Chapter 5:
The socioeconomic benefits of investing in women's health

The role of women goes beyond childbearing

Any country that limits women's contribution to society to only childbearing pays a heavy price in terms of its socioeconomic development. However, the fundamental importance of childbearing and child raising for development makes it an obvious place to start the analysis of the socioeconomic benefits of investing in women's health. Undertaking this analysis does not mean that the argument for investing in women's health is primarily utilitarian. As stated in Chapter 1, women's health is above all a human rights issue and should be supported and promoted as such but for policy makers faced with the reality of interministerial discussions, an awareness of the underlying economics of women's health in the Region may be considered valuable.

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In sub-Saharan Africa, as in every other region of the world, mothers are the primary caregivers of their children.

Older women, e.g., aunts or grandmothers, play important supporting roles, but it is the mother who shoulders most of the responsibilities and it is her health and her well-being that largely determines the health and well-being of her children.[1] Where the mother thrives the children are better fed and better educated. Where the mother becomes sick or even dies the children suffer. In sub-Saharan Africa, children who survive their mothers while being born have a vastly reduced chance of surviving their first year.[2] When a mother dies or has protracted illness, her children are likely to be sent into foster care where they may be exposed to serious health risks.[3,4]

Mothers not only care for their children by nurturing, feeding, bathing and clothing them, but also by protecting them. When they are in a position to do so, women also direct household resources to the care and upbringing of their children. Studies in a variety of low-income settings have shown that where women are income earners they are more likely than men to spend their earnings on goods and services that benefit the household, e.g., food, education and medicine.[5,6] If women borrow, the pattern is repeated as evidenced by research on microcredit showing that household consumption increases roughly two-fold when women borrow compared to when men borrow.[1]

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Borrowing by women has also been shown to have a greater positive impact on the children's nutrition.[7] Studies undertaken in Gambia and Rwanda show that in households led by women more calories are consumed per person per day than in households led by men. Meanwhile, women traders in Dakar and Bamako have been shown to spend more money than their male counterparts on food with high nutritive value for their families such as fish and fishery products, condiments, vegetables, and fruits, etc.[8] All these examples show that policies designed to boost women's income earning potential have a direct impact on children's health.

The presence of a mother can also have a significant positive impact on children's education.[9,10] A strong indicator of this is the drop in child school attendance that can follow the mother's death as suggested by a study undertaken in Tanzania. The study showed that where an adult woman had died within the past 12 months, children spent half as much time in school as did children from households where no such death had occurred or where rather an adult male had died.[11]

Clearly therefore, substantial socioeconomic benefits are derived if a mother stays healthy, while significant costs are incurred from her sickness or premature death. These costs are by no means limited to the family concerned as illustrated in **Table 5.1** showing a causal link traceable, for example, from the death of a mother to broader societal detriment across a range of variables. However, it is in the home that the emotional and financial implications of sickness and premature deaths are felt most directly. This is particularly the case in the context of health systems based on out-of-pocket payment, the predominant financing model in sub-Saharan Africa.

In Nigeria, for example, 70% of women with breast cancer or cervical cancer report significant loss of revenue resulting from their illness, 62% report their inability to work, while 33% report that their illness disrupted a relative's work. Studies have also shown that with cancers, even when treatment is provided free of charge or covered by health insurance, the financial burden can absorb up to 50% of the family's annual income.[11] This subject has been examined extensively in Chapter 3 and will not be rediscussed here, suffice it to recall that 90% of global financial catastrophe occurs in the Region where the borrowing and selling of assets to finance health care are common coping strategies.[12] It is also worth remembering that user fees are a particular problem for women in the African Region because they are often dependent financially on men.

Table 5.1 Potential adverse effects of maternal morbidity and mortality on children, families, households and society

Potential effects	On children	On families and households	On society
Demographic	Death	Loss of deceased Dissolution of family/household Increased number of orphans	Loss of deceased Increased number of one-parent households
Health	Illness Injury Malnutrition Poor hygiene	Reduced allocation of labour to health-maintaining activities Poor health for surviving household members	Reduction in the allocation of labour to health-maintaining activities
Economic	Increased child labour	Reduced productivity of ill adult Lost output of deceased adult Reallocation of land and labour Medical costs of treatment Loss of savings Changes in consumption and investment Funeral costs, legal fee Transfers Changes in household management	Reduced productivity of ill adult Lost output of deceased adult Reallocation of land and labour Loss of savings Changes in consumption and investment Transfers Economic burden of one-parent family
Psychological	Depression Other psychological problems	Depression Other psychological problems Grief of loved ones	Grief Loss of community cohesion
Social	Social isolation Reduced education Reduced parental supervision and care	Social isolation Changes in care for children, the elderly, and the disabled	Changes in responsibility for care of children, elderly, and disabled Loss of community/societal leaders Changes in women's right, heath policy, other public policy

Source: Koblinsky M, *et al.*,[13] quoted by Gill K, *et al.*[1]

While it is relatively easy to assess the impact of a mother's illness or death on a household, the impact on the broader economy is unclear and hard to assess given the lack of research in this area and the paucity of available data.

A growing literature exists illustrating the link between overall health and economic growth.[14–16] Unfortunately the impact of poor maternal health on economic growth remains largely unexamined.

Women's health and economic growth

In general terms, improvement in women's health increases productivity in two ways: (i) directly, such as through a reduction of days lost to sickness or disability; and (ii) indirectly, through lessening the need for informal care by family members and/or friends who may also be part of the labour force. Improved women's health can also free resources that can be used for child health care, education and feeding, contributing to an increase in future productivity.[17]

There is a large body of evidence of the positive impact of good health on economic performance.[15,18,19] The evidence is focused particularly on health indicators such as adult survival rates and their strong positive correlation with GDP growth.[19] An empirical study using data from 53 countries over the period 1965–1990 revealed that a percentage increase in average adult survival rate corresponded to an increase in income growth of 0.23% annually.[20]

Research has also shown that health enhances labour productivity and has a positive, sizable and statistically significant effect on aggregate output.[21] Other studies[18,21] indicate that countries that devote substantial resources to health and education experience higher growth rates. While pregnancy is obviously not a sickness, giving birth exposes women to health risks and high fertility has an impact on health in diverse ways as well as a significant economic impact. Research has shown that high fertility and poor maternal health are correlated and have an adverse impact on productivity. Furthermore, studies by Blackburn and Cipriani have shown that high fertility and mortality rates are both negatively related to per capita income.[22]

“While pregnancy is obviously not a sickness, giving birth exposes women to health risks and high fertility has an impact on health in diverse ways as well as a significant economic impact.”

Research has tended to be on the health of populations in general, rather than on women’s health in particular. Meanwhile, empirical evidence on the relationship between health and economic output in African countries is lacking. However, because women are the dominant source of farm labour, the economic benefits of improving women’s health in the Region would appear to be significant. Moreover, several studies suggest that poverty is more prevalent among female-headed households; therefore initiatives targeting women’s health would have a huge impact on overall poverty reduction.

Table 5.2 provides an indication of the economic cost of maternal mortality and presents the estimates of the Commission on Women’s Health in the African Region regarding loss of productivity per capita due to maternal death in the WHO African Region in 2008 International Dollar values. What is immediately striking is the wide range of losses incurred, with Angola suffering a loss of I$ 25.41 per citizen as a result of maternal death, compared with the relatively low I$ 0.54 loss incurred by Zimbabwe. In terms of the estimated total productivity loss, Nigeria carries the greatest economic burden, having lost over I$ 1.5 billion due to maternal mortality. For the Region as a whole the economic loss was I$ 6.85 per capita which, multiplied by the total population of the Region, implies a total economic loss of just under I$ 5.4 billion.

At the global level estimates by USAID suggest that the economic cost of maternal and newborn mortality is over US$ 15 billion annually in terms of lost potential productivity, of which roughly half is attributed to women and half to newborns.[23]

In sub-Saharan Africa, other estimates for four countries based on 2001 data indicate that the cost of total productivity loss per year associated with poor maternal, newborn and infant health ranges from around US$ 8 million in Mauritania to US$ 85 million in Uganda (using different assumptions, and adding household and health centre costs to such estimates, the annual cost of productivity loss in Uganda is closer to US$ 102 million) and US$ 95 million in Ethiopia.[24,25] Meanwhile per capita annual productivity losses are estimated to range from US$ 1.5 in Ethiopia to over US$ 3 in Uganda and Mauritania, and almost US$ 5 in Senegal.[26] At the regional level, Kirigia *et al.*[27] estimate that US$ 49 224 per annum is lost due to maternal mortality, as each maternal death is associated with a loss of about US$ 0.36 per year.

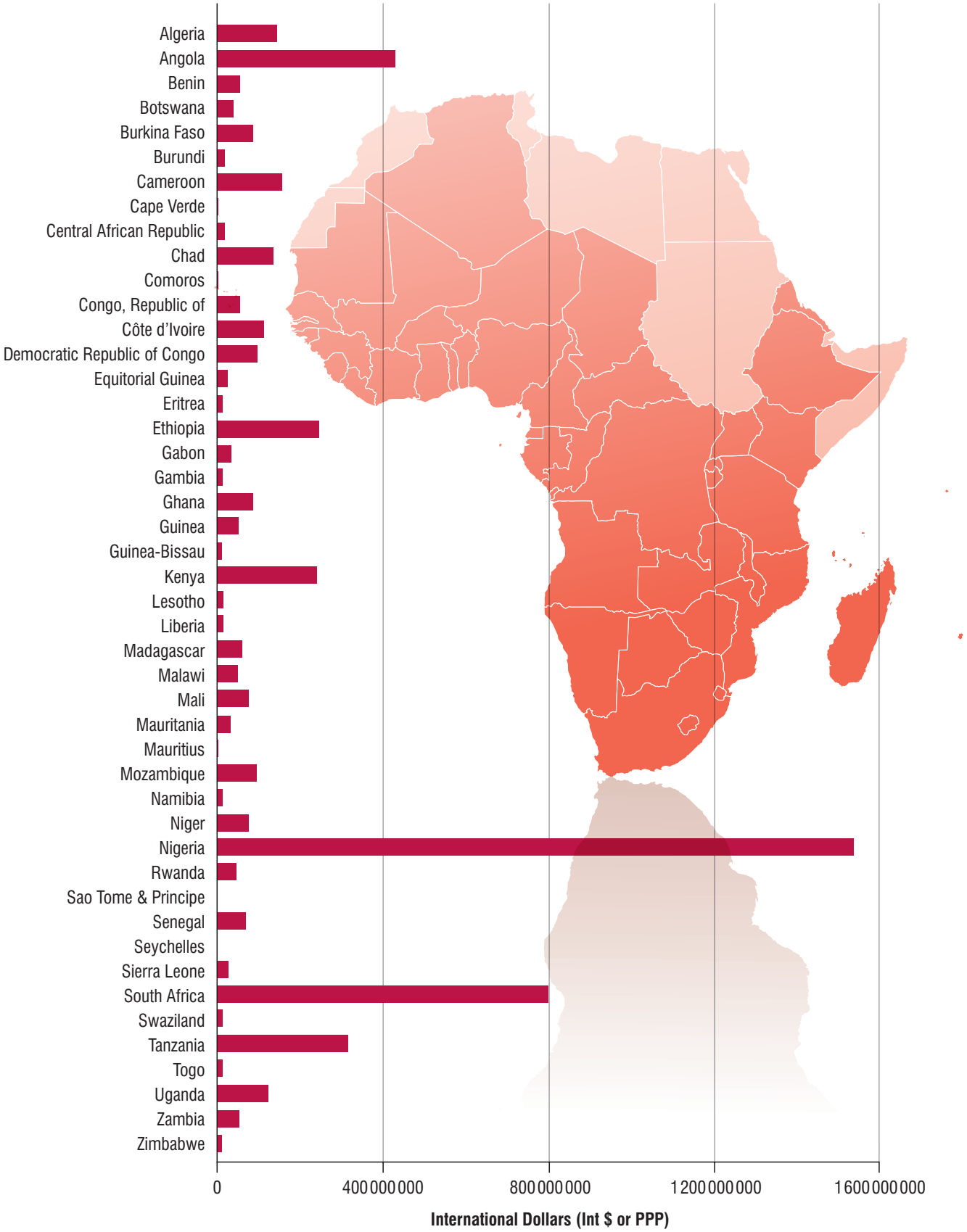
Table 5.2 **Per capita productivity loss due to maternal deaths in the WHO African Region, International Dollars, 2008**

Country	(A) Population in 2008	(B) Total productivity loss in International Dollars (PPP)	(C=B/A) Productivity loss per capita (Int$)
Algeria	34 800 000	138 114 369	3.97
Angola	16 808 000	427 031 289	25.41
Benin	8 107 000	52 763 225	6.51
Botswana	1 546 000	33 374 887	21.59
Burkina Faso	14 042 000	80 580 567	5.74
Burundi	7 949 000	16 276 373	2.05
Cameroon	19 383 000	154 233 972	7.96
Cape Verde	504 000	928 584	1.84
Central African Republic	4 355 000	13 542 844	3.11
Chad	9 730 000	130 473 086	13.41
Comoros	652 000	1 691 898	2.59
Congo, Republic of	3 650 000	50 875 450	13.94
Côte d'Ivoire	19 031 000	109 666 830	5.76
Democratic Republic of Congo	62 885 000	96 565 663	1.54
Equatorial Guinea	1 240 000	20 705 511	16.70
Eritrea	5 006 000	8 636 556	1.73
Ethiopia	79 179 000	239 658 186	3.03
Gabon	1 454 000	30 135 783	20.73
Gambia	1 630 000	6 940 738	4.26
Ghana	22 532 000	83 155 341	3.69
Guinea	10 279 000	47 533 534	4.62
Guinea-Bissau	1 717 000	4 997 113	2.91
Kenya	35 265 000	239 590 136	6.79
Lesotho	2 451 000	6 060 570	2.47
Liberia	3 942 000	9 235 673	2.34
Madagascar	20 215 000	59 859 205	2.96
Malawi	13 656 000	43 384 564	3.18
Mali	13 360 000	73 158 411	5.48
Mauritania	3 032 000	24 437 451	8.06
Mauritius	1 272 000	1 648 778	1.30
Mozambique	20 747 000	90 772 756	4.38
Namibia	2 045 000	12 092 537	5.91
Niger	13 765 000	74 108 291	5.38
Nigeria	147 810 000	1 541 708 626	10.43
Rwanda	9 591 000	41 235 267	4.30
Sao Tome & Principe	160 000	–	0.00
Senegal	12 519 000	67 141 257	5.36
Seychelles	82 000	–	0.00
Sierra Leone	5 887 000	23 925 759	4.06
South Africa	48 687 000	800 816 164	16.45
Swaziland	1 022 000	11 711 729	11.46
Tanzania	39 743 000	312 536 495	7.86
Togo	6 625 000	12 260 758	1.85
Uganda	32 042 000	119 274 121	3.72
Zambia	12 450 000	52 300 391	4.20
Zimbabwe	11 732 000	6 375 405	0.54
Totals	**784 579 000**	**5 371 516 143**	**6.85**

Source: Commission's calculations.

Notes: (i) Population estimates are from Source of population data: International Monetary Fund, World Economic Outlook Database, October 2008; (ii) Total productivity loss in International Dollars (PPP) and productivity loss per person in population (Int$) are estimates of the Commision on Women's Health in the African Region; (iii) Estimates for Sao Tome and Principe and Seychelles are missing because the maternal mortality statistics were missing in the WHO/UNICEF/UNFPA/World Bank latest estimates. Estimates of the indirect costs of maternal deaths for the same year also show the burden carried by Nigeria in **Figure 5.1**.

Figure 5.1 **Indirect cost of maternal deaths in WHO African Region in 2008**



Source: Commission's calculations.

Table 5.3 Cost of services, and pregnancy outcomes, according to use of family planning and maternal and newborn health services in sub-Saharan Africa, 2008

Cost and health outcome categories	Cost of current level of services	Cost of 100% of met needs for services
Services	**US$ million**	**US$ million**
Family planning services	290	2380
Maternal and newborn care	1460	8100
Total	**1750**	**10 480**
Pregnancy outcomes	**Number in thousands**	**Number in thousands**
Intended births and miscarriages*	26 950	26 950
Unintended births and miscarriages	11 730	2750
Induced abortions	5310	1240
Total	**43 990**	**30 940**
	Number of deaths	**Number of deaths**
Maternal	290 000	90 000
Newborn	1 220 000	670 000
Total	**1 510 000**	**760 000**

Source: Guttmacher Institute and UNFPA (United Nations Population Fund). New York: UNFPA; 2009.
*Number of current intended births and miscarriages are unaffected by the scaling up of family planning services.

The estimated costs of addressing maternal and newborn morbidity and mortality strongly suggest that the costs are significantly outweighed by the potential benefits. Here again, though research is lacking, it has been estimated that 30–50% of the Asian economic growth between 1965 and 1990 was attributable to favourable demographic and health changes that were largely a result of reductions in infant and child mortality and subsequently in fertility rates, as well as improvements in reproductive health.[28–32]

Focusing on sub-Saharan Africa, a study by Guttmacher Institute in collaboration with United Nations Population Fund (UNFPA) suggests that providing all pregnant women in the Region with the recommended standards of maternal and newborn care would cost US$ 8.1 billion but only if investments were concurrently made in modern family planning. Without that crucial investment in family planning the study estimated that the cost of providing care would be US$ 2.7 billion higher.[33] However, the considerable investment benefits would include a 77% drop in unintended pregnancies from 17 million to 4 million and a 77% decline in unsafe abortions (see **Table 5.3**). Family planning services would also be expected to save 750 000 lives annually, 200 000 among women and 550 000 among newborns. This would represent a 69% decline in maternal mortality and a 45% decline in newborn deaths. Similarly there would be a two-thirds decline in the number of healthy years of life lost because of disability and premature death among women and their newborns, DALYs dropping from 61 million to 22 million. The benefits of extending effective family planning services to women include a saving in the cost of providing maternal and newborn care that would be equivalent to 130% of the cost of providing family planning services.

These benefits would have profound implications for the Region's socioeconomic development. By simply reducing the number of unplanned births among adolescents, for example, policy makers could expect more young women to stay in school and find employment later. This would also contribute to improvements

in gender equity, health status and economic output which would in turn lead to a reduction in poverty. Other studies have come to similar conclusions regarding the savings that could be made by simply investing in family planning services. The World Health Organization estimates that in a number of low-income settings including sub-Saharan Africa investing one US Dollar in family planning can save four US Dollars that would otherwise be spent later to address the complications resulting from unplanned pregnancies.[34] Specific interventions that can help countries achieve these positive results will be discussed in the next chapter.

Finally, it is worth noting that investment in maternal health not only improves maternal and newborn health outcomes, but has significant spill-over benefits for overall health service delivery and use.[1] To take just one example, where facilities are upgraded to provide essential obstetric care they also become capable of responding to other kinds of accidents and emergencies,[5,6] since the equipment used for maternity care, such as blood pressure gauges and IV kits, are also used for many other clinical interventions.[35]

Women's health and cycles of disempowerment

Thus far, this report has focused on the socioeconomic benefits of investing in maternal and newborn health. However, as stated at the outset, women in sub-Saharan Africa have much more to contribute to society than bearing and nurturing children, as important as these roles may be. A range of pressures including poor health often prevents them from realizing their potential, including their potential for wealth generation. Furthermore, "solutions" focusing solely on "public health" (e.g. the provision of comprehensive maternal health care) miss the fundamental interrelationships between health and other issues, the recognition of which is at the core of the multisectoral "rethinking" that this report seeks to encourage. Sickness, ignorance and poverty are part of the cycle of disempowerment of women in the Region (see **Figure 5.2**), as the components of this cycle combine in different ways and in different settings to harm women. As noted in Chapter 2 this cycle can begin to turn at an early age even if the girl child herself is healthy. If the mother becomes ill, her daughter, already burdened with household work, may have to take up more responsibilities, thus missing crucial opportunities for education.

Investing in women's health is an investment in development, hence an investment in the future. The investment will only be effective if there is concurrent investment in women's education and other initiatives designed to encourage their economic advancement. Women's socioeconomic empowerment feeds into better health, just as their health promotes socioeconomic empowerment (**Figure 5.3**).

Figure 5.2 The cycle of women's disempowerment

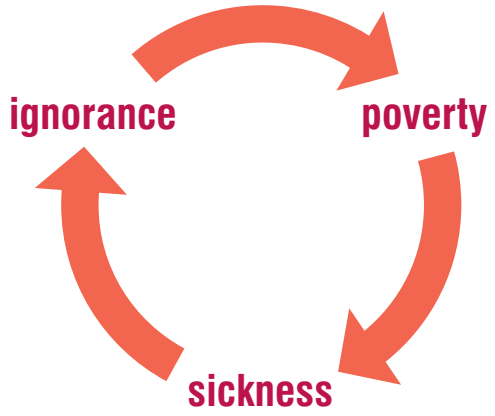
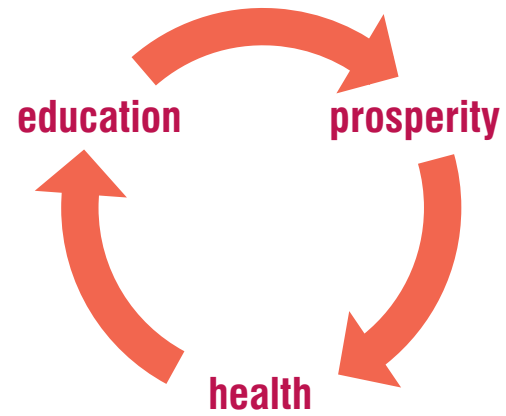


Figure 5.3 The cycle of women's empowerment



A discussion of women's empowerment in sub-Saharan Africa should begin with the recognition of what women already contribute to society especially in terms of their economic output. Despite the lifelong adversity they face, women already make a significant contribution to the Region's economy, contributing at least as much as men. Comparisons are complicated because much of what women do takes the form of unremunerated services, but some attempts have been made at comparison, notably by Campbell-White *et al.* in a study demonstrating that in some countries women actually produce more than men.[36] In Uganda, for example (**Table 5.4**), women's contribution to GDP is estimated to be slightly higher than men's overall contribution (50.6% compared with 49.4) and is significantly higher in agriculture, estimated at 75% compared with 25%. The same study notes that women's share of output is relatively low in the industrial sector (15%) and quite substantial in the service sector (32%).

Table 5.4 Breakdown of productivity in Uganda by sector and gender (in percentages)

			Gender intensity of production	
Sector	**Share of GDP**	**Share of exports**	**Women**	**Men**
Agriculture	49.0	99.0	75.0	25.0
Industry	14.4	1.0	15.0	85.0
Services	36.0	0.0	32.0	68.0
Total	**100.0**	**100.0**		
Contribution to GDP			50.6	49.4

Source: Campbell-White A, *et al. Reproductive Health: The Missing Millennium Development Goal. Poverty, Health and Development in a Changing World.* Washington, DC: The World Bank; 2006.

The importance of women's contribution to the agricultural sector is well documented. It is estimated that women's input in farm labour accounts for almost 70% of the total work done by women in the Region. Women also produce an estimated 60–80% of the food[37] in the Region. Because women are the dominant source of labour for agriculture, which is the mainstay of economies in the Region as a whole, investing in their health (e.g. through better primary health care) will generate significant economic gains. Again, if this issue is considered solely from one standpoint, there is a risk of missing the big picture which, as already stated, comprises a number of discrete but interconnected elements. Improvement in women's health contributes to increased productivity which is, to a large extent, influenced by prosperity.

Crucially, if the woman in the field cannot benefit from her own work, her prospects of achieving better health are limited as are the prospects of better health and education for her children. Sadly this is the situation faced by many women in the Region. For example, despite the tremendous importance of women's work to the agricultural sector, women own just 1% of farmlands.[38] Moreover, they receive just

7% of the agricultural extension services (education designed to improve land use provided by governments and/or NGOs), and less than 10% of the credit made available for smallholder agriculture.

Limited access to credit, land and extension services hampers women's contribution in their households, particularly in the area of cash crop production.[39,40] Where women are freed from such constraints they have increased crop yields by up to 22%.[39] A study undertaken in Burkina Faso estimates that shifting existing resources between the farmland of women and those of men within the same household could increase output by 10–20%, while in Zambia, if women had the same overall degree of capital investment in agricultural assets, including land, as their male counterparts, output would increase by up to 15%.[39] Women are similarly excluded from the benefits of their labour when they go to market. The proceeds from the sale of farm products – the bulk of which are obtained from the labour of women – are often controlled by men.[41,42]

Women's associations in rural and urban areas, such as rotating savings and credit associations (ROSCAS) in Eastern Africa, and the *tontine*, *mbotaay*, *nat* and *tuur* in West Africa, have helped create social networks capable of mobilizing investment resources for women in rural localities, but much more can be done. The role of African women in the marketing of essential commodities in some settings is well documented.[43] Examples include market women in Yoruba communities in Nigeria, the "Mammies" in Ghana or the "Nana Benz" in Togo.

Similar examples can be found throughout Africa where women entrepreneurs are contributing to wealth creation in their communities. Although their market activities are informal, and usually concentrated in crafts and the sale of goods and personal services, they represent the germ of entrepreneurial activity that has the potential to penetrate other sectors. Unfortunately, Africa trails other developing regions in promoting women's entrepreneurship and African women face considerable challenges in accessing business credit and basic social services such as health care and education and this stifles their entrepreneurial activities.[43]

"...granting women property rights enhances their participation in civic activities, a crucial aspect of women's empowerment."

Another effect of giving women a greater stake in the economy, e.g., by granting them property rights or enhancing their access to credit, is that it raises their status within the household and the community and strengthens their negotiating positions in household decisions, notably decisions related to their health needs. It has also been shown that granting women property rights enhances their participation in civic activities, a crucial aspect of women's empowerment.[44,45] Women are significantly under-represented in politics in Africa, as most countries in the Region have fewer than 10% female members of parliament. This deficit begins at the grassroots level because women do not feel they have a voice.

Fortunately the situation is improving in some countries, especially in Rwanda where women account for more than half of the membership of parliament. Women are also quite active in politics in Burundi, Mozambique and Tanzania. The picture is similarly bleak with regard to women in cabinet positions or senior appointments in the civil service. Women's participation in the highest political structures of government is clearly crucial to mainstreaming women's health issues. It has already been important in supporting the enactment of laws that fight gender-based discrimination and harmful cultural practices such as female genital mutilation.[43]

The link between low levels of education and exposure to health risks has already been discussed in terms of research on HIV/AIDS infection rates in Zambia (see Chapter 2) and the postponement of sexual debut in Kenya.[46] This issue is a crucial aspect of women's empowerment, particularly insofar as it relates to women's entry into formal work. According to a recent study by Jorge Saba Arbache *et al.*[47] on gender dynamics and its impact on work-related indicators such as employment, unemployment, sector of activity and pay gap, African women are about half as likely as men to obtain formal employment, the main underlying reasons being lack of education among women and the constraints imposed by domestic obligations. The proportion of women in formal sector employment in the Region is estimated at 25.2% and where women find salaried work, it tends to be in lower cadre positions. Women are also less well paid than men for equivalent work, some estimates suggesting women's remuneration to average out to 50% of that of men.

Clearly one of the most direct ways to reduce the gender gap in the African labour market is to make sure that women are given the same opportunities in education as their male peers.

Once again this is an issue requiring a multisectoral approach that recognizes, at the very least, the need for attitudinal change at the household and community levels (e.g. making boys participate in household tasks rather than putting the burden of domestic work solely on young girls), and for building schools designed to accommodate both sexes. Policy makers should also think about using conditional cash transfers to encourage families to enrol girls in school, an approach that has worked so well in a number of low-income settings.[48] Evidently, educating young women with a view to increasing their opportunities for employment will have only a limited impact if those opportunities do not exist – a point made in the Saba Arbache study noting that countries having the highest job rate for men also have the least gender inequality.[47]

Despite women's important contribution to the Region's economy, women's disempowerment, expressed differently in different settings *but always with poor women's health as a key component*, has substantially undermined development on the continent.[36] The development of sub-Saharan Africa is closely linked to the health of its female population. The fact that women's health is a core consideration in virtually all the Millennium Development Goals (**Table 5.5**) is indicative that this view is shared by the global community as well.

It is important to note, even at the risk of repetition, that women's health cannot be separated from the broader issue of women's empowerment which in turn has implications for development. It is no coincidence that 19 of the 20 countries at the bottom of the United Nations Gender Development Index are in the African Region[49] where women also carry an inordinate share of the global burden of disease and death. There is, therefore, an urgent need for change and, as already stated, one of the key agents of that change is African women themselves. To that end, women need the support and commitment of policy makers to enable them to break the cycle of poverty, illness and ignorance that prevents them from enjoying the health that is their right, and leaves untapped their immense physical and intellectual potential.

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Table 5.5 Women's health and MDGs

Number	Title of MDG	Relationship of women's health to MDG
1	Eradication of extreme poverty and hunger	Women carry the largest burden of poverty in Africa and it is a key determinant of their health. But it is important to realize that sickness feeds poverty too and no poverty reduction policy can achieve its intended goals in Africa without addressing the issue of women's health
2	Achievement of universal primary education	Education is key to the empowerment of women and the basis of women's contribution to socioeconomic development
3	Promotion of gender equity and empowerment of women	Equity in access and use of health services is essential to promotion of gender equality and empowerment of women
4	Reduction of child mortality	Maternal health affects children's health to such a degree that in many ways it is meaningless to discuss one without the other
5	Improvement in maternal health	Improving maternal health is the immediate goal of investing in women's health
6	Combating HIV/AIDS, malaria and other diseases	Women are the group most affected by the issue in sub-Saharan Africa
7	Ensuring environmental sustainability	As the primary users and managers of natural resources, women are directly concerned with sustainable development issues
8	Developing a global partnership for development	Development is also about helping the most vulnerable or least-privileged people to meet their needs in a sustainable manner. Since women make up a larger group of the population, women's health and gender inequality issues are crucial to the development of such global partnership

Source: Compiled from Millennium Development Goals National Reports, UN Millennium Project, United Nations, New York.

Key considerations and points for action

a) The important role that women play in socioeconomic development must be acknowledged.
b) It should be recognized that the economic benefits of addressing maternal and newborn morbidity and mortality far outweigh the costs.
c) Limited property rights, poor access to credit and agricultural extension services hamper women's contribution to the African economies, particularly in the area of cash crop production – and these issues should be actively addressed.
d) Africa lags behind in promoting women's entrepreneurship. The considerable challenges that African women face in accessing business credit and basic social services should be understood and acknowledged.
e) Women's empowerment, which has implications for social and economic development, cannot be separated from issues related to women's health – and should be actively encouraged.

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