per cent of maternal deaths could be averted, if women had access to basic health care services and skilled health care providers.[5]

In some regions of the world, primarily in sub-Saharan Africa and South Asia, women are still

When

limit childbearing, better access to and use of high-quality health-care services, as well as broader social changes such as increased education and enhanced status for women.[7]

The continuing high incidence of maternal and perinatal mortality and morbidity is unacceptable precisely because it is solvable. Successfully reducing maternal mortality requires policy makers and program managers to refocus program content, to shift the focus from development of new technologies toward development of viable organizational strategies that manage and ensure a continuum of care. It also requires managers to enable women to access health services by addressing the root causes of the high incidence of maternal mortality.

For discussion:

infected with HIV in sub-Saharan Africa in 2008 alone, accounting for 71% of all new infections globally.[8]

In many countries, especially those hardest hit by the epidemic, most of the care for people living with HIV is home-based and is provided largely by women and girls (accounting for up to 90% of AIDS-related caregiving work). Many women and children also have to serve as breadwinners, compensating for lost family income due to AIDS deaths or sickness of family member(s). In most cases, the caregiving work is unremunerated and often accompanied by HIV-related stigma and discrimination. A range of broad gender-sensitive strategies to reduce the overall impact of AIDS on affected households and communities is necessary, including state assistance to families and community and faith based organizations to meet the burden of care, as well as social protection services for persons affected by AIDS, psychosocial support, and free access to legal support.

Analysis of the data also indicate that the impact of the AIDS response is high where HIV programmes have been integrated with other health and social welfare services. Taken out of isolation, the AIDS response can be effectively leveraged to promote achievement of other MDGs and contributes to the broader health and development agenda. Recent evidence shows that HIV may have a significant impact on maternal mortality, i.e. 50,000 maternal deaths in South Africa were associated with HIV in 2008. The disease also accounts for up to 30% of infant deaths in sub-Saharan Africa. Programmes on HIV, maternal and child health must work in synergy in order to contribute significantly to the achievement of their common goals (MDGs 4-6). Effective integration of voluntary family planning services, sexual and reproductive health, and HIV programmes will not only help prevent babies from becoming infected with HIV, but will also protect and enhance the health of HIV-positive women and allow them to better exercise their reproductive rights.

Scaling up efforts to prevent the spread of HIV/AIDS

It is obvious that despite the significant progress made in treatment, the epidemic continues to outpace the response in sub-Saharan Africa, whereby more people become infected as compared with those accessing treatment. In order to sustain the valuable gains achieved thus far and to mount a more effective response to the epidemic, it is critical to **strengthen HIV prevention** and to match it with actual needs, including protecting women and girls and mitigating the impact of the epidemic.

HIV prevention programmes are showing some positive impact on sexual behaviors. For example, available data indicates a trend towards safer sexual behavior among both young men and young women (15-24 years old) in Southern Africa in the period of 2000-2007, as well as an increased delay of sexual debut among young people in many countries. However, the high prevalence of inter-generational sexual partnerships can play an important role in young women‘s disproportionate risk of HIV infection. Mixed results are emerging from the studies on men having multiple sexual partnerships (i.e. decreased in Swaziland, but increased in Uganda).

by 43% in Ghana and by 24% in Lesotho. However, in Uganda, prevention resources as a share of national HIV spending rose from 13% to 33.6% between 2003 and 2007.

Prevention strategies also often fail to address the evolving patterns of the epidemics across and within countries. Data show that few HIV prevention programmes exist for people over 25, for serodiscordant couples, people in stable relationships, widowers and divorcees. These are the same groups in which HIV prevalence has been found to be high in many sub-Saharan countries.

Of particular concern is the recent trend in Africa towards the overly broad **criminalisation of HIV transmission** and those most affected by HIV, such as sex workers, injecting drug users and men who have sex with men. The criminalisation of HIV transmission can have significant negative implications for women. Women often learn about their HIV-positive status before their male partners because they are more likely to access health services and thus, are blamed for ―bringing HIV into the relationship.‖ Women may also face prosecution as a result of their failure to disclose out of fear of violence, abandonment or other negative consequences. An alternative – and more effective approach – for protecting public health is to ensure access to voluntary and confidential HIV testing and counseling, as well as access to HIV information and commodities; enact and enforce laws against sexual violence; eliminate discrimination based on gender and HIV status; and ensure equal rights and opportunities for women and girls in education, employment, and domestic relations including property ownership, inheritance and child custody.

A multi-country study conducted by the WHO found that between 1% and 21% of women reported sexual abuse before the age of 15, and between 20% and 50% of females reported that their first sexual experience was forced. Children who are sexually abused are more likely to engage in behaviors known to be risky for HIV as adults. Violence against women and girls is both a cause and consequence of HIV infection, and therefore needs to be dealt with as an integral part of HIV programmes.

Critical to this is also the need to raise awareness and improve HIV knowledge among young women, both through formal and non-formal education. This will be addressed in the next section.

For discussion:

- *Have HIV/AIDS budgets been impacted by the financial crisis and limited financing of healthcare? How is this issue being addressed?*
- *How can public-private partnerships, domestic NGOs and local communities best complement government efforts to provide quality primary health care to all?*
- *How are HIV/AIDS programmes being integrated with other social services to work towards the attainment of other MDGs? What are examples of these synergies?*
- *What actions can governments take to empower women to contain the spread of the HIV/AIDS pandemic?*
- *How can gender-sensitive policies be implemented in other areas (i.e. economic, education) to prevent the spread of HIV/AIDS?*

5. Empowering women to improve their health

[illegible]
for women, with spillover affects that will benefit their families, communities and societies.

Empowerment over their lives: setting their [illegible] gaining skills, building self-confidence, solving problems, developing self-reliance, and expressing their voice. It is both a process and an outcome.[13]

A mu[illegible] in the allocation of resources such as income, credit, education, health [illegible] being.[14] [illegible]

information that would enable them to take a more active role in their well-being, or even save [illegible]

[illegible]

Economic Empowerment

Poverty and low socioeconomic status are associated with worse health outcomes. An important linkage exists between labour market equality and empowerment in terms of women's involvement in the decision-making process and bargaining power. Inequalities in the labour market spill over to inequality in health, education, political involvement and other demographic vulnerabilities. Women in the poorest households experience higher levels of maternal mortality and are less likely to have a skilled

[illegible][20] A study that took place in [illegible] - check for some activities that were [illegible] resulted in greater involvement in household decision [illegible]

[illegible][21]

In addition to accessing employment, women in Africa face other barriers to the market, with many unable to access credit, market information, technology, and infrastructure. Oftentimes, household assets are less readily available to women regardless of who was responsible for obtaining them. Women farmers in Africa receive only 1% of total credit to agriculture.[22] The inability to obtain financial credit hinders women from participating in entrepreneurial activities. This lack of asset ownership is shown to have adverse health outcomes for women. Studies show that when women have control over their own earnings and other assets, households are more likely to allocate more resources to health and education.[23] A microfinance and training project designed to empower South African women was associated with a significant reduction in HIV risk behaviour and partner violence.[24]

Land is crucial for increasing women‘s empowerment, as it is an important factor of production for a wide range of economic activities, particularly in Africa where natural resources provide a main source of income and livelihood. According to the OECD, as of 2007, women owned less than 1% of the African continent‘s landmass.[25] Widespread limits on the ability of African women to own land has serious repercussions on their effective engagement in economic activities,[26] thereby limiting their decision-making in the household. Research conducted by Human Rights Watch in Kenya and Zambia shows that women with HIV are particularly vulnerable to violations of property-based rights, and that depriving them of their property can lead to ill health and other negative consequences.[27] Ownership of land is affected by gender biased family laws, customary practices and land policies. In Rwanda, the government passed a law in 1999 giving women inheritance rights equal to those of males, overruling traditional norms by which only male children could inherit. This has enabled widows and female orphans of the 1994 genocide to secure land.[28]

A number of policies can be enacted to provide women with economic empowerment as a means to improve their own health. The generation of rural employment opportunities both off and on the farm is vital for creating a dynamic economy. Taking account of the gendered impacts of agricultural policies and social protection for informal workers is also important with regards to women‘s health. A sound investment climate for women can be created through securing property rights for women, providing access to technical assistance, improving communications and transport, removing barriers to finance and providing legal protection. Women‘s access to land and an extension of labor rights can be ensured through legal reforms and state led programs.

[20] Mudege and Ezeh 2009.
[21] Blumberg 2005.
[22] OECD 2007.
[23] Blumberg 1988.
[24] Alcorn 2008.
[25] OECD 2007.
[26] UNECA et al. 2008b.
[27] Gerntholtz 2009.
[28] UNECA et al. 2008b.

Political empowerment

Women in sub-Saharan Africa on average hold 18.2% of the seats in national parliaments, close to the global average of 18.6%. The proportion for the Middle East and North Africa is much lower at 8.6%.[29] The UN Commission on the Status of Women (CSW) recommends a critical 30%

when to get married, when to initiate sex, when [illegible] school, when [illegible] ies, how many to have, and how the children should be spaced.[34]

These gender inequalities and limitations on women's decision-making are reflective of the attitudes and ideas that pervade a society or culture. In every society, people have ideas about what men and women should be and do, and may even espouse overt preferences for boys over girls. Reflecting religion, culture, tradition, as well as experience, attitudes are part of complex ideologies that have been constructed over long periods of time.

While every society follows its own path of socialization, certain mindsets have become deeply entrenched and have fueled attitudes of male superiority and gender discrimination to various degrees throughout the continent of Africa. These attitudes influence justice systems, social institutions, economic structures, and have created certain cultural norms and practices that are harmful to women, such as genital mutilation. Patriarchy –

enrollment and completion rates means that more African youth can now read and write, thereby facilitating their access to information and services related to sexual and reproductive health. In addition to mandatory universal education, better-functioning schools and gender-sensitive learning content and environments can address inequities in education.

However, a country‘s literacy rate is not a clear indication of a population‘s level of health literacy, defined as the –cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health.‖[41] For example, Zimbabwe and South Africa have some of the highest literacy rates in Africa, yet they are also the countries most severely challenged by HIV/AIDS. The proportion of adults living with HIV is 18.1% in South Africa and 15.3%in Zimbabwe.[42]

Health literacy campaigns must include components that address access to information and knowledge, informed consent, and negotiating skills. The media is increasingly becoming a key source of health information for many people, and is influential in shaping culture in both developed and developing countries. They can provide learning opportunities that are more interactive and visual than pamphlets and older forms of health instruction.[43]

A Way Forward

–Gender inequality is not one homogeneous phenomenon, but a collection of disparate and interlinked problems.‖[44] In order to address gender inequality in healthcare, women must be empowered in all other spheres so that they are equipped with the knowledge, power and voice

the entire budget through a gender lens to identify the differences in gendered impacts and to translate gender commitments into budgetary commitments can enhance transparency and accountability for revenue and public expenditure. Fiscal decentralization can also take into account gender differentiated needs at a local level.[47]

Cultural norms and attitudes that fuel gender inequality and prohibit women from making decisions about their health and overall well-being can be addressed through educational programs, media campaigns and grass roots activities. Harmful attitudes can be addressed by enlisting civil society, the media, academia, religious organizations, businesses and politicians to promote the benefits of women's participation for families and communities as a whole.

For discussion:

What government policies and programmes have been most successful in creating more inclusive markets for women?

What legal frameworks are in place to guarantee decent work, labour rights, property rights, and asset ownership for women? Conversely, what types of customary laws or patriarchal norms hinder womenôs economic empowerment?

How can civil society groups and local communities best complement government efforts to change attitudes and gender-biased mindsets to increase womenôs political voice and participation?

Have female leaders in Africa implemented more gender-sensitive policies, or put in place more social-oriented programmes, during conflict resolution and during peace time?

Have political quotes helped to create more balanced gender representation in political bodies?

How might new information technologies be applied to reach wider audiences on health education?

How can health literacy programmes be targeted to hard-to-reach populations?

What are the trends in the region to mainstream the gender component into national development programmes and priorities?

[47] Chakraborty and Bagchi 2007.

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