sup>53</sup> African Union (2003: Article 14 (2)(b)).

<sup>54</sup> WHO, UNICEF, UNFPA, World Bank and United Nations (2015). Northern Africa includes Algeria, Egypt, Libya, Morocco, and Tunisia.

<sup>55</sup> *Ibid.*



Most maternal deaths in Africa is as a result of haemorrhage especially after childbirth, high blood pressure during pregnancy, pre-existing medical conditions including HIV/AIDS, infections, unsafe abortions, and complications from delivery<sup>56</sup>. In 2015, more than 10 percent of maternal deaths were due to HIV infection in 5 African countries: **South Africa** (32 percent), **Swaziland** (19 percent), **Botswana** (18 percent), **Lesotho** (13 percent) and **Mozambique** (11 percent)<sup>57</sup>.

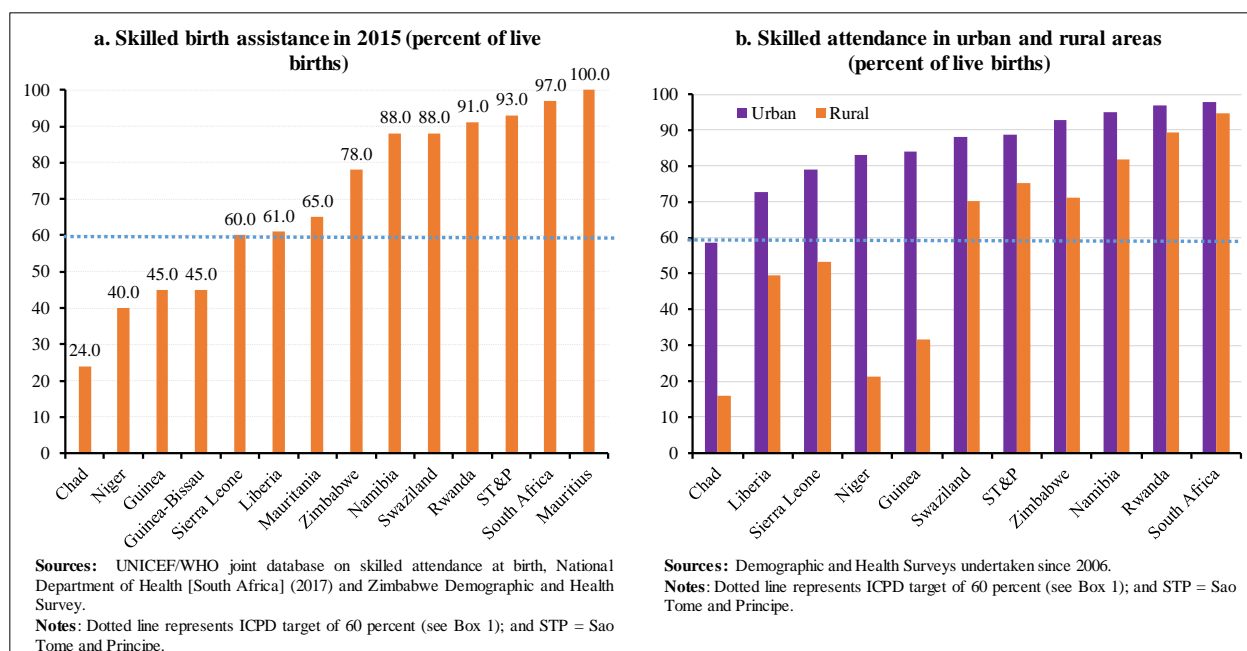
Most maternal deaths are preventable. Prevention requires access to antenatal care, safe delivery in health facilities with the help of skilled birth attendants<sup>58</sup>, emergency obstetric care, post-natal care and support, and quality family planning services. Charts 7 and 8 show that low skilled attendant at delivery is broadly associated with high maternal mortality ratios in 2015. More than 85 percent of births were attended by skilled professionals in **Rwanda**, the **Small Islands Developing States** and **countries from Southern Africa** (except for **Zimbabwe**) with figures in excess of 95 percent for Mauritius, Seychelles and **South Africa** (Chart 8a). **Niger**, **Guinea-Bissau**, **Guinea** and **Sierra Leone** had coverage of skilled attendant at delivery of between 40 and 60 percent, whereas in **Chad** only 24 percent of births were delivered by a skilled birth attendant.

**Chart 8: Skilled birth attendance (percent of live births).**

<sup>56</sup> Graham et al. (2015).

<sup>57</sup> WHO, UNICEF, UNFPA, World Bank and United Nations (2015).

<sup>58</sup> WHO (2004) classifies skilled birth attendants as an accredited health professional — such as a midwife, doctor or nurse — who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns.



A number of socioeconomic, demographic and structural factors conspire to ensure that women do not access the maternal healthcare they need to prevent deaths. Like for child mortality, these include poverty, having to travel long distances to reach health facilities, poor transportation infrastructure, lack of information on when to seek care, inadequate health facilities, and shortages of quality equipment and trained midwives, doctors or nurses to provide the care during labour, delivery and just after birth. These factors are especially important for women in rural and remote areas. Using data from Demographic and Health Surveys undertaken since 2006 for countries covered by the report, a lower percentage of births are assisted by skilled birth attendants in rural areas than in urban areas (Chart 8b). The urban-rural differential is especially significant in **Guinea** (2.7 times), **Chad** (3.7 times) and **Niger** (3.9 times) where the proportion of births delivered by skilled birth attendants in urban areas is more than twice that for rural areas (Chart 8b). The urban-rural differential is 3 percent in **South Africa** and 7.5 percent in **Rwanda**.

African countries covered by this report had taken a number of steps to reduce maternal deaths. These are summarized<sup>59</sup> below organized by the WHO strategic objectives for reducing maternal mortality (see Box 6).

#### BOX 6 STRATEGIES FOR REDUCING MATERNAL MORTALITY

Most maternal deaths occur during labour, delivery and in the first 24 hours following childbirth. In order to prevent maternal deaths, all women need access to antenatal care in pregnancy, skilled care during childbirth, and care and support in the weeks after childbirth. Antenatal care allows for the screening and detection of early signs of or risk factors for disease, followed by timely intervention to reduce maternal and infant mortality and morbidity. Antenatal care also promotes birth preparedness, and serves as a means to distribute antimalarial drugs and antiretroviral therapy. WHO recommends that all women should have at least 4 antenatal care visits. Skilled care during childbirth is best provided when women deliver in health facilities with the assistance of midwives with the help of other attendants. This is important for safety, primary prevention, and early detection and management of problems, including life-threatening ones. In addition, the provision of affordable and quality family planning services and, where abortion is legal, safe abortion services, to allow women to delay pregnancy, space births, avoid unintended pregnancies and reduce unsafe abortions are important to reduce maternal deaths.

<sup>59</sup> This section is based on findings from the AGDI National Reports. Other sources consulted are referenced separately where appropriate.

WHO has proposed 5 strategic objectives for reducing maternal deaths. These are:

- Address inequities in access to and quality of sexual, reproductive, maternal and newborn health care.
- Ensure universal health coverage for comprehensive sexual, reproductive, maternal and newborn health care.
- Address all causes of maternal mortality, reproductive and maternal morbidities, and related disabilities.
- Strengthen health systems to respond to the needs and priorities of women and girls.
- Ensure accountability to improve quality of care and equity.

**Sources:** Campbell et al. (2006), WHO (2015) and WHO (2016b).

**Ensure universal health coverage for and address inequities in access to and quality of sexual, reproductive, maternal and newborn health care.** Health services in public health facilities are free at the point of use to all citizens of **Mauritius** and **Seychelles**. Public health care services for pregnant women, lactating mothers and children under 5 years of age have been free in **South Africa**, **Niger** and **Sierra Leone** since 1994, 2006 and 2010 respectively. The *National Sexual and Reproductive Health Strategy and Plan of Action 2017-2020* of **Mauritius** have family planning, safe motherhood, infant and child health and adolescent and youth sexual and reproductive health among its components. In **Seychelles**, the maternal and child health programme ensures that appropriate ante and post-natal care is available to all women in regional centres across the country. In **Rwanda**, the *Health Sector Strategic Plan III (2012-2018)* aims to ensure universal accessibility of quality health services for all Rwandans. A comprehensive and community-based health insurance scheme to ensure vulnerable populations' access to primary health care with a focus on reproductive, maternal, newborn and child health services. Community health workers are in charge of maternal and new born health in **Niger** (Box 3), **Sierra Leone** (Box 4) and **Rwanda** (Box 7) in remote and rural areas as part of a decentralised health system. **Swaziland** has accelerated enrolment opportunities to antiretroviral therapy by decentralizing services to lower level facilities, integration of HIV in other programs such as Maternal Child Health service and the Tuberculosis programme.

#### **BOX 7 INTERVENTIONS TO REDUCE CHILD AND MATERNAL DEATHS IN RWANDA**

In response to high rates of child and maternal mortality, the Government of Rwanda implemented major health sector reforms that prioritized reproductive, maternal, newborn and child health. The main interventions were the following.

The community-based health insurance. The scheme known as *Mutuelle de Santé* was piloted in 1999 and extended nationally in 2006 through a network of 30 district-based mutuelles with the aim to reduce excessive out-of-pocket payments. By 2012, 90 percent of the population was enrolled in the scheme. Services covered by the scheme include antenatal care, deliveries, emergency obstetric and neonatal care, family planning, laboratory tests and essential drugs, and ambulance transport.

Health workforce development. Rwanda established elected female community health workers who are in charge of maternal and newborn care. The tasks of the community health worker include: identifying and registering women of reproductive age, promoting family planning services utilization, identifying pregnant women in the community, and encouraging them to utilize antenatal care services, especially all four visits to achieve birth preparedness and delivery at health facilities. The community health worker even accompanies women in labour to health facilities to help them get delivery assistance by qualified personnel. Pregnant women are tested for HIV/AIDS as one of the antenatal care services provided.

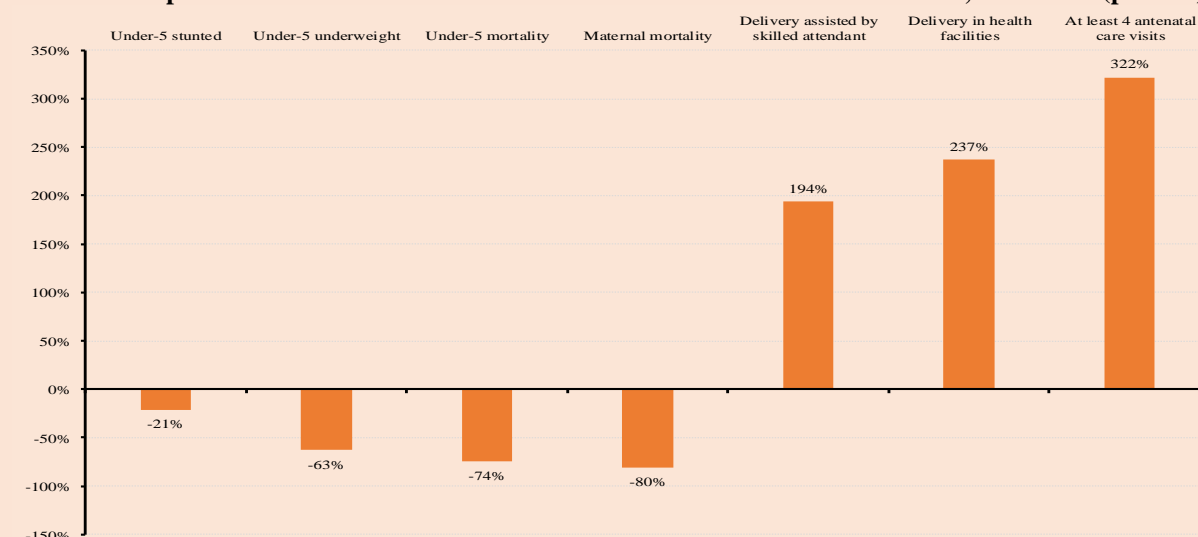
Performance-based financing. Health facility staff and community health workers receive financial incentives in addition to their monthly salaries. The incentives are based on a number of indicators including the proportion of women delivering at health facilities; the percentage of children receiving a full course of basic immunizations.

Outcomes monitored using evidence. A web-based Health Management Information System has been developed in 2007 to inform health sector strategic plans, monitor results, assess progress and facilitate priority setting, planning and resource allocation.

Use of technology. All community health workers have mobile phones and connected which are linked to a central Ministry of Health server by RapidSMS, an information tracking tool which use short message service text messages. Using this tool, the community health workers stay connected with pregnant women, monitor antenatal care, identify and refer women at risk and alert the nearest health facility in case of an emergency, and report births and maternal and child deaths.

These reforms have contributed to significant improvements in health outcomes (Chart B1).

**Chart B1: Improvement in selected child and maternal health indicators in Rwanda, 2000-2015 (percent)**



**Sources:** AGDI Country Report, Ministry of Health [Rwanda] et al. (2015), NISR et al. (2001) and NISR et al. (2015).

**Address all causes of maternal mortality, reproductive and maternal morbidities, and related disabilities.** In **Seychelles**, an antenatal programme follows mothers and their pregnancies, providing dental care, voluntary counselling and testing for HIV and other blood-borne diseases such as Hepatitis C. ART is available for all pregnant women who are HIV positive to prevent progression to AIDS and transmission to the child. High risk pregnancies are referred to ante natal specialised referral points at Victoria or Praslin Hospitals. Early booking for ante-natal care is encouraged, aiming for over 95% of women booked within the first 10 weeks of pregnancy. All women receive a post-natal home visit within 2 weeks of delivery by a midwife at community level. Almost 100% of births are attended to by trained and skilled health staff in **Mauritius** and **Seychelles** (Chart 8), and all maternal deaths are investigated and recommendations are made to prevent any such death. In **South Africa**, the National Committee for Confidential Enquiry into Maternal Deaths was initiated in 1998 to investigate the causes of maternal mortality and offers recommendations for reducing maternal mortality. **Rwanda** undertakes maternal death reviews in three forms: facility-based audits, verbal autopsies (community-based reviews) and confidential enquiries<sup>60</sup>. The use of drones is being tested for quick transportation of blood to health facilities in remote areas; blood loss is the leading cause of death for pregnant women. In **South Africa**, 2, 967 doctors and 6, 776 professional nurses have been trained in the management of obstetric haemorrhaging in particular which continues to be a major cause of maternal mortality.

<sup>60</sup> *Ibid.*

**Strengthen health systems to respond to the needs and priorities of women and girls.** In **Mauritius** and **Seychelles**, almost 100% of births are attended to by trained and skilled health staff. **Niger** and **Rwanda** recruited community health workers and trained them to provide essential health services at the village level. In **Rwanda**, there is a single integrated monitoring and evaluation framework for maternal and child health services (see Box 7). Nationwide Internet access and rapid SMS technology was developed to facilitate communication between the different stakeholders in the community health system.

**Ensure accountability to improve quality of care and equity.** In **Rwanda**, health facilities and community health workers are rewarded financially based on a number of indicators (see Box 7). Each pregnancy is registered, the parents educated, and the couple urged to seek prenatal, safe delivery, and postnatal care and family planning services, including effective engagement with community health workers. Various community committees verify health facility activity reports and provide feedback on health service provision<sup>61</sup>. In **South Africa**, the National Committee for Confidential Enquiry into Maternal Deaths produces regular *Saving Mothers* reports on the causes of maternal deaths and recommendations for their reduction.

[To update] Table A2 shows that in general countries score themselves highly for policy commitment, development of a plan, targets, institutional mechanism and involvement of civil society in reducing maternal mortality. Law, budget and human resources are weak areas. In general, there is a fairly strong correlation between the AWPS scores and the maternal mortality ratio, with **Seychelles** and **Mauritius** scoring very high and **Sierra Leone** having the lowest AWPS score with 50 percent.

## Family planning

States Parties shall ensure that women have “the right to control their fertility; the right to decide whether to have children, the number of children and the spacing of children; the right to choose any method of contraception; ... the right to have family planning education”<sup>62</sup> [*Protocol to the African Charter on Human and Peoples’ Rights of Women in Africa*]

Access to family planning services is important in fertility planning, the prevention of childhood and maternal mortality and mother-to-child transmission of HIV, reducing the risk of HIV infections, unwanted pregnancies and the number of unsafe abortions, and improving women’s educational and economic prospects. This is especially important for adolescent girls who face increased risks of death in childbearing, their children are at higher risks of dying in childhood, and along with young women, face a higher risk of being infected with HIV.

[To update] As with their achievement in meeting commitments on maternal mortality, countries score themselves highly on policy commitment, development of a plan, targets, institutional mechanism and involvement of civil society in providing quality family planning services (Table A3). Weak areas were law, budget, human resources, capacity enhancement and accountability/transparency. **Mauritius** and **Seychelles** scored themselves 100 percent, while **Sierra Leone** and **South Africa** scored themselves less than 60 percent. Box 8 highlights the evolution of family planning policies of **Mauritius**.

### BOX 8 FAMILY PLANNING POLICIES IN MAURITIUS

Mauritius was one of the first countries in Africa to formulate a population policy in the early 1970s. At first, however, in part because of the religious diversity of the population, the government decided not to become directly involved in family planning activities but rather to encourage private, voluntary organizations to promote family planning. The Mauritius Family Planning and Welfare Association (MFPWA), which was established in 1957,

<sup>61</sup> Ministry of Health [Rwanda] et al.

<sup>62</sup> African Union (2003: Article 14 (1)(a), (b), (c) and (f)).



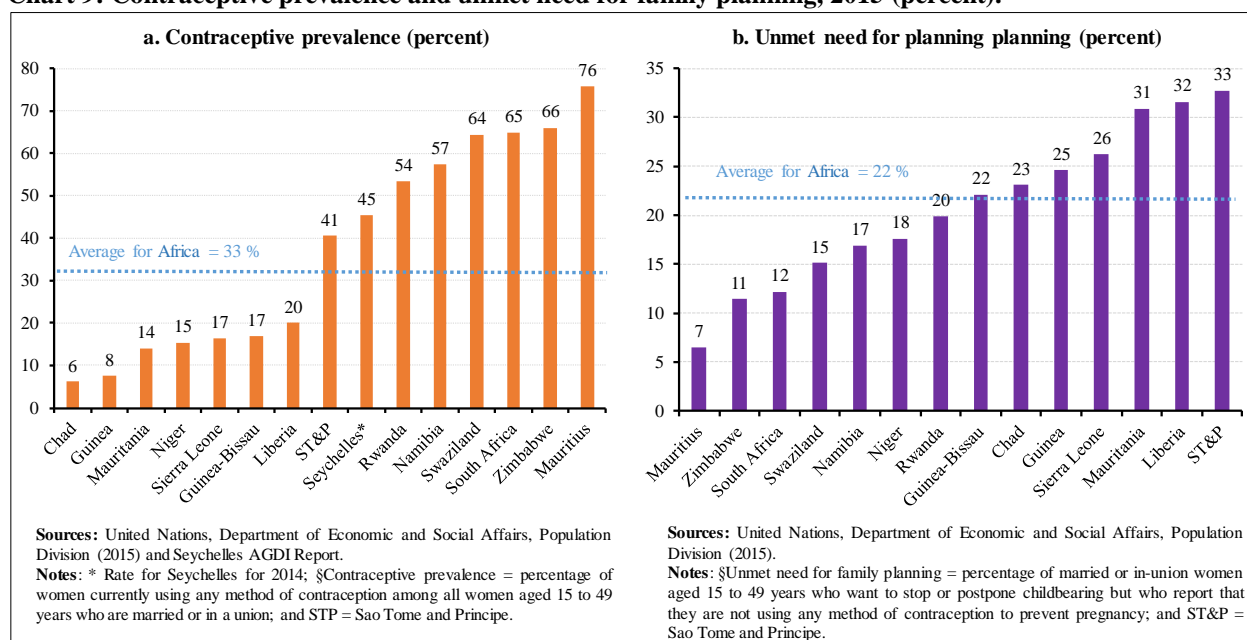
introduced contraception in 1958. In addition, a private Catholic organization, *Action Familiale*, was established in 1962 to encourage the use of natural family planning methods only. MFPWA was given official status through in 1967 and, in 1969, the government established nationwide family planning services. In 1972, the MFPWA was absorbed by government and the family planning programme was integrated into the state maternal and child health programme.

The results of the programme have been significant. Fertility has declined by about two thirds and is currently below replacement level, whereas the total fertility rate in the early 1970s was about 6.0 children per woman. Several factors have contributed to this rapid fertility decline. The small size of the country rendered the issue of overcrowding a threat to economic and social stability. Moreover, private family planning agencies and then public agencies conducted widespread campaigns, influencing public opinion through the press and other media. Mauritius currently has the highest contraceptive prevalence rate in Africa.

**Source:** Mauritius AGDI report.

At 33 percent, the contraceptive prevalence or the proportion of women of reproductive age who were married or in a union using any method of contraception in Africa in 2015 was the lowest of all regions<sup>63</sup>. The rate was 17 percent and 23 percent in Western Africa and Central Africa respectively. This situation is paralleled by the high level of unmet need for family planning for the region: an estimated 22 percent of African women of reproductive age who want to stop or postpone childbearing re not using any method of contraception<sup>64</sup>.

**Chart 9: Contraceptive prevalence and unmet need for family planning, 2015 (percent).**



Contraceptive prevalence for the countries covered by the report from **Central and West Africa** have rates below the rate for Africa as a whole (Chart 9a). **Rwanda**, the **Small Island Developing States** and **Southern African countries** all have prevalence rates above the African average, with **Mauritius** recording a high of 76 percent. **Mauritius**, the **4 Southern African countries**, and **Niger** have unmet need for family planning below the average for Africa (Chart 9b). The countries from **Central and West Africa** – except **Niger** – have unmet need for family planning above the Africa average, with **Sao Tome and Principe** with the highest rate at 33 percent.

<sup>63</sup> United Nations, Department of Economic and Social Affairs, Population Division (2015).

<sup>64</sup> *Ibid.*



Even if all the countries covered by this report has policies to reduce adolescent fertility in 2013<sup>65</sup>, adolescent girls often face significant barriers to access and use sexual and reproductive information, goods and services. The chief barriers include laws and policies that place age restrictions on access to sexual and reproductive health services, social norms that hinder their ability to seek information about their sexual and reproductive health, early marriage and sexual coercion and violence<sup>66</sup>. In **South Africa** youths below the age of 12 years need their parents' consent to access sexual and reproductive health services; the corresponding age for **Swaziland** and **Zimbabwe** is 16 years<sup>67</sup>, and 18 years for **Seychelles**<sup>68</sup>. Barriers to access sexual and reproductive information, goods and services contribute to an increase in teenage pregnancies. Table 3 shows that the percentage of girls between the age of 15 and 19 have begun childbearing in **Chad, Guinea, Liberia** and **Niger** were above 30 percent.

**Table 3: Percentage of adolescent girls age 15-19 years who have begun childbearing, 2006-2016 (%).**

Less than 10%	Between 10-20%	Between 20-30%	Between 30-40%	More than 40%
Rwanda: 7.3 %	South Africa: 15.6% Namibia: 18.6%	Swaziland: 22.6% Sao-Tome and Principe: 22.8% Sierra Leone: 27.9%	Liberia: 31.3% Guinea: 34.3% Chad: 37.7%	Niger: 40.4%

Source: Demographic and Health Surveys (various years).

As with access to HIV services discussed above, an important gender issue regarding family planning services is that men are less likely to access services compared to women. As discussed in the **Rwanda** AGDI report, this can be partly explained by gender norms that perceive men that are concerned about their health as weak. A study undertaken in **Swaziland** reported that men indicated a lack of privacy and confidentiality as barriers to accessing sexual and reproductive services especially if the provider was a young female<sup>69</sup>.

## Safe abortions

“State Parties shall take appropriate measures to protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus<sup>70</sup> [*Protocol to the African Charter on Human and Peoples' Rights of Women in Africa*]

Ensuring universal access to sexual and reproductive health-care services, including for contraceptive services would help women to avoid unintended pregnancies and the need for abortion. However, given that no contraception method is 100 percent effective and that women may not want to carry a pregnancy to term as is the case of rape, women require access to safe abortion services<sup>71</sup>. Otherwise seeking abortion may resort to unsafe procedures that put them at risk of physical harm.

Guaranteeing safe abortions is in line with the *Protocol to the African Charter on Human and Peoples' Rights of Women in Africa* (the Maputo Protocol). **Chad, Mauritius, Niger, Sao Tome and Principe** and **Sierra Leone** have not ratified the Maputo Protocol (see Table 1 in the section on women's rights). Table 4 shows the legal grounds on which abortion is permitted in the 15 countries covered by the report in 2017.

<sup>65</sup> United Nations, Department of Economic and Social Affairs, Population Division (2014).

<sup>66</sup> UNOHCHR (no date) and Chandra-Mouli et al. (2017).

<sup>67</sup> UNFPA (no date).

<sup>68</sup> Seychelles AGDI Report.

<sup>69</sup> Integra (2014).

<sup>70</sup> African Union (2003: Article 14 (2)(c)).

<sup>71</sup> WHO (2012).

**Table 4: Legal grounds on which abortion is permitted, 2017.**

	On request	Economic or social reasons	Foetal impairment	Rape	Incest	Intellectual or cognitive disability of the woman	Mental health	Physical health	Health	Life
Chad	✗	✗	✓	✗	✗	✗	✗	✗	✓	✓
Guinea	✗	✗	✓	✓	✓	✗	✗	✗	✗	✓
Guinea-Bissau	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Liberia	<i>i</i>	<i>i</i>	✓	✓	✓	<i>i</i>	✓	✓	<i>i</i>	<i>i</i>
Mauritania	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Mauritius	✗	✗	✓	✓	✗	✗	✓	✓	✗	✓
Namibia	✗	✗	✓	✓	✓	✓	✓	✓	✗	✓
Niger	✗	✗	✓	✗	✗	✗	✗	✗	✓	✓
Rwanda	✗	✗	✓	✓	✓	✗	✗	✗	✓	✓
Sao Tome and Principe	✓	✗	✓	✓	✓	✗	✓	✓	✗	✓
Seychelles	<i>i</i>	<i>i</i>	✓	✓	✓	✓	✓	✓	<i>i</i>	✓
Sierra Leone	<i>i</i>	<i>i</i>	<i>i</i>	<i>i</i>	<i>i</i>	<i>i</i>	<i>i</i>	<i>i</i>	<i>i</i>	<i>i</i>
South Africa	✓	✓	✓	✓	✓	✓	✓	✓	<i>i</i>	✓
Swaziland	✗	✗	✓	✓	✓	✗	✓	✓	✗	✓
Zimbabwe	✗	✗	✓	✓	✓	✗	✗	✓	✗	✓

Source: UNDESA and WHO Global Abortion Policies Database (2017).

Notes: A tick (✓) indicates that abortion is permitted. A cross (✗) indicates that abortion is not permitted on that specific ground. *i* means no explicit reference to an issue. ST&P = Sao Tome and Principe.

**Guinea-Bissau** and **Mauritania** do not permit abortion under any circumstances (Table 4). All other countries permit abortion if the continuation of pregnancy will seriously affect the health of the unborn baby and the life of the mother. **Chad** and **Niger** do not permit abortion in the case of both rape and incest. **Chad**, **Guinea**, **Niger** and **Rwanda** do not permit abortion to preserve both a woman's physical and mental health. **Sao Tome and Principe** and **South Africa** allow abortion upon request. In **South Africa**, the *Choice on Termination of Pregnancy Act*, 1996 allows abortion on demand up to the 12<sup>th</sup> week of pregnancy, under broadly specified circumstances from the 13<sup>th</sup> to the 20<sup>th</sup> week, and only for serious medical reasons after that.

[To update] Providing safe abortions is the area among the four in this section where countries scored themselves worse in general. In particular, **Niger**, **Guinea** and **Sierra Leone** scored less than 50 percent with **Niger** scoring 0 in all areas (Table A4). **Seychelles** and **Mauritius** scored themselves very high for safe abortions. In general, countries scored themselves relatively high for law, policy commitment and institutional mechanisms and relatively low on budget, targets and research. Box 9 highlights the concluding observations issued by three treaty bodies from 2013 to 2017 regarding the policies on unsafe abortions of the countries covered by this report.

#### BOX 9 CONCLUDING OBSERVATIONS ISSUED BY TREATY BODIES RELATED TO ABORTION, 2013-2017

**Mauritania** (CEDAW, 2014): “[T]he Committee is concerned that abortion is criminalized in the State party, even in cases of incest, rape and severe foetal impairment”.

**Namibia** (CEDAW, 2015): “The Committee remains concerned ... at the high prevalence of HIV/AIDS and unsafe abortions, which have contributed to the increase in the maternal mortality ratio in the State party. The Committee is particularly concerned that, while abortion is permissible on prescribed grounds such as rape, incest, threat to the

health and life of the pregnant woman and foetal malformation, pursuant to the Abortion and Sterilization Act of 1975, women still undergo complex and onerous administrative procedures to obtain approval for abortion.”

**Rwanda** (CRC, 2017): “The Committee (...) is also concerned that: (a) Maternal mortality is further exacerbated by unsafe abortions, to which many women must resort due to the criminalization of abortion and its legalization under restrictive exceptions only, with particularly cumbersome requirements, namely a court order in cases of rape, incest or forced marriage and the authorization of two doctors, if the health of the pregnant woman or the foetus is in danger, which in practice render legal abortion inaccessible; (b) An alarming number of women are serving prison sentences for abortion, many of whom were arrested when seeking emergency health care following abortion complications”.

**Seychelles** (CEDAW, 2013): “[T]he Committee is concerned about ... the increase in the number of unsafe abortions and the provision, in the Penal Code, of heavy sanctions in case of illegal abortion”.

**Sierra Leone** (CEDAW, 2014): “The Committee ... notes with concern: (...) (d) The fact that the law on abortion criminalizes the procedure without providing any exception, the high incidence of sexual violence and unwanted pregnancies resulting in unsafe abortions, which account for 13 per cent of maternal mortality, and delays in adopting the abortion bill, which decriminalizes the termination of pregnancy based on various socioeconomic grounds”.

**South Africa** (HRC, 2016): “The Committee welcomes the following legislative and institutional measures taken by the State party: [...] (f) The passing of the Choice on Termination of Pregnancy Act in 1996 and other measures designed to increase access to safe abortion resulting in a significant decrease in maternal mortality and morbidity.”

**Swaziland** (CEDAW, 2014): “The Committee remains concerned, however, at the high prevalence of HIV/AIDS and of clandestine abortions, which have contributed to the increase in maternal mortality in recent years. The Committee calls upon the State party: (...) (b) To step up efforts to reduce the incidence of maternal mortality, such as providing safe abortion and post-abortion care services.”

**Zimbabwe** (CRC, 2016): “[T]he Committee is ... extremely concerned about: [...] (c) The restrictive abortion law and the lengthy procedures for authorizing abortions, which result in illegal and unsafe abortions”.

**Source:** UNDESA and WHO Global Abortion Policies Database (2017).

**Notes:** CEDAW = Committee on the Elimination of Discrimination against Women; CRC = Committee on the Rights of the Child; and HRC = Human Rights Council.

# ANNEX

**Table A1: Scores for HIV/AIDS.**

	Law	Policy commitment	Development of a plan	Targets	Institutional	Budget	Human resources	Research	Involvement of civil society	Information and dissemination	Monitoring and evaluation	Capacity enhancement	Accountability/ transparency	Total	Maximum score	Percentage (%)
Chad															26	
Guinea	2	2	2	2	2	2	2	1	2	2	2	2	2	25	26	96
Guinea-Bissau															26	
Liberia															26	
Mauritania															26	
Mauritius	2	2	2	2	2	2	2	2	2	2	2	2	2	26	26	100
Namibia	2	2	2	2	2	1	1	1	2	2	1	1	2	21	26	81
Niger	2	2	2	2	1	2	2	2	1	2	2	2	1	23	26	88
Rwanda	0	2	2	2	2	2	1	2	2	2	2	1	2	22	26	85
Sao Tome and Principe															26	
Seychelles	2	2	2	2	2	2	2	2	2	2	2	2	2	26	26	100
Sierra Leone	1	1	1	1	1	1	1	1	1	1	1	1	1	13	26	50
South Africa	1	1	2	2	1	1	1	2	2	1	2	1	1	18	26	69
Swaziland	1	2	2	2	1	1	1	1	2	2	2	1	2	20	26	77
Zimbabwe															26	

Source: AGDI National Reports.

**Table A2: Scores for maternal mortality.**

	Law	Policy commitment	Development of a plan	Targets	Institutional	Budget	Human resources	Research	Involvement of civil society	Information and dissemination	Monitoring and evaluation	Capacity enhancement	Accountability/ transparency	Total	Maximum score	Percentage (%)
Chad															26	
Guinea	1	1	2	2	2	1	2	1	2	1	1	1	1	18	26	69
Guinea-Bissau															26	
Liberia															26	
Mauritania															26	
Mauritius	0	2	2	2	2	2	2	2	2	2	2	2	2	24	26	92
Namibia	2	2	2	2	2	1	1	2	2	1	1	2	2	22	26	85
Niger	2	2	2	2	1	1	1	1	1	1	2	1	1	18	26	69
Rwanda	0	2	2	2	2	2	1	2	2	2	2	1	2	22	26	85
Sao Tome and Principe															26	
Seychelles	2	2	2	2	2	2	2	2	2	2	2	2	2	26	26	100
Sierra Leone	1	1	1	1	1	1	1	1	2	1	1	1	1	14	26	54
South Africa	1	2	2	1	2	1	1	2	2	1	2	2	1	20	26	77
Swaziland	2	2	2	2	2	1	1	1	2	2	2	1	1	21	26	81
Zimbabwe															26	

Source: AGDI National Reports.

**Table A3: Scores for family planning.**

	Law	Policy commitment	Development of a plan	Targets	Institutional	Budget	Human resources	Research	Involvement of civil society	Information and dissemination	Monitoring and evaluation	Capacity enhancement	Accountability/ transparency	Total	Maximum score	Percentage (%)
Chad															26	
Guinea	1	1	1	2	2	1	2	1	2	2	1	1	1	18	26	69
Guinea-Bissau															26	
Liberia															26	
Mauritania															26	
Mauritius	2	2	2	2	2	2	2	2	2	2	2	2	2	26	26	100
Namibia	2	2	2	2	2	1	1	2	2	1	1	1	1	20	26	77
Niger	2	2	2	2	1	1	1	1	1	1	2	1	1	18	26	69
Rwanda	0	2	2	2	2	2	1	2	2	2	2	1	2	22	26	85
Sao Tome and Principe															26	
Seychelles	2	2	2	2	2	2	2	2	2	2	2	2	2	26	26	100
Sierra Leone	1	1	1	1	1	1	1	1	2	1	1	1	1	14	26	54
South Africa	1	2	2	1	1	1	1	1	1	1	1	1	1	15	26	58
Swaziland	1	2	2	2	2	1	1	1	2	2	2	1	1	20	26	77
Zimbabwe															26	

**Source:** AGDI National Reports.**Table A4: Scores for safe abortions.**

	Law	Policy commitment	Development of a plan	Targets	Institutional	Budget	Human resources	Research	Involvement of civil society	Information and dissemination	Monitoring and evaluation	Capacity enhancement	Accountability/ transparency	Total	Maximum score	Percentage (%)
Chad																
Guinea	1	1	0	1	1	0	1	0	1	1	1	1	1	10	26	38
Guinea-Bissau															26	
Liberia															26	
Mauritania															26	
Mauritius	2	2	1	1	2	2	2	2	2	2	2	2	2	24	26	92
Namibia	2	2	2	2	2	1	1	2	1	1	1	1	1	19	26	73
Niger	0	0	0	0	0	0	0	0	0	0	0	0	0	0	26	0
Rwanda	2	1	2	0	2	1	1	0	0	2	2	1	2	18	26	69
Sao Tome and Principe															26	
Seychelles	2	2	2	2	2	2	2	2	2	2	2	2	2	26	26	100
Sierra Leone	1	1	1	1	1	0	1	1	2	1	0	1	1	12	26	46
South Africa	2	2	1	1	1	1	1	1	2	1	1	2	1	17	26	65
Swaziland	2	2	2	1	2	1	1	1	1	2	2	2	1	20	26	77
Zimbabwe															26	

**Source:** AGDI National Reports.

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