Chapter 2:
The health status of women in the African Region: from birth to the onset of sexual activity

An unacceptably heavy burden of disease and death at all stages of the life course

Women living in the African Region face a daunting range of threats to their health throughout their lives. Given the importance of the mother's health for the foetus she carries, it is clear that for the growing infant, whether a girl or a boy, the challenges begin at the moment of conception. If a mother is malnourished, her child is more likely to suffer growth retardation in the uterus and to be born undersize and underweight. This in turn increases the chances of the baby dying in the first few days of life. Even for children who survive, this has consequences for their subsequent development. Of the 40 countries worldwide reporting child stunting prevalence of 40% or more, 23 are in Africa.[1]

The hazards of childhood

Where the child survives birth, whether girl or boy, he or she is exposed to the same environmental and social challenges with similar health outcomes during infancy. The child will depend on its mother for food. Breast milk is the ideal food for newborns and infants, it improves their health and chances of survival. The African Region is characterized by generally low rates of exclusive breastfeeding (31%),[2] complementary feeding is untimely and foods are nutritionally inadequate and unsafe. The contamination of complementary food, including infant "formula" and the water with which it is mixed, is estimated to cause up to five episodes of diarrhoea per child per year in the Region,[3] and each episode exposes the child to the risk of dehydration and death. Oral rehydration therapy (ORT), the simplest treatment for diarrhoea and also the most effective, should be within reach of all including the poorest of mothers. However, only 37% of children in the Region receive it, mothers often preferring to treat diarrhoea with substances and medicines unsuited for the purpose, most notably antibiotics.

For mothers living with HIV, there is another source of confusion because of the belief that the risk of transmission makes breastfeeding too dangerous. Recent research evidence, however, shows that providing antiretroviral (ARV) interventions to either the HIV-infected mother or the HIV-exposed infant can reduce the risk of postnatal transmission of HIV through breastfeeding to less than 2%.[4] Even in the absence of ARV interventions exclusive breastfeeding carries a lower risk of transmission than mixed feeding.[5] The greatest declines in breastfeeding have taken place in countries where there has been extensive distribution of food aid – South Africa being a prime example.

Low breastfeeding rates – the South African experience

In South Africa, 20% of infants under the age of three months are not breastfed at all, making it a country with one of the highest rates of non-breastfeeding in sub-Saharan Africa. This situation has arisen partly as a result of lack of health workers with the skills needed to offer good counselling and support when problems arise, as they often do; breastfeeding may be natural, but is not always simple. Too often mothers are told to stop breastfeeding altogether and to give artificial substitutes. This advice is even more likely to be given where representatives of formula companies, in violation of the International Code of Marketing of Breast-milk Substitutes, engage with health workers to promote the sale and use of their products. Furthermore, food, including infant formula, was also distributed to prevent the transmission of HIV from mother-to-child, an initiative which inevitably undermined breastfeeding, including among mothers not infected with HIV.[6]

Unfortunately formula milk is not a sterile product and is easily contaminated. Most children born of HIV-infected mothers and raised on formula die not from HIV but from undernourishment, diarrhoea and other non-HIV-related ailments.[4]

Diarrhoea is closely followed by malaria as a cause of premature death in girls aged 0–4 years (see **Figure 2.1**); malaria being responsible for 16% of under-five deaths in the African Region, compared to a 7% average globally. Malaria is also an indirect cause of maternal mortality as discussed below, and contributes to stillbirth, premature delivery and low birth weight.[5]

Because of the infant's dependence on the mother, the mother's health is also a measure of the child's health. Indeed in the case of mothers living with HIV, the mother herself represents a direct threat. Mother-to-child transmission (MTCT) is a significant risk in sub-Saharan Africa. In 2009 MTCT occurred in an estimated 370 000 live births.[7] Indeed almost all HIV infections in children are the result of infection from the mother. In 2009 alone, of all new HIV infections among children worldwide, 91% occurred in the African Region.[1]

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Fortunately, this is an area where some progress is being made. So far 43 countries in the Region have implemented programmes for the prevention of mother-to-child transmission (PMTCT) of HIV. The percentage of pregnant women living with HIV who received ARV interventions for PMTCT of HIV in sub-Saharan Africa increased from 15% in 2005 to 45% in 2008 and 54% in 2009. Most of this progress has been made in East and Southern Africa where HIV prevalence is highest.

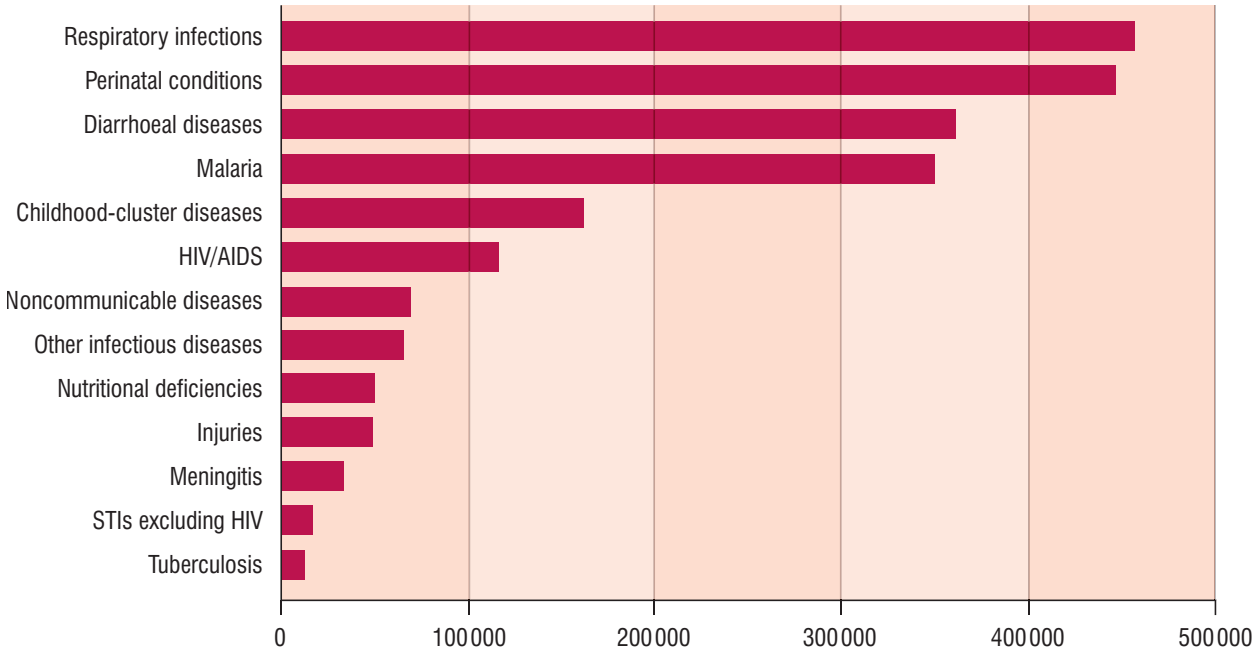
Even without the threat of infection or the challenge posed by being born undernourished and underweight, birth itself exposes the child, whether a girl or a boy, to the danger of asphyxiation and trauma – risks that increase dramatically if the mother is denied access to appropriate care administered by skilled birth attendants. Unfortunately this is too often the case in the Region. In general,

coverage of skilled birth attendance in the Region remains low at around 47%, although rates vary widely among African countries. For the Region as a whole, perinatal conditions such as asphyxiation and trauma are the second leading cause of premature death and disability among children under-five years after acute respiratory infections, mainly pneumonia, and account for about one in five deaths in this age group.[8,9]

Given the range of adversity with which the child must cope, it is perhaps not surprising that under-five mortality in the African Region remains the highest in the world, despite its decrease from 172 per 1000 in 1990 to 119 per 1000 in 2010. Over the same period the global average rate fell from 88 per 1000 to 57 per 1000.[10]

Child mortality in the Region has been declining at an average rate of 1.2% per year between 1990 and 2000, and 2.4% between 2000 and 2010 compared to the required decrease of 8% in order to meet MDG 4 by 2015. That requirement is unlikely to be met without a massive increase in investment over the next four years. Eight countries are on track to achieve this target; 27 countries are making progress, although it is insufficient; and 12 countries have made no progress.[11] Algeria, Cape Verde, Eritrea, Liberia, Madagascar, Malawi, Mauritius and Seychelles are all estimated to be on track.

Figure 2.1 The main causes of death in the African Region, females 0–4 years in 2004



Source: Constructed from World Health Organization, GBD 2004 Summary Tables, Health Statistics and Informatics Department, World Health Organization, Geneva, Switzerland, October 2008.

As the girl child in the African Region grows she must cope with challenges comparable to those faced by her male siblings especially exposure to malaria and malnutrition. In some settings, especially matrilineal societies and some bilinear societies with a strong matrilineal historical background, girls are actually given preferential treatment when it comes to feeding. This is true of the Wolofs of West Africa who believe that a girl child brings luck to the family particularly if she is the

first born. However, generally speaking, there is a marked preference for boys in the Region typically in some ethnic groups in Nigeria where, according to some studies, boys are better fed than girls because of their belief that the survival of the lineage depends on the male.[12,13] Some cultures also maintain food consumption hierarchies in which women are at the bottom of the pecking order. The past two decades have seen no change in the percentage of children suffering from malnutrition in the Region and an estimated 30 000–50 000 children die as a result each year.

Unsafe drinking water and poor sanitation pose another threat and many waterborne pathogens cause diseases such as diarrhoea, which is one of the leading child killers in the Region. The percentage of the world's population using "improved" drinking water sources increased from 77% to 87% between 1990 and 2008, a rate sufficient to achieve the MDG 7 target globally. However, in the African Region, despite the increase in the percentage from 50% in 1990 to 61% in 2008, it still falls short of the MDG 7 target and the percentage of the population using improved sanitation facilities is increasing too slowly – from 30% in 1990 to 34% in 2008.[2]

The challenges of childhood and adolescence

After the hardships of early childhood, the African girl actually starts to face the challenges that will distinguish her from her male siblings for the rest of her life as she begins to approach womanhood and starts sexual activity. Early in this period, the girl child begins to suffer the gender discrimination that is one of the socioeconomic determinants so crucial to women's health outcomes. From the earliest years the girl is likely to be assigned day-to-day housework such as cleaning, washing, fetching of water and fuel, and food processing and cooking.

In many settings girls are involved in household chores as soon as they are physically capable. They are given tasks outside the home, such as going to market to sell or trade food and goods. Should the mother die or become disabled through illness, the burden of the household work often falls on daughters who may also be given the responsibility of caring for the elderly or the mentally ill. Obviously, such work often jeopardizes girls' schooling.

As already noted in Chapter 1 there is evidence of correlation between the education and health status of girls. For example, several studies on HIV/AIDS undertaken by Jean Vandemoortele and Enrique Delamonica in Zambia[14] found that HIV/AIDS spread faster among uneducated girls compared to educated girls.[15] While there is no clear causal relationship, available data and information show that in Africa the education of girls works at a number of levels that are beneficial to the health of girls and the health of the women they later become. This is notably the case with issues of social empowerment where education can enhance young women's negotiating position with regard to sex. In Kenya, girls who stay in school have been shown to be more likely to postpone their sexual debut than those who drop out of school.[15]

In the African Region as a whole illiteracy among adults remains high and sub-Saharan Africa has the lowest ratio of female to male adult literacy worldwide apart from South Asia. It also has the lowest percentage of female youth literacy, the lowest primary school enrolment ratio and the lowest primary school attendance ratio. When it comes to secondary education, the gap compared with the rest of the world, including South Asia, really increases: in the period from 2000 to 2007 net secondary school attendance for girls in sub-Saharan Africa was 22%, compared with 43% for South Asia (see **Table 2.1**).

Table 2.1 Educational attainment of females in Africa relative to other world regions, 2000–2007

Region and subregions	Adult literacy rate: females as a % of males	Youth (15–24 yrs) literacy rate		Primary school				Secondary school			
				Enrolment ratio		Attendance ratio		Enrolment ratio		Attendance ratio	
		M	F	M	F	M	F	M	F	M	F
Sub-Saharan Africa	75	77	68	75	70	64	61	28	24	26	22
Eastern and Southern Africa	79	78	69	83	81	66	66	30	27	20	18
West and Central Africa	72	77	66	67	58	63	56	26	20	31	26
Middle East and North Africa	78	93	85	86	81	88	85	67	62	54	52
South Asia	71	84	74	88	83	81	77	–	–	51	43
East Asia and Pacific	93	98	98	98	97	92	92	60	62	60	63
Latin America and Caribbean	99	97	97	94	95	90	91	69	74	–	–
CEE/CIS*	97	99	99	92	90	93	91	79	75	79	76

*Central and Eastern Europe and the Commonwealth of Independent States; M = male; F = female

Source: UNICEF. *Rapport sur la situation des enfants dans le monde.* New York: UNICEF; 2009.

“Societies limiting girls’ access to education pay a huge price...”

Furthermore, girls are excluded from education for other reasons including inability of families to pay school fees, and familial preference to commit resources to the education of sons. Early marriage can also be a factor as well as school environments that are not designed to cater for girls’ physical needs, e.g. absence of toilet facilities specifically designed for girls.[16,17] Societies limiting girls’ access to education pay a huge price not only in terms of the obvious economic burden imposed by the relatively poor health of adult women later in life, but also in terms of the attendant loss of economic development as roughly 50% of the population is excluded from professional advancement. The latter part of this terrible equation cannot be overstated and will be discussed further in Chapter 5.

Just as girls often experience cultural pressure to do domestic tasks, so are they prepared for their role as bearers of children. In some countries this preparation finds expression in ritual practices some of which are harmful. Female genital mutilation (FGM), which involves partial or total removal of the female external genitalia by cutting, burning or scraping,[18] is inflicted on more than two million girls between the ages of four and twelve, notably in Ethiopia, Kenya, Nigeria and Uganda. Meanwhile roughly 92 million females above the age of ten are thought to be living with the indignity and pain of genital mutilation, more than 12 million of whom are girls between the ages of 10 and 14.[19] Female genital mutilation is

indeed harmful to the health of women, the psychological and physical trauma often being accompanied by profuse bleeding, wound sepsis, HIV infection and, subsequently, complications of childbirth. It is a condemnable human rights violation warranting prosecution.

Many sub-Saharan African countries including Benin, Burkina Faso, Ghana, Senegal, Tanzania and Uganda have passed laws penalizing the practice, but laws alone have seldom led to sustainable behavioural change. People – women as well as men – continue to mutilate young women in spite of the law or simply cross the border to perform the procedure beyond the reach of the judicial authorities. There is also evidence that the procedure is sometimes "medicalized" in order to circumvent the law and that an increasing number of girls are being mutilated before the age of five.

Female genital mutilation elimination efforts have been most successful when made jointly and in partnership with the perpetrators, i.e. the custodians of such traditions. For example, since 1993, *Maendeleo Ya Wanawake* Organization (MYWO) of Kenya in collaboration with an NGO (PATH) has worked with traditional leaders to persuade communities to replace the traditional cutting ceremonies with symbolic gift giving, while preserving other aspects of the traditional rite of passage. The number of girls participating in this alternative ceremony thus grew from 79 in 1996 to over 1000 in 1998.[20] As horrifying as FGM may be, the good news is that, it is not part of every African girl's experience.

Unfortunately, violence against girls in this age group is relatively common, often linked to forms of sexual predation. Indeed sexual coercion and sexual violence are prevalent in many African countries and affect girls from an early age as evidenced by data on early unplanned pregnancies.[21,22] This violence becomes more acute in crisis situations such as natural disasters or armed conflicts when girl children and adolescents are most vulnerable. Unfortunately, such situations abound in the Region and Africa has one of the highest burdens of internally displaced people in the world. Such movements of displaced people are also commonly associated with human trafficking, especially of young girls. Roughly 80% of the victims of trafficking are women and children and 43% of them are sexually exploited and otherwise oppressed.[23]

Young women in conflict situations

The collapse of social structures resulting from protracted conflicts exposes children of both sexes to a range of health risks from cholera to malnutrition and from deliberate mutilation to sexual abuse. According to Pernille Ironside, a child protection specialist working with UNICEF, 'most' of the girls returning from conflict zones have experienced extensive sexual violence which she describes as systematic rape often accompanied by mutilation over extended periods, sometimes years. According to the United Nations, between June 2007 and June 2008, in Ituri province in eastern Democratic Republic of Congo, 6766 cases of rape were reported – a number which probably represents only a fraction of the assaults actually taking place in that province. Of these reported cases, 43% involved children, mostly girls.

The psychological trauma resulting from these experiences is accompanied by an elevated risk of sexually transmitted infections particularly HIV/AIDS. Traumatic fistula, the rupturing of tissues caused by violent sexual assault, is also widely reported as is obstetric fistula.

“...more than half of all maternal deaths occur in women between 16 and 19 years, and this age group also bears the greatest burden of disease due to violence.”

In the African Region, the onset of sexual activity, an activity largely considered as one of the richest, life-affirming human experiences is too often a source of misery, death and disease. Among young women aged between 16 and 19 years HIV/AIDS accounts for almost a third of deaths, while complications of pregnancy and childbirth account for 28%. It is also worth noting that more than half of all maternal deaths occur in this age group which also bears the greatest burden of disease due to violence.

In some settings the onset of sexual activity happens remarkably early. In Lusaka, for example, one study revealed that 16% of all deliveries were by girls aged 12–19 years.[24] The same study showed that 10% of all patients undergoing manual vacuum aspiration due to abortion-related complications were between 12 and 19 years old. Moreover, among the women hospitalized in Lusaka University Teaching Hospital for abortion-related complications, 60% were aged between 15 and 19 years.

For African girls who, for various reasons, decide not to carry their baby to term, there is the danger of unsafe abortion which accounted for 35 592 deaths in the African Region in 2004 and is thought to be increasing, particularly among unmarried young women in urban areas.[25] The prevalence of unplanned pregnancies will predictably increase in sub-Saharan Africa over the next few decades, driven by the problems of early sexual activity and low use of contraception.[25]

The challenges relating to reproductive health in the Region will be further addressed in detail in the next chapter which details the reproductive years.

Key considerations and points for action

a) Addressing the many health challenges faced by young women in sub-Saharan Africa in their early years requires a multisectoral approach.
b) Gender discrimination begins at an early age with young girls being forced to take responsibility for household work which is often a hindrance to their education.
c) Education, associated with better health outcomes, has a number of other beneficial effects.
d) Violence against young women is widespread particularly in conflict situations and is often a part of sexual coercion. In some cases violence is expressed in harmful practices such as female genital mutilation.
e) The onset of sexual activity is associated with morbidity and mortality especially from HIV infection and maternal mortality.

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