

Dimensions of gender equity in health in East and Southern Africa

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Executive summary

Gender inequalities are an important dimension of wider inequalities in health and health care and important determinants of health. Gender roles, which are socially and culturally determined, influence the different behaviour, roles, responsibilities and expectations of men and women. They influence access to resources and information, as well as the power to make decisions, both individually and within communities. In relation to health this influences nutrition, educational opportunities, employment and income, which are all important determinants for good health. It also influences whose needs and priorities are addressed. Within health systems this can mean that the needs of women and girls are not addressed.

This report was commissioned by the Regional Network for Equity in Health in East and Southern Africa (EQUINET). It highlights areas of concern for gender equity in health in East and Southern Africa (ESA), based on a review of published literature. The report provides examples of key areas of gender equity in health drawn from the literature. It does not provide a systematic analysis using household data and is not a comprehensive assessment of all dimensions of gender equity. Rather by presenting key dimensions of gender inequity, it raises the argument for more systematic audit and mainstreaming of gender within health systems in ESA countries.

The researchers used a hierarchical literature review strategy, using Medline and web databases. The papers included were identified first through review of titles and abstracts, excluding those that were not relevant or were repeated. The remaining papers were then reviewed in full. Google searches were used to include the grey literature. The review presents an overview of the findings on gender equity and health, and case studies of interventions that aim to improve gender equity and health.

The first section of the report **contextualises gender equity and the social determinants of health in the ESA region**. It opens with a discussion of the structural determinants of health and presents evidence on education, employment, water and sanitation, the representation of women in nationally elected parliaments and the global treaties and agreements relating to gender. We present evidence of women's role in decision making within the household. Gender roles and power relations often lead to women being disadvantaged in these areas. For instance, while globalisation has led to women's participation in the job market, women have often been employed in jobs that are insecure and informal. These jobs may directly increase women's exposure to ill health, such as through pesticide exposure in agricultural workers in South Africa. Due to their informal nature, these jobs may provide little social protection from the employer and the state, further increasing the likelihood of ill health.

The next section explores gender equity in health outcomes, with a particular focus on sexual and reproductive health; nutritional status and HIV and AIDS prevention and care. These three areas show that biologically and socially determined roles influence the different exposures and vulnerabilities to illness men and women experience. Access to sexual and reproductive health is important for both men and women. Provision of effective and assessable maternity services is particularly vital to prevent women from dying during childbirth. Nutritional deficiencies can cause ill health in men, women and children. However, malnutrition is particularly marked in pregnant and lactating women and can be impacted on by household access to, and division of, resources. Gender roles play an important role in vulnerability to HIV in ESA countries. Notions of masculinity often condone multiple sexual partnerships and unsafe sexual practices, such as sex without a condom. They also influence treatment-seeking behaviour with men presenting later for testing and treatment, which in turn can influence treatment

outcomes. Gender roles, which influence women's access to economic resources, can also increase vulnerability to HIV and other sexually transmitted infections (STIs) because women may be more economically dependent on men and therefore less able to negotiate the terms of sexual exchanges.

The third section examines **gender equity in redistributive health systems** focusing on four areas: the allocation of health resources; the policies and pay for health workers within the health system; the impact of user fees and the voices and representation of community members in the design of health systems. The allocation of health resources, like many other areas of government funding, often fails to consider gender. Gender budgeting has been introduced in some contexts to ensure that funds are allocated in ways that equitably benefit women and men. Health worker policies can often have varying impacts on men and women. Such policies should provide for fair remuneration of workers, particularly those in the lowest paid jobs. Increasing privatisation of health provision, encouraged by global policies, has had a particularly negative impact on women, as the cuts in public health funding has led to women providing care for free within the home. User fees is raised as one area where gendered impacts exist, in terms of who seeks care and when. Cost barriers are not only direct, and the indirect costs of seeking health care also have a gendered impact, such as in the relative loss of productive time by household members. Ensuring community voices are captured in the design and application of health policies is important in guaranteeing that the services meet the needs of those who are using them.

Taking action on gender equity and health requires intervention both within and outside the health system:

Health services need to be accessible and responsive to the needs of men and women. One way of doing this is to devolve services to primary health centres, as community-based facilities are more accessible to poor people. Beyond this there is need for further measures to ensure that men and women are both comfortable in using services. Beyond removing user fees, gender responsive budgeting is necessary to ensure that governmental policies take into account women's needs relative to men's and to allocate funds accordingly. For example funding the adequate provision of services and overcoming barriers to access to family planning services is vital for women's autonomy, choice and participation within society.

Addressing gender inequity calls for deeper levels of action, to address the structural drivers of inequities in health outcomes. The measures range from improved women's and girls' access to education and particularly to post-primary educational opportunities; ensuring working conditions are both safe and responsive to both women's and men's needs; to increasing, meaningful, informed and representative participation in all levels of decision-making, from within the household and in the community to national bodies such as the legislature.

These changes need to be supported by changes in institutional governance and capacities and by evidence and exchange of promising practice. This includes advocating for gender disaggregated health information systems, together with other important factors that shape vulnerability and resilience to ill-health (poverty, age, literacy, dis/ability). It would be important to audit gender equality within the health system, and to encourage programmes to carry out such assessments, to implement gendered evaluations and to consult and obtain feedback from women and men in the community to strengthen gender equity.

1. Introduction and conceptual framework

This report was commissioned by the Regional Network for Equity in Health in East and Southern Africa (EQUINET). It flags areas of concern for gender equity in health in East and Southern Africa (ESA), based on a review of published literature. The report highlights examples of key areas of gender equity in health drawn from the literature. It does not provide a systematic analysis using household data and is not a comprehensive assessment of all dimensions of gender equity. Rather by presenting key dimensions of gender inequity, it raises the argument for more systematic audit and mainstreaming of gender within health systems in ESA countries.

Three concepts are central to this report: gender, gender power relations and gender equity in health.

Gender may be defined as the way in which a person's biology is culturally valued and interpreted into locally accepted ideas of what it is to be a woman or man. 'Gender' and the hierarchical power relations between women and men based on this are socially constructed, and not derived directly from biology. Gender identities and associated expectations of roles and responsibilities are therefore changeable between and within cultures. Gendered power relations permeate all social institutions so that gender is never absent (Reeves and Baden, 2000).

Gender power relations are hierarchical relations of power between women and men that tend to disadvantage women. These gender hierarchies are often accepted as 'natural' but are socially determined relations, culturally based and subject to change over time (Sen, Ostlin and George, 2007). They can be seen in a range of gendered practices, such as the division of labour and resources, and gendered ideologies, such as ideas of acceptable behaviour for women and men (Reeves and Baden, 2000). Gender relations of power constitute the root causes of gender inequality and are among the most influential of the social determinants of health (Sen, Ostlin and George, 2007). Gender power relations intersect with age and life-cycle as well as other social stratifiers, such as economic class, race or caste (Iyer, Sen and Ostlin, 2008; Sen and Ostlin, 2008).

A gender equity approach in health is concerned with the role of gender power relations in the production of, and vulnerability to, ill health or disadvantage within the health system. 'Achieving gender equity in health implies eliminating unnecessary, avoidable and unjust health inequities that exist as a result of the social construction of gender. It means that women and men should have the same opportunities to enjoy living conditions and services that enable them to be in good health, without becoming ill, disabled or dying by causes that are unjust and avoidable' (Pan American Health Organisation and GenSalud undated). Sen et al argue that 'gender inequality ... [is] among the most influential of the social determinants of health' (ibid: 1).

The root causes of gender inequalities in health are gender power relations that place women and girls in a subordinate position to men and boys. This subordinate position influences the roles and responsibilities that women and men undertake, as well as who has access to and control over information and power at all levels of decision-making, from the household to the national level.

This differential access to resources and information can influence who is able to seek health care and when they are able to seek care. Further, socially ascribed roles can influence vulnerability to ill health. For instance, women's responsibility for collecting water can mean they are more vulnerable to schistosomiasis (Vlassoff and Manderson 1998). They also impact on men's psychological and emotional health, which can lead to risk-taking behaviours (such as increased alcohol use), further leading to higher levels of mortality and morbidity (Sen, Ostlin and George 2007). Gender also intersects with economic inequality,

racial or ethnic hierarchy, caste domination, differences based on sexual orientation, and a number of other social markers (Reeves and Baden 2000). Gender inequalities are endemic in health systems globally (Ostlin 2009). These inequalities are reflected in the organisational structures of health systems, which often privilege male power. Policies and services are designed and implemented in ways that provide women and girls with insufficient employment opportunities (Ostlin 2009). They also influence the remuneration of health care providers, particularly those clustered at the lower end of the system, who are overwhelmingly female.

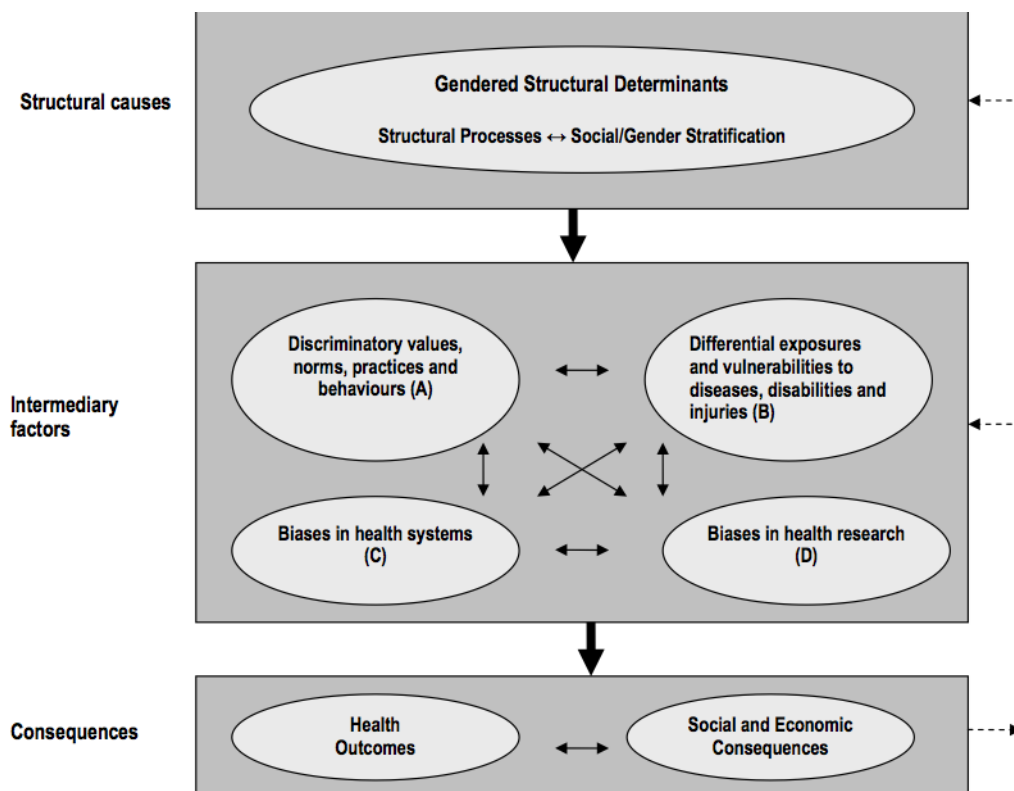
As Sen et al point out:

'Because of the numbers of people involved and the magnitude of the problems, taking action to improve gender equity in health and to address women's rights to health is one of the most direct and potent ways to reduce health inequities overall and ensure effective use of health resources' (2007: 1).

Because of the nature of gender power relations and the way they permeate a wide spectrum of human life, action to address gender inequalities in health is required not just within the health sector but in many domains of society.

The framework for conceptualising the role of gender as a social determinant of health in the WHO Commission on Social Determinants of Health report (Sen, Ostlin and George 2007) provides a useful tool to guide our analysis for this report. See *Figure 1*.

Figure 1: Conceptual framework for this report



Note: The dashed lines represent feedback effects.

Source: Sen, Ostlin and George, 2007

Within the framework it can be seen that the links between the gendered structural determinants and the intermediary factors that determine health outcomes are complex. *Box 1* draws on Sen et al's discussion of the different components of the framework.

Box 1: The structural determinants of gender equity and health

Structural determinants are important to understanding the relationship between gender equity and health. Sen et al (2007) argue that gender systems interact with structural systems to constitute the gendered structural determinants of health. These are shaped by a number of factors which operate at different levels to influence people's health.

Within the conceptual framework, there are four main intermediary factors:

- discriminatory values, norms, practices and behaviours
- differential exposures and vulnerabilities to disease, disability and injury
- biases within health systems
- biases in health research.

Norms values, practices and behaviours

The gendered norms and expectations that households and communities project onto women, men, girls and boys have important implications for health. They can influence who is responsible for different community needs and roles, as well as who has the right to make decisions within the household and within the community.

Differences in exposure and vulnerability

Men and women experience different exposures and vulnerabilities to ill health. Some of these differences are related to their different biological roles. Women are particularly vulnerable to ill-health during pregnancy and labour. This exposure and vulnerability is also linked to the gendered roles that are often ascribed by societies, as the patriarchal power relations that privilege men can adversely affect both men and women's health.

Biases in health systems

Within the health system a lack of awareness of women's health problems can create barriers for women's access to and use of health services. Their ability to access health services depends on the demand for health care for women, as well as on how services are supplied, in terms of how they are funded, where they are located and how they meet the needs of women who use them. All these aspects can impact on women's decision making to seek health care and therefore will have important implications for women's health. These intermediary factors in turn result in biased and inequitable health outcomes, which may have serious economic and social consequences for all members of society. Feedback effects – from outcomes and consequences to the structural determinants and intermediary factors – can also be important.

Source: Sen et al, 2007: xiii- xvii

The framework provided in *Figure 1* has been used to inform and organise the collection and analysis of evidence for this report.

Section 3 of the report, entitled 'Gender equity in the contexts for and social determinants of health, discusses the broader structural determinants of health including access to education, employment, water and sanitation, national representation of women in parliaments and the global treaties and agreements that relate to gender. This section also includes a discussion of women's ability to make decisions within the household that relate to the discriminatory norms, practices and behaviours section of the conceptual framework (refer to *Figure 1*).

The differential exposures and vulnerabilities to disease, disability and injury will be addressed in the sections exploring maternal mortality, HIV and AIDS and tuberculosis. Finally the biases within the health system will be discussed in the section on gender equity in resourcing redistributive health systems.

2. Methods and limitations

Electronic database searches for all relevant academic work on gender equity and health in Southern and East Africa were conducted using a hierarchical literature search strategy.

The following search terms were used: gender, sex, women, men, maternal, reproductive health, disease, ill-health, well-being, sickness, equity, fair, justice, equality, finance, funding, funder, fiscal, revenue, investment, budget, policy, government, development, Africa, Eastern Africa and Southern Africa.

We conducted database searches using Medline and Web of Knowledge. Through these searches 1,291 potentially relevant published articles were identified. All titles and abstracts were read and any duplicates or papers that were not relevant to the topic were omitted. This left 189 unique papers that were reviewed in full before removing a further 40 manuscripts with irrelevant or repeated data. In addition we identified other articles from the grey literature by conducting Google searches and reviewing references in journal articles – an additional 26 papers were identified using these methods.

The data presented here pertains to the 16 countries in Southern and Eastern Africa that make up EQUINET's focal areas, namely: Uganda, the Democratic Republic of Congo, Kenya, Tanzania, Zambia, Malawi, Mozambique, Madagascar, Mauritius, Angola, Namibia, Botswana, Swaziland, Lesotho, South Africa and Zimbabwe.

One of the key limitations of this review was related to the paucity of primary data available in numerous fields related to gender and health. Despite sustained calls for data from the international community, there still remain large gaps where evidence is not available, or is of low or anecdotal quality. This in part may reflect gendered bias in research priorities. There was little disaggregation of data by sex, socio-economic position or ethnicity. There was also little data on health funding and gender projects. There was more data available for South Africa and Kenya than for other countries.

One of the key challenges in collecting data for the tables was that researchers and advocacy agencies use a number of different indices in measuring gendered determinants of health. Within the literature there was a strong focus on describing how gender equity shapes women's and men's health. However, there was little empirical work that identified positive gender equity action in health. For example, within the HIV literature where the broader structural drivers of HIV risk – particularly gendered ones – have been well articulated and where multiple calls for action from the national and international community have been made, there were only two key studies published in academic journals that actually implemented interventions addressing gendered structural drivers in Africa. Both these studies were conducted in South Africa (Jewkes et al. 2008; Pronyk et al. 2006). As a consequence of the limited availability of effective evidence for change, this report relies primarily on descriptive case studies and refers to successful interventions for gendered action where such projects were identified. These examples of best practice are included as boxes throughout the report.

A further limitation of the report is related to men and gender. Men's well-being and health are also affected by gender power relations. Therefore, a discussion of gender should not simply relate to the position of women in society. However, we found very few studies from our literature review that focused on men and how gendered norms and expectations can impact on their health. As far as possible within the report and where evidence does exist (particularly relating to TB and HIV) we have discussed the intersection between masculinity and health. As a consequence of this limitation however, this report overwhelmingly focuses on women.

The rest of the paper discusses the findings from the literature review and is presented in five sections:

- Section 3: Gender equity in the contexts for and social determinants of health
- Section 4: Gender equity in health outcomes
- Section 5: Gender equity in health systems
- Section 6: Acting on gender equity in health

The first section, 'The context of gender equity in health', focuses on the broader structural determinants that place women and girls in a lower societal position and which in turn impact upon their health. Later sections then examine the key health areas and discuss how action can be taken to promote gender equity and improve health outcomes.

3. Gender equity in the contexts for and social determinants of health

Gender inequities continue to impact on the health of millions of women and girls across the world (Sen, O'stlin and George 2007). As these are deeply rooted in entrenched attitudes and societal institutions, progress towards gender equity requires action in a wide range of sectors.

In this section, we discuss the context of gender (in)equity in health and present data from EQUINET's 16 focal countries. Drawing on the conceptual framework, we consider the broader structural determinants of gender, equity and health. We summarise the level of gender inequality across the 16 ESA countries covered, including through the United Nations Development Programme's (UNDPs) Gender Inequality Index.

3.1 International agreements affecting gender equity in health

The human rights discourse and its policy space form part of the broader gendered structural determinants of health. In the past thirty years there have been important international meetings and agreements that have put gender equity on the international agenda. These include:

- the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted in 1979
- the Fourth International Conference on Population and Development (ICPD), held in Cairo in 1994
- the Fourth World Conference on Women, held in Beijing in 1995
- the Millennium Development Goals, adopted in 2000
- the African Women's Charter, adopted in 2003.

In 1979, the UN General Assembly adopted the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). The Convention defines discrimination against women as:

'...any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field' (United Nations, 1979: Article 1, part 1).

All 16 ESA countries covered in the report have ratified CEDAW.

Countries that have ratified or acceded to the Convention are legally bound to put its provisions into practice and to submit national reports at least every four years on measures they have taken to comply with the treaty obligations. CEDAW provides a framework for the advancement of women's rights and has been used as a means of advancing action in a

number of countries (Sen, Östlin and George 2007). According to the UNFPA website, CEDAW has ‘...became an important international tool that helped civil society groups working at the national and regional levels to increase their pressure on governments to “denaturalise” violence against women’ (UNFPA 2006).

In 1994, at the Fourth International Conference on Population and Development (ICPD), held in Cairo, there was a radical international policy shift from viewing sexual and reproductive health in terms of population control to a focus on individual and collective needs and rights. The conference specifically committed the 179 countries that agreed to the Programme of Action to:

- advance gender equality
- eliminate violence against women
- ensure women had the ability to control their own fertility
- commit to universal access to sexual and reproductive health (SRH) information and services (United Nations 1994).

The key outcome of the conference was a call for universal access to sexual and reproductive health services by 2015 (Glasier et al. 2006).

The Cairo conference was an important precursor to the Fourth World Conference on Women, which was held in Beijing in 1995. At this conference, participating governments expressed their commitment ‘to advance the goals of equality, development and peace for all women everywhere in the interest of humanity’ and adopted the Beijing Platform for Action. The Beijing Platform for Action recommended that national governments should strive to make gender mainstreaming a central component of their strategies for guiding policy when interacting with external funders, as well as to provide support for specific programmes for women.

The conferences in Cairo and Beijing firmly established the relationship between reproductive rights, women’s rights and development more broadly (Gerntholtz, Gibbs and Willan 2011). Despite these commitments, Ortayli et al (2010) argue that the years following these landmark conferences were marked by confusion rather than enthusiasm for meeting the goals. For example, between 1995 and 2003 external funder support for family planning commodities and service delivery fell from US\$560 million to \$460 million (Cleland et al. 2006). Glasier and Gülmezoglu (2006) argue that one of the reasons for this gap in funding for sexual and reproductive health was the large financial contribution that governments and external funders were making to HIV and AIDS, another significant health issue in the ESA region.

Against a different political background and with considerably less participation from women’s organisations than seen at the Cairo and Beijing conferences, the Millennium Development Goals (MDGs) were adopted in 2000 by UN member states. Sexual and reproductive health rights were notably absent from the planning, development and wording of the MDGs (Glasier and Gülmezoglu 2006).

While three of the eight MDGs are directly related to health (Goal 4 – reduce child mortality, Goal 5 – improve maternal health and Goal 6 – combat HIV and AIDS, malaria and other diseases), none contain specific reference to sexual and reproductive health rights. Other goals and targets are only indirectly related to health, for example, Goal 1 – eradicate extreme poverty and hunger.

The third Millennium Development Goal on universal education does provide a target for gender equality and empowerment of women. However, the goal narrowly defines gender parity in relation to education, the share of women in wage employment and the proportion of seats held by women in national legislatures. Other important components of gender equity, such as prevention of violence against women and the promotion of sexual and reproductive health, are not addressed.

One of the main problems with the MDGs is that they are too broad to allow disaggregation of outcomes by groups, such as women. Further, the sidelining of women's health issues – specifically sexual health and reproductive health – meant that these were not deemed to be priority areas for funding, action and research in the international health agenda over the subsequent 15 years. The strong emphasis on outcomes (for example reductions in mortality) means that less focus is placed on the procedures and processes by which outcomes are achieved. For example, this may mean that determinants of gender inequality in sexual and reproductive health rights may not be considered as markers of progress or as important endpoints in their own right and as such receive less attention from national governments, international organisation and researchers.

The Overseas Development Institute (ODI) (2008) points out 'this explicit inclusion [of gender] in just *two* MDGs is too narrow, and sidelines other gender-specific risks and vulnerabilities, roles and responsibilities, and power relations. It is unlikely to lead to gender equality and the empowerment of girls and women, or tackle the development challenges that must be overcome for sustainable poverty reduction. These limitations are compounded by the gender-blindness of other MDG indicators, and the fact that the gender dynamics that cut across the goals are relatively invisible in policy dialogues' (ibid: 1).

A more recent development in women's rights in Africa is the African Union's (AU) Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (or, the African Women's Protocol). It was adopted by the AU in 2003 and became legally binding for the countries who signed and ratified the protocol in November 2005 (Gerntholtz, Gibbs and Willan 2011). Of the 16 EQUINET focal countries, Angola, the Democratic Republic of Congo, Kenya, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania, Uganda and Zimbabwe have ratified the treaty. Those who have signed the treaty only (not ratified) are Madagascar, Mauritius and Swaziland. The signature of a treaty is evidence of the state's intention to ratify the instrument at some time in the future, but is not legally binding for a state. Botswana is the only EQUINET focal country which has neither signed nor ratified the treaty (ibid).

Gerntholtz et al state that the Protocol is 'particularly strong on women's reproductive rights, and is a tool for ensuring universal access to reproductive health and the creation of an enabling environment' (ibid: 3). Articles 14(1&2) of the African Women's Protocol set out three major components of women's reproductive health rights:

- reproductive and sexual decision making, including the number and spacing of children, contraceptive choice and the right to self-protection from HIV
- access to information about HIV and AIDS and reproductive health
- access to reproductive health services, including antenatal services and abortion-related services.

The Charter goes beyond binding treaties such as CEDAW in outlining reproductive health rights. It also contains the first reference to HIV in an international treaty and the first expression of a right to abortion, although this is limited to sexual assault, rape or instances where pregnancy endangers a woman's mental or physical health.

Unfortunately, only 29 of the 52 countries in Africa have signed and ratified the Charter and there are still significant barriers to translation of the Protocol into national legislation and implementing its provision (Gerntholtz, Gibbs and Willan 2011). For countries to be able to domesticate the protocol into national legislation, they must first undertake a comprehensive legal review of the provisions of the protocol in relation to their current legislation, a prohibitively expensive exercise (ibid). Many countries have raised concerns about the cost of reviewing legislation and implementing reproductive rights. In addition, countries with customary laws often encounter tensions arising between these and reproductive rights.

3.2 Summary index of gender inequality

The Gender Inequality Index (GII) is part of the United Nations Development Programme (UNDP) and is constructed from three dimensions – reproductive health (maternal mortality and adolescent fertility), empowerment (female parliamentary participation and secondary-level education) and women’s participation in labour markets. (UNDP 2011). A higher score on the index means that gender inequality is more pronounced in the country.

While the index includes only a limited number of indicators of gender inequality, it provides a useful summary of gender inequities across countries. It indicates that in countries where human development is uneven there is also high inequality between men and women. *Table 1* below presents UNDP Gender Inequality Index for EQUINET’s 16 focal countries. Mauritius has the lowest gender inequality and the Democratic Republic of Congo has the highest. The civil war in the DRC is likely to play an important role in explaining why the DRC performs poorly in this index. War can be especially damaging to the rights of women and children. In the DRC there have also been extensive reports of rape, sexual slavery, purposeful mutilation of women’s genitalia, and killings of rape victims, particularly in eastern Congo (Wakabi 2008). In comparison, Mauritius has a stable democracy with one of the highest per capita incomes in Africa.

Table 1: UNDP Gender Inequality Indices, 2011

| EQUINET focal countries | UNDP Gender Inequality Index 2011 |
|-------------------------|-----------------------------------|
| DRC | 0.71 |
| Kenya | 0.63 |
| Zambia | 0.63 |
| Mozambique | 0.60 |
| Malawi | 0.59 |
| Tanzania | 0.59 |
| Uganda | 0.58 |
| Zimbabwe | 0.58 |
| Swaziland | 0.55 |
| Lesotho | 0.53 |
| Botswana | 0.51 |
| South Africa | 0.49 |
| Namibia | 0.47 |
| Mauritius | 0.35 |
| Angola | Data unavailable |
| Madagascar | Data unavailable |

Source: UNDP, 2011

The next subsections explores further the dimensions of gender inequality.

3.3 Education

Education is an important structural determinant of health, as a woman’s educational level is an independent predictor of whether she has access to and utilises health care (Fransen 2003). One example of this has been in intrapartum delivery care: women with higher literacy rates had higher rates of skilled attendance at delivery (Fransen 2003). Also, low levels of maternal education are a risk factor for maternal mortality (Karlsen et al. 2011). In sub-Saharan Africa, women having some secondary education or higher are, on average, two times more likely to have their need for family planning met, compared with women who have no formal education (Ortayli and Malarcher 2010). *Table 2* compares primary school attendance for boys and girls in the 16 countries discussed in this report. It can be seen that the DRC has one of the lowest ratios whereas Mauritius has one of the highest. Again, the war and the fear of sexual violence are likely to impact on girls’ attendance. In 1994, Malawi

embarked on a programme to improve female literacy which may explain Malawi's success in improving girl's attendance in primary school.

Table 2: Ratio of primary school attendance of girls to boys, 1990, 2000 and 2007

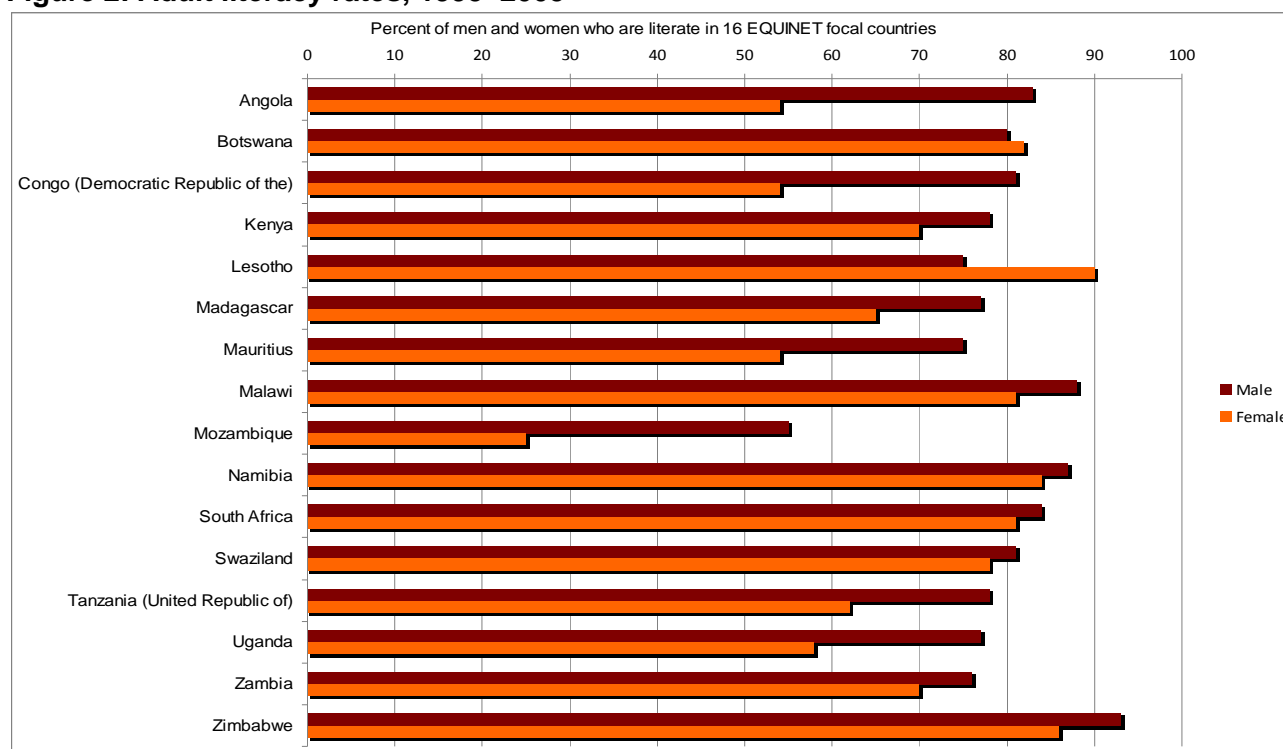
Boys are set at 100 so the girl's figure is relative to this

| Country | 1990 | 2000 | 2007 |
|-----------------------------|-------------|-------------|-------------|
| Angola | 92 | Unavailable | 94 |
| Botswana | 107 | 100 | 97 |
| DRC | 70 | Unavailable | 82 |
| Kenya | 97 | 99 | 99 |
| Lesotho | 122 | 104 | 104 |
| Madagascar | 96 | 96 | 97 |
| Malawi | 87 | 97 | 104 |
| Mauritius | 101 | 99 | 100 |
| Mozambique | 75 | 75 | 84 |
| Namibia | 100 | 101 | 108 |
| South Africa | 99 | 95 | 96 |
| Swaziland | 99 | 95 | 93 |
| Uganda | 80 | 92 | 100 |
| United Republic of Tanzania | 99 | 99 | 98 |
| Zambia | Unavailable | 93 | 97 |
| Zimbabwe | 99 | 97 | Unavailable |

Source: World Bank, 2011

However, despite these achievements girls are still less likely to be in school than boys. As can be seen in *Figure 2* there is also a wide disparity between male and female adult literacy, with adults aged 15 years and older. At the extreme end of the scale, Mozambican women are 50% less likely to be literate than men. Only in Botswana and Lesotho do women have higher rates of literacy than men.

Figure 2: Adult literacy rates, 1995–2005



Source: World Health Organisation, 2011

Various initiatives have been taken to improve literacy and education outcomes in females. In 1994, Malawi, with low levels of female attendance relative to male (See Table 2) embarked on a programme to improve female literacy – see *Box 2*.

**Box 2: Free primary education to improve enrolment in primary schools:
A case study from Malawi**

Providing free primary education has been an important intervention in improving both girls' and boys' attendance in schools. In 1994, Malawi introduced free primary school education for all children. This led to a rapid increase in the number of children attending from 1.9 million to 2.9 million in one academic year. Parents of school-age children responded immediately to the removal of this financial barrier. However, Chimombo found that while the number of pupils attending primary school increased, the quality of the teaching and the learning environment worsened. This was because the introduction of free primary education was not accompanied by an increase in funding for more teachers or materials, which resulted in a marked decline in grades and numbers of children graduating to secondary school. This case highlights the importance of addressing not just the availability of free education but also the quality of that education once it has been provided.

Source: Chimombo, 2005

Conditional transfers have also been used to increasing female literacy, as shown in *Box 3*.

**Box 3: Intervention to improve primary and secondary school attendance:
Conditional cash transfers**

Governments and external funders have used conditional cash transfers worldwide to improve the education, health and nutrition of vulnerable children. Conditional cash transfers are small amounts of money that are paid upon achievement of certain social goals, such continued attendance at school. While the largest number of studies examining conditional cash transfer programmes have come from Latin America and Asia, important results are emerging for Africa. This includes Malawi, where a recent study was published in the *Lancet*, and South Africa where trials are on-going.

In the educational sector cash transfers have the potential to increase children's attendance as well as make them more likely to stay in school. This is because they can be used to cover school expenses such as school uniforms and travel, compensating for lost income if children go to school rather than work and ensuring children are better nourished at school. If the transfer is given as an incentive this can increase children's attendance. In high HIV prevalence countries, the transfers can be particularly advantageous to girls as they are often the ones who provide care for HIV-positive family members. There have also been studies showing a positive relationship between girls' enrolment in a cash transfer programme and reduced frequency of sexual activity as well as reduced HIV risk.

Sources: Adato and Bassett, 2009 ; Duflo et al, 2006; Pettifor et al, 2008; Baird et al, 2012

Beyond access, issues of the quality and orientation also affect whether education systems challenge or reinforce the norms that lead to gender inequality, with a positive example shown in *Box 4*.

Box 4: The Forum of African Women Educators: Developing a gender-sensitive curriculum for schoolgirls

The Forum of African Women Educators, through its Female Education in Mathematics and Science in Africa programme, aims to increase girls' participation and achievement in maths, sciences and technical subjects through multiple interventions. One way is through a gender-sensitive curriculum and pedagogy that relates these subjects to girls' daily experiences and to the uses of science and math in the local community. The programme recommends that material should be presented in ways that engage girls, such as through problem solving and collaborative learning.

Source: UN Millennium Project, 2005a

3.4 Fertility rates

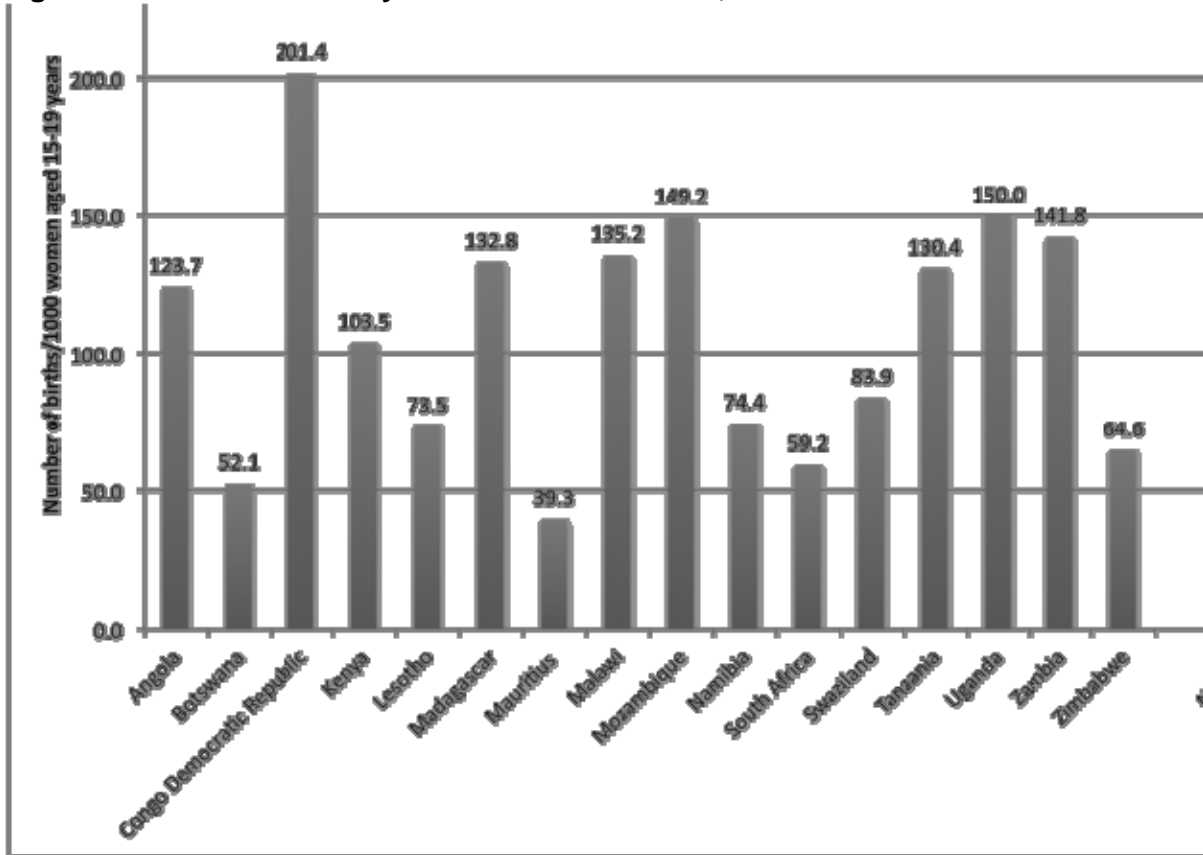
Reproductive self-determination contributes to women’s autonomy over their reproductive role, as well as improving health outcomes. Women’s empowerment is inextricably linked to their ability to control their reproductive capacity. Many other aspects of women’s lives, such as education and employment opportunities are impacted on by their fertility. Reproductive decision-making may be shaped by considerations of access and importantly, may reflect socio-political norms and power relations in any given context.

The reproductive role of women is one of the most important factors that shape their vulnerability to ill health. This is because multiple pregnancies can have a serious impact on women’s health, dramatically increasing their risk of death and morbidity. Limited control over their reproductive rights can also limit women’s ability to participate in the labour market as well as in community activities.

Power relations within the household affect decision-making on the use of contraception. This and the accessibility of modern contraceptive methods are important determinants of women’s fertility rates. As shown in *Figure 3*, adolescent fertility rates in the 16 ESA countries covered are high, raising the risk of intrapartum complications and death. The high fertility rates are indicative of poor access to contraceptives and a poorer ability to negotiate their use.

Mauritius has the lowest fertility rates and DRC the highest. The threat of sexual violence may play a role in women’s ability to negotiate safer sex in the DRC. The nature of conflict settings can often lead to large gaps in the functioning of the health system. Therefore, in the DRC access to contraception may be severely disrupted. In comparison to the 10 highly developed countries the fertility rates in all of the EQUINET countries are much higher. This highlights the importance that development is likely to have on adolescent fertility rates.

Figure 3: Adolescent fertility rates in ESA countries, 2009

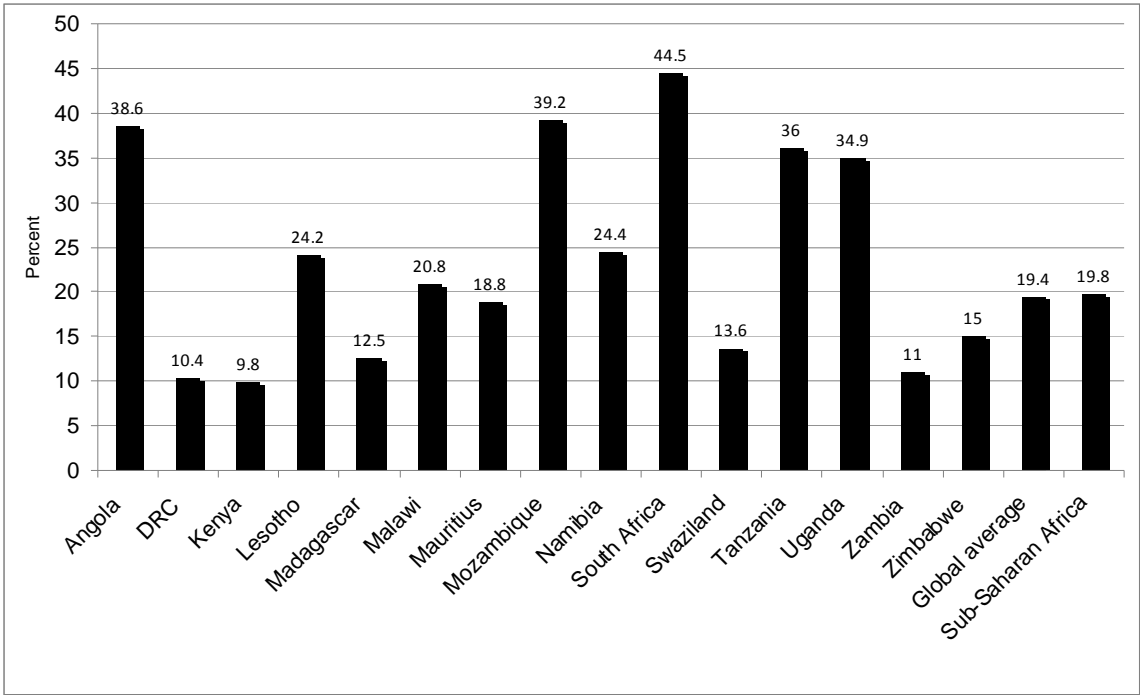


Source: United Nations Department of Economic and Social Affairs, 2009

3.5 Participation in decision making at national level

Women are commonly under-represented in national legislative bodies and executives in many countries globally. The first requirement of a representative democracy is that it represents all its citizens. In *Figure 4* the low percentage of seats held by women in national parliaments in 2011 in the 16 focal countries, as well as the global and Sub-Saharan African averages, are shown. By failing to ensure that women are adequately represented at the national level, states are failing to fulfil the central tenet of representative democracy. Moreover, by failing to provide their political representation, women they are denied a voice in national as well as international politics. This denial of voice is replicated in all representative institutions nationally and internationally.

Figure 4: Percentage seats held by women in national parliaments, ESA countries, 2011



Source: Inter-Parliamentary Union, 2011

The percentage of women in parliaments in Sub-Saharan Africa (19.8%) is slightly greater than the global average (19.4%). Globally, South Africa has been seen as a successful case in improving female representation. It is one of the few countries in the world that has almost reached gender parity in representation. One key reason for this success has been the mobilisation of the women’s movement during the transition to democracy. The movement lobbied the African National Congress (ANC) to introduce quotas for women (Goetz and Hassim 2003). In Kenya, women’s political representation falls far below the global and sub-Saharan averages for women’s representation. Unlike South Africa, political parties have not instituted gender quotas to ensure female candidates are fielded at elections. This highlights the important differences in electoral systems between the two countries. In order to improve women’s political representation the introduction of quotas is an important first step.

Although these trends are positive, women’s increased representation has not automatically reflected increased participation by women in the decision-making processes in national legislators. This is because once women enter elected bodies they may face a number of obstacles, including lack of support from their own political parties or a political system that privileges men (Ballington and Karam 2005). Further, national media may not support their political agenda and women’s movements may not be able to support the candidate (ibid).

3.5 Participation in decision making within households

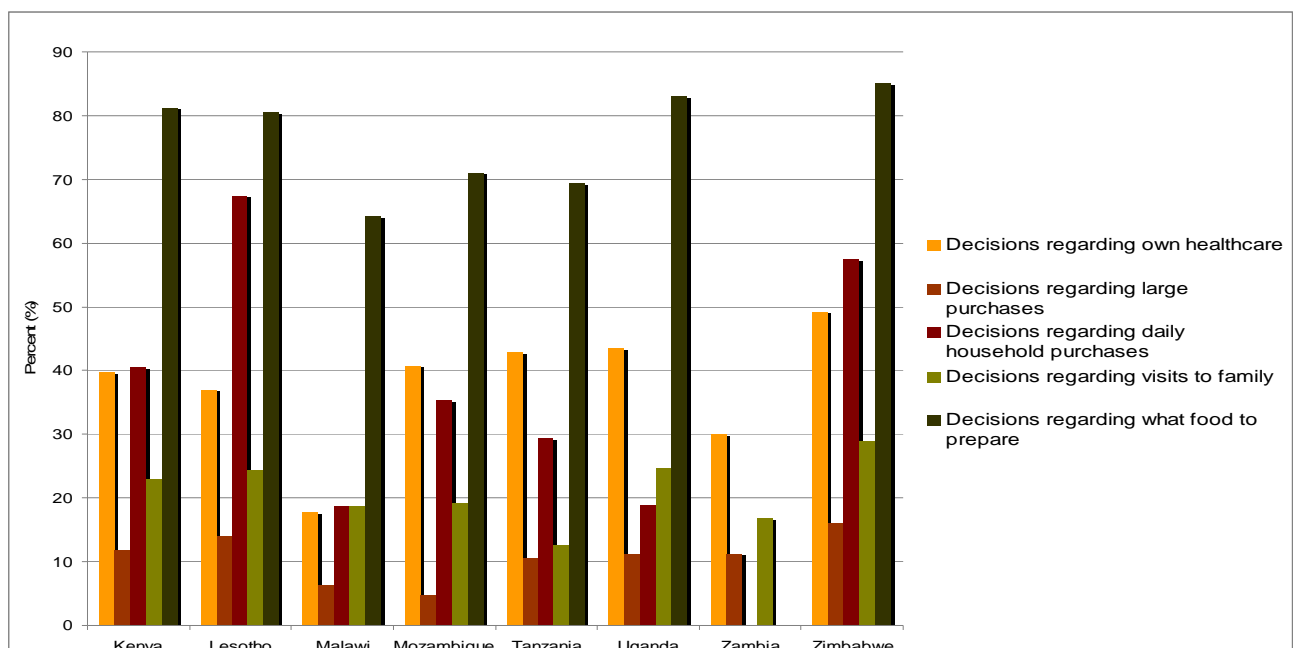
As the section above highlights, women are often absent from national parliaments, which can severely limit their voice in international and national decisions. This lack of voice and, by extension, lack of autonomy can also be found within households and is often rooted in imbalances of power between men and women. There is evidence that how resources are distributed within households is influenced by who receives and controls the income. Studies in developing countries have shown that women tend to allocate more income to children's needs than men (Duggan 2011; Kanbur and Haddad 1994).

Economic models have often theorised that households are unitary (Basu 2006) with the assumption that household members pool income and behave altruistically towards one another (Duggan 2011). Feminist economists have played an important role in dispelling this notion and unpacking gendered power dynamics within households. Ultimately, who is able to access resources and make decisions depends on a number of factors including an individual's perceived contribution to the household's livelihood or what Sen (1990) terms their 'breakdown' position: the social or economic position an individual would be left with in the event of a breakdown of their relationship.

This decision-making process is often referred to as intra-household bargaining, and influences who has access to and control over the resources within the household (Kandiyoti 1988). A woman's bargaining position is strengthened by her ability to earn an independent income, to find employment outside the home, to have ownership rights and to have access to education (Sen 1999). The power to make decisions and access economic resources are important for health, as it influences when household members, in particular women and girls, are able to seek treatment when they are sick, or when mothers are able to seek treatment for their children. If they do not control resources, women may not be able to cover the indirect costs of seeking health care such as transportation.

Figures 5 and 6 show women's involvement in a range of issues relevant to their daily lives and households, shown separately for those married or not.

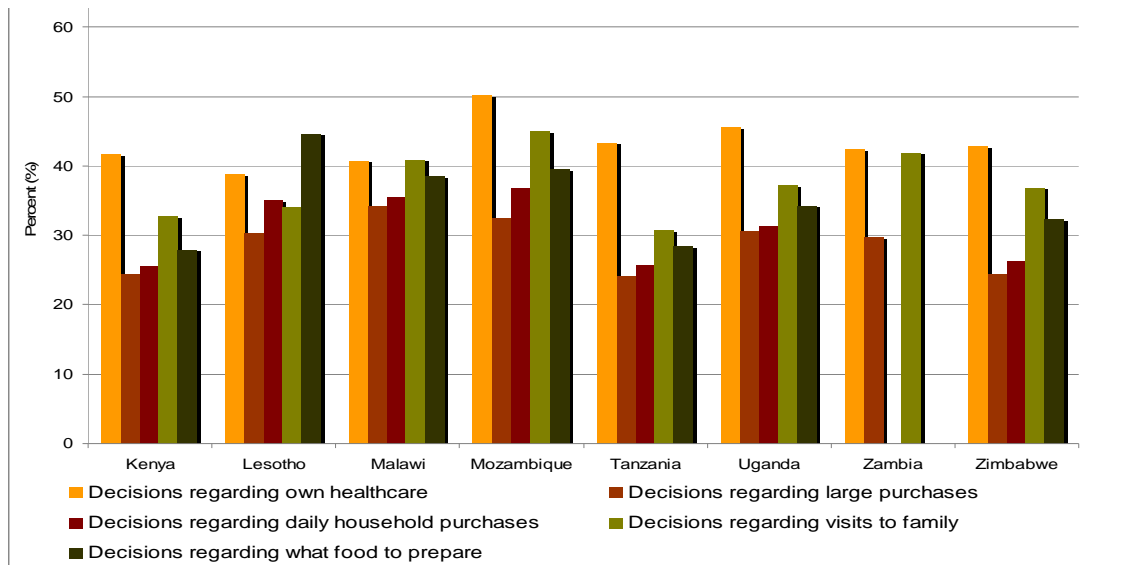
Figure 5: Proportion of married women involved in household decision-making, 2011



No data for Angola, Botswana, DRC, Madagascar, Mauritius, Namibia, South Africa, Swaziland.

Source: Measure DHS STAT compiler, accessed 2011

Figure 6: Proportion of unmarried women involved in household decision-making, 2011



No data for Angola, Botswana, DRC, Madagascar, Mauritius, Namibia, South Africa, Swaziland.
 Source: Measure DHS STAT compiler, data for 2011

As can be seen from the figures, married women have more involvement in decision-making in terms of what food is prepared within the household, as well as what daily purchases are made. Women, whether married or not, were not equally involved in decisions regarding large purchases. Strikingly, fewer than 50% of women were involved in decisions regarding their own healthcare in all 16 countries. Women appear to be restricted in their ability to make decisions, even regarding their own health and may require permission from their husbands/partners to do this. This has important implications for gender equity and health. If women are unable to seek treatment without their husband's permission, it may mean that they seek treatment and in turn, care, later rather than sooner and may become considerably more ill in the process and therefore require more expensive treatment.

Gender roles dictating that men should be the economic provider within the household may also influence when men themselves seek care. Evidence from research on treatment-seeking for HIV services suggests that masculine norms and identities may shape men's identities and limit their access of ART (Bila and Egrot 2009; Skovdal et al. 2011). Research in Zimbabwe found that social constructions of masculine ideals requiring men to exert control, and to be knowledgeable, strong and free of illness as well as sexually and economically 'productive' were in direct conflict with the requirements of health-care facilities providing HIV care. Not only were men more likely to play down, or deny the risk of their exposure to HIV, but they also resisted attendance at facilities they viewed as primarily 'female' spaces (Skovdal et al 2011:11).

3.6 Access to sanitation and clean water

Access to clean water is vital to good health and development. This is reflected in the first Millennium Development Goal, which committed countries to improving access to clean water and sanitation for all their citizens. In nearly all societies women have the primary responsibility for management of household water supply and sanitation (UN Water 2006). Water is required for drinking, food production and preparation, care of domestic animals, personal hygiene, care of the sick, cleaning, washing and waste disposal (UN Water 2006). All of these activities are vital for all members of households to remain healthy.

Women and men have different exposure to water-borne diseases because of their gendered roles within society. For example, women's gendered roles may place them at an increased vulnerability to water-borne diseases due to their water-collection and cleaning

duties. In secondary schools, inadequate toileting provision can prevent menstruating girls from attending school (UN Water 2006).

Within households, water distribution may be gendered, with men given preferential access over women and girls. As an adequate quantity of clear water is essential for prevention of diarrhoeal diseases, women may be at increased risk (Moshabela et al. 2011).

These gendered structural determinants may mean that women are unable to enjoy and exercise their rights. For example, the prevalent gendered norm that women (and not men) are responsible for water collection and for the sanitation of the family means that women expend considerably more time than men on these domestic tasks, often at the expense of schooling and economically productive activities (UN Water 2006).

Despite the importance of providing access to water and sanitation and the commitment of the MDGs, at the end of 2004 there were 1.1 billion people, or 18% of the world's population, who lacked access to safe drinking water, while 2.6 billion (40%) lacked access to improved sanitation services (ibid). Providing physically accessible clean water is an essential component of enabling women and girls to devote more time to pursue their education or income-generating activities.

3.7 Gender inequalities in employment

Both formal and informal work can play an important role in determining women's and men's relative wealth, power and prestige (Messing and Östlin 2006). This in turn can generate gender inequities in the distribution of resources, benefits and responsibilities that can then impact on health. In other words, gender inequalities are both manifested and sustained in the workplace (ibid).

The global division of labour within the formal workforce continues to be gendered. Despite the growing number of women entering the workforce, they still rarely occupy high-ranking positions in the formal sector. Instead, they tend to be clustered in the informal sector where jobs are less secure, wages are lower and people are given fewer rights (UNWOMEN 2011b). In every country in the world women are paid less than their male counterparts. This is true across different groups of workers (agricultural, production, supervisory) and different types of earnings (monthly, hourly, salaries) (UN Millennium Project 2005a). Globally, women's salaries are 17% lower than men's (UNWOMEN 2011b). Women also suffer more from growing competitive pressures, resulting in job insecurity, limited possibilities for training and promotion, and inadequate social benefits (e.g. insurance or sick leave) (UNWOMEN 2011b).

In spite of the changes that have occurred in women's participation in the labour market, women still continue to carry most of the responsibility for care within the home. This includes caring for children and other dependent household members as well as doing housework. Women who are working can therefore experience a double burden of trying to juggle paid work with family responsibilities. This can have a detrimental effect on women's health as they are less likely to take breaks and may work much longer hours than men.

Within low-income settings women's workload in the household can be extremely physical (WHO 2004). Women providing water and fuel can carry heavy loads and walk long distances, which can lead to muscular-skeletal disorders and reproductive health problems (ibid). Washing clothes can expose women to water related diseases such as schistosomiasis, malaria and worms (ibid). Women cooking at home on open-stoves can risk burns and exposure to smoke containing toxic pollutants.

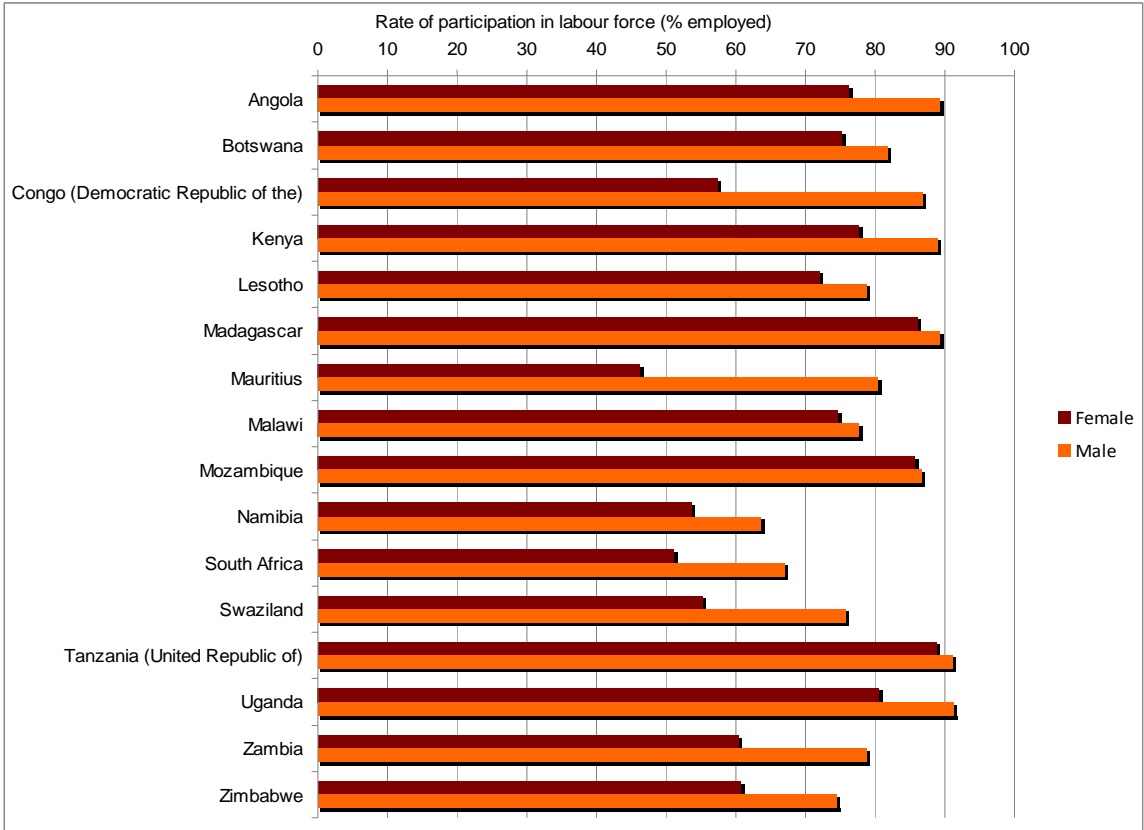
Exposures to ill health at work also have important gender dimensions. In developing countries women and men work different tasks in the areas of agriculture, mining,

manufacturing and services (ibid). In South Africa, for example, women are exposed more often to pesticides indirectly during planting and harvesting and men directly during application (ibid). Men often occupy high-risk professions such as long distance truck driving, mining and fishing – all professions where men risk mortality or morbidity. In Southern and Eastern Africa the structural environment has also increased vulnerability to HIV for men working in these professions (Morris, Morris and Ferguson 2009; Piot et al. 2001; Ramjee and Gouws 2002).

Gendered notions of masculinity that reinforce roles that men are economic providers can also influence men’s identity when they fail to find employment. Research conducted in Kenya and Tanzania points to the gendered significance of addressing male identity in the light of socio-economic deprivation and disempowerment over decades (Silberschmidt 2001). Evidence from qualitative and quantitative findings suggests that men’s increased poverty and lack of employment opportunities in East African contexts has contributed to a lack of self esteem, which in turn, leads to men’s need to reinforce their sense of masculinity through multiple sexual encounters (Silberschmidt 2001). These observations reinforce the importance of addressing notions of masculinity in relation to gender, development and health.

Figure 7 below shows the differences between male and female participation in the 16 countries covered. The ‘rate of participation in the labour force’ is derived from the proportion of a country’s working-age population that engages in the labour market, either by working or actively looking for work, and is expressed as a percentage of the working-age population.

Figure 7: Rate of participation in the labour force, 2011



Source: UNDP, 2011

In all the countries there is a higher labour force participation rate for men than women. However, between countries there is also a large difference. In the Democratic Republic of Congo only 54.7% of women participate compared to 88.8% in Tanzania.

Globalisation has led to growth in non-regular and increasingly flexible employment (UN Millennium Project 2005a). Women have dominated these roles in both manufacturing as well as for agricultural export markets (Standing 1999). In South Africa, women are the preferred sex for temporary work in the grape export industry, yet they only make up a small share of those with permanent jobs (Barrientos 2001). Informal employment is often characterised by unhealthy working conditions, low and irregular incomes, and long working hours. These long working hours can also impact on utilisation of health care, particularly those based in the community that often have limited opening hours for patients.

In the informal employment sector access to markets, finance, training and technology is often limited (UN Millennium Project 2005a). All these factors are likely to have an impact on the health of those who occupy these roles (both for men and women). However, despite facing increased risks from their working conditions, informal workers usually have little or no social protection and receive little or no social security (either from employers or government) to cushion them if they did face adverse health issues (ILO 2002).

4. Gender equity in health outcomes

This section presents our findings gender equity in health outcomes in the 16 ESA countries. Selecting from the progress markers on the EQUINET Equity Watch (Loewenson et al 2010), we discuss using a gender lens:

- i. the nutritional status of women and girls
- ii. sexual and reproductive health, including fertility and measures of maternal health and mortality
- iii. access to HIV and AIDS prevention and treatment services.

4.1 Gender dimensions of nutrition

The United Nations' Food and Agricultural Organisation (FAO) estimates that globally approximately one billion people are undernourished (FAO 2011b). These micronutrient deficiencies affect approximately two billion men and women and can lead to blindness, poor growth, increased severity of infections and sometimes death (FAO 2011b).

Nutritional status can also have a detrimental effect on women's reproductive health and is an issue which is often overlooked (UN Millennium Project 2005a). However, a child's early survival and development often depends on the nutritional status of their mother. A woman who has poor nutritional status when she conceives or does not gain enough weight during her pregnancy is likely to give birth to a baby with a low birth weight (UNICEF 2011). The children of women who have never received an education are 50% more likely to suffer from malnutrition or to die before the age of five (UNFPA 2002). *Box 5* provides key areas for action to improve nutrition for pregnant women.

Box 5: Key areas for action: Improving nutrition for pregnant women

Nutrition programmes that aim to improve reproductive health outcomes mainly focus on the time when women are pregnant or postnatal. These interventions often provide women with iron folate supplements. However, this has a limited impact on the prevalence of malnutrition in both women and children. Research has shown that a better time to intervene is before pregnancy. This is because the risks attached to under-nutrition are as great from being underweight before pregnancy as from being underweight during pregnancy.

This suggests that designing programmes that target non-pregnant women and adolescents could be an important approach. This could be undertaken by improving access to family planning services to prevent unwanted pregnancy particularly in adolescent girls. Family planning services could also be adapted to encourage later marriage as well as improvements in women's diet through food security measures, diet diversity and reducing infections such as intestinal worms.

Sources: Allen and Gillespie, 2001; UN Millennium Project, 2005a

Approximately 14% of infants in the Southern and Eastern region of Africa weigh less than 2.5 kilos at birth (and so are classified as 'low birth weight'). Low birth weight is a leading cause of neonatal mortality (UNICEF 2011). It is estimated that approximately 60% of the chronically hungry people in the world are women and girls (World Food Programme 2011). Despite reductions in the number and proportion of malnourished children in Africa in the 1970s and 1980s, since 1990 the numbers have increased (United Nations 2004).

There are multiple causes of malnutrition at the local, national and global level. The FAO see rural poverty, population growth and environmental degradation as the root causes (FAO 2011a). These have been exacerbated by the global economic downturn, volatile food prices, war (especially in the Horn of Africa) and the impacts of climate change. Neo-liberal economic policies and the resulting reduction in social spending (Gonzalez 2004), as well as commodity trading in agriculture have all played a role in pushing up the price of food. In Southern and East Africa these effects are particularly pronounced, given the high levels of rural poverty.

Loewenson et al (2010) explored the link between globalisation and nutritional outcomes in sub-Saharan Africa, focusing on the pathways of women's occupational roles on the food produced, consumed, and secured for households. They found evidence that globalisation-related economic and trade policies have been associated with shifts in women's occupational roles and resources, which have contributed to poor nutritional outcomes in Africa.

Approximately 70% of the population in Southern Africa depends on agriculture as their main source of food, income and employment (Gawaya 2008). Men and women tend to occupy different positions however, with women providing 70% of the food in the region (Gawaya 2008). In sub-Saharan Africa, women – particularly those in rural areas – have fewer social and economic opportunities than men as well as less access than men to productive resources such as land (FAO 2011a). The gender gap is found for many assets, inputs and services and it imposes costs on the agriculture sector, the broader economy and society as well as on women themselves (FAO 2011a).

4.2 Sexual and reproductive health

Sexual and reproductive health rights address the health and well-being of people in matters related to sexual relations, pregnancy and birth. The ability of women to realise their sexual and reproductive rights is vital to achieving gender equity in health as well as the empowerment of women.

Cleland et al. (2006) present data showing that in countries with high birth rates and rapid population growth, the promotion of family planning has the potential to reduce hunger and poverty and to avert 32% of all maternal deaths and nearly 10% of childhood deaths. Family planning also frees women from the load of excessive and unwanted childbearing and means they have control over the consequences of their sex life. The WHO estimates that sexual and reproductive ill health accounts for almost 18% of all disability adjusted life years (DALYs) (Thomas 2006). The WHO measures Disability Adjusted Life Years as the sum of years of potential life lost due to premature mortality and the years of productive life lost due to disability.

Women's inability to control their sexual and reproductive health can result in frequent unwanted pregnancies, high fertility rates, may limit women's ability to do paid work, and may increase the risk of complications during childbirth, all of which put them at an increased risk of maternal mortality (Cleland and Ali 2004).

Globally, the politics of SRH has always been contentious. Of all the public health interventions, they are the most likely to be influenced by politics, tradition and religion rather than scientific evidence, especially where gendered issues are concerned. The

unease that many people feel about discussing sex and the low status of women in many countries has meant that SRH rights have not always been enacted (Buse et al. 2006).

Buse et al argue that the political and legal frameworks for sexual health have largely been determined by the perceptions of cultural norms and moral standards of the countries concerned. SRH policies have been met by both passive and active resistance (at both local and international levels) and this has often influenced implementation of policies (Buse et al. 2006). Religious conservatives fiercely fought international agreements such as the Cairo and Beijing plans of action to enfranchise girls and women (as discussed in Section 3).

Since 1985, United States (US) funding for sexual and reproductive health in developing countries has depended on the political orientation of the US president. This is because of the Mexico City Policy – many women’s right organisations refer to it as the ‘Global Gag Rule’. The rule was first introduced by Ronald Reagan to prevent US financial assistance being given to organisations who educate either governments or the public on the need for safe abortion. The policy allows for exemption in cases of rape and incest, and where the life of the mother is endangered, but not for the pregnant woman’s physical or mental health (Centre for Health and Gender Equity 2011).

Of the 20 million unsafe abortions which took place in 2003 nearly, 98% of them were in developing countries with restrictive abortion laws (WHO 2003), while nearly 200 women die each day from abortion related complications (Gordon et al. 2010). Africa accounts for 25% of all illegal abortions performed worldwide and less than 1% of all legal abortions (Baggaley, Burgin and Campbell 2010). An estimated 90% of deaths from unsafe abortions and 20% of obstetric mortality could be averted by universal access to modern family planning methods. As can be seen in *Table 3* on abortion laws in the 16 ESA countries overleaf, every country allows abortion on the grounds of saving a women’s life. However, there is a wide variation on whether women can get an abortion for any other reason. Angola, Democratic Republic of Congo and Lesotho have the most restricted while South Africa has the most liberal abortion laws. In 1996, following the end of apartheid rule and the transition to democracy, the South African government introduced the Choice on Termination Act, No. 92 of 1996, which granted abortions on a number of grounds, including on request.

As can be seen from *Box 6*, legalisation of abortion in South Africa is associated with reduced mortality of women due to unsafe abortion. South Africa also provides an important example of how women’s groups can mobilise in the political context for improved rights to abortion.

Box 6: Abortion in South Africa

In South Africa, clause 59.1 of the post-apartheid Constitution (1996) requires that Parliament facilitate public involvement in legislative and other processes of the assembly and its committees. Women’s rights groups successfully used this clause to mobilise for legalisation of abortion. One of the key strategies was to allow women who have withstood the worst of unsafe abortions to speak about the need for liberal abortion laws before Parliament. These women also provided quantitative evidence of costs to government (that could be avoided) due to complications of unsafe abortion. As a result, South Africa has one of the most liberal abortion laws. The Choice on Termination Act 92, 1996 allows abortion on request up to the first trimester, permits midwives to conduct abortions and allows adolescent girls the right to access abortion without parental consent.

Jewkes and Rees report a 91% reduction in deaths from unsafe abortion from 1994 (before the Termination Act had been passed) to 2000 (once the was in operation). They compared the number of abortion-related deaths found in the Confidential Enquiries into Maternal Deaths by the

Department of Health (1999 and 2003) and the 2000 national incomplete-abortion survey with the estimates of pre-legislative reform pre-1994 mortality found in the 1994 national incomplete-abortion survey. The latter survey estimated that there were 425 deaths each year in public facilities from unsafe abortion. When the survey was repeated in 2000, no deaths were detected in the three-week data collection period in any study hospital. Therefore they could conclude that a significant decline in mortality had occurred although it was not possible to estimate the annual number of deaths.

Sources: Jewkes and Rees, 2005; Murthy, 2008

Table 3: Legal grounds for abortion, 2007

| Countries | Grounds on which abortion may be permitted | | | | | | |
|---|--|-----------------------------|---------------------------|----------------|-------------------|---------------------------|------------|
| | To save a woman's life | To preserve physical health | To preserve mental health | Rape or incest | Foetal impairment | Economic or social reason | On request |
| Angola ² | ✓ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Botswana | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✗ |
| Democratic Republic of Congo ² | ✓ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Kenya ¹ | ✓ | ✓ | ✓ | ✗ | ✗ | ✗ | ✗ |
| Lesotho | ✓ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Madagascar ² | ✓ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Malawi ² | ✓ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Mauritius ² | ✓ | ✗ | ✗ | ✗ | ✗ | ✗ | ✗ |
| Mozambique | ✓ | ✓ | ✓ | ✗ | ✗ | ✗ | ✗ |
| Namibia | ✓ | ✓ | ✓ | ✓ | ✗ | ✗ | ✗ |
| South Africa | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Swaziland | ✓ | ✓ | ✓ | ✗ | ✓ | ✗ | ✗ |
| Tanzania | ✓ | ✓ | ✓ | ✗ | ✗ | ✗ | ✗ |
| Uganda ¹ | ✓ | ✓ | ✓ | ✗ | ✗ | ✗ | ✗ |
| Zambia | ✓ | ✓ | ✓ | ✗ | ✓ | ✓ | ✗ |
| Zimbabwe | ✓ | ✓ | ✗ | ✓ | ✓ | ✗ | ✗ |

¹. The abortion laws in these countries wither expressly allow abortions to be performed only to save the life of the woman, or are governed by general principles of criminal legalisation which allow abortions to be performed for this reason on the ground of necessity.

². The abortion laws in these countries do not expressly allow abortions to be performed to save the life of the woman, but general principles of criminal legislation allow abortions to be performed for this reason on the grounds of necessity.

Source: UN, 2007

4.3 Maternal mortality

Women's access to antenatal services and support during labour are vital elements of sexual and reproductive health rights. Maternal mortality is defined as the death of a woman during pregnancy, childbirth or in the first 42 days after giving birth (Hogan et al. 2010). The Maternal Mortality Ratio (MMR) is the number of maternal deaths in a population divided by the number of live births (WHO et al. 2007). It is one of the health indicators which shows the greatest gap between rich and poor – both between countries and within them (Ostlin 2009). This is highlighted by the fact that 99% of all maternal deaths occur in developing countries, with more than half of these deaths occurring in sub-Saharan Africa (WHO et al. 2007). A woman's lifetime risk of maternal death is 1 in 7,300 in developed countries versus 1 in 75 in developing countries (WHO et al. 2007). Power dynamics within the household can mean that women are unable to take control over their reproductive health, putting them at increased risk of maternal death.

With the adoption of Millennium Development Goal 5 (MDG 5), countries have committed to reducing the maternal mortality ratio by three quarters between 1990 and 2015. However, between 1990 and 2005 the maternal mortality ratio declined by only 5%. Achieving MDG 5 requires accelerating progress. According to the 2005 data, few of the low- and middle-income countries will achieve this target. The global maternal mortality ratio (MMR) of 450 deaths per 100,000 live births in 2005 has barely changed since 1990 and there has been no measurable improvement between 1990 and 2005 in the African region, where maternal mortality is 900 per 100,000 live births (WHO et al. 2007). In stark contrast, in the United Kingdom maternal mortality is less than 10 per 100,000 live births, highlighting the inequality that exists between developing and developed countries (ibid).

With the exception of Mauritius, none of the ESA countries in this review are likely to achieve their MGD5 target (Hogan et al, 2010). There has been a downward trend in mortality in many of these countries, including the DRC, Madagascar, Kenya and Tanzania. The improvements in maternal mortality in these countries may be explained by a number of factors. Hogan et al. (2010) argue that globally total fertility rates have been declining since 1980 (3.70 in 1980, to 3.26 in 1990 and 2.56 in 2008). There has also been an increase of per capita income (although this is less marked in ESA countries than in other regions of the world). Rising per capita income can impact on maternal mortality through improving women's nutritional status and their financial access to health. Educational attainment may also play a role in these improvements (maternal educational attainment is a strong correlate of maternal mortality) and has been rising in Sub-Saharan Africa since 1980 (Hogan et al. 2010). The upward trend of worsening maternal mortality in other countries, mainly Southern Africa including South Africa, Namibia, Swaziland and Zimbabwe may be due to the HIV epidemic, which has led to a significant increase in maternal deaths (ibid).

Nearly half of all maternal deaths in developing countries occur during labour, delivery or the immediate post-partum period (UN Millennium Project 2005a). The main causes of death are: postpartum hemorrhage (24%); indirect causes such as anemia, malaria, and heart disease (20%); infection (15%); unsafe abortion (13%); eclampsia (12%); obstructed labour (8%); and ectopic pregnancy, embolism, and anesthesia complications (8%) (Nour 2008).

Nour (2008) argues that there are three key delays that increase maternal mortality in resource poor settings. These are:

- delay in deciding to seek care
- delay in reaching care in time
- delay in receiving adequate treatment.

The delays arise due to a number of factors both outside and within the health system. The decision to seek treatment is usually made by the mother, family or community members. Economic resources and distribution of these resources within the family may prevent or delay women from seeking treatment (ibid). Unskilled attendants who do not have the medical knowledge to predict or prevent bad outcomes often attend women in rural settings.

Further delays may occur if the birth attendant or mother are unable to recognise a life threatening condition treatment.

The accessibility of health services may lead to delays in women reaching care. Challenges in accessing care may arise due to distances to facilities, the condition of the roads and availability of transport (ibid). Any or all of these conditions could lead to women with life-threatening problems not reaching facilities. Even if women are able to make it to the health facility there may be inadequate treatment due to inadequate health workers, medicines or equipment to provide women with a safe birthing experience.

Interventions to prevent maternal mortality need to be enacted both within the health system as well as outside the health system. The focus of interventions also needs to go beyond simply focusing on pregnant women. Tolhurst et al (2009) provide important insights into how using advocacy and taking an inter-sectoral approach is important to improving sexual and reproductive health. They argue for advocacy for policies, services, and resource allocations to establish the sexual and reproductive rights of women, men, boys and girls and to ensure that they are met (ibid). Nour also emphasises the importance of safe abortions as well as family planning – particularly for hard-to-reach populations. Intervening also means going beyond simple service delivery and using inter-sectoral collaboration to improve women's bargaining power and access to and control over resources (Tolhurst et al, 2009).

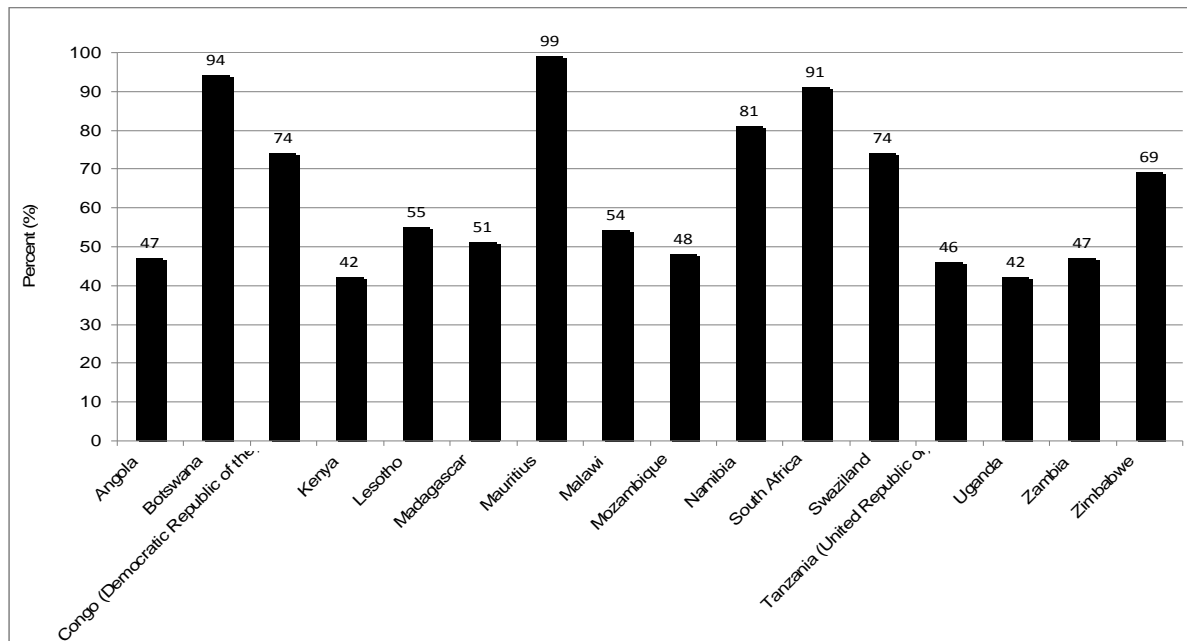
Governmental policies must aim to improve maternity rights, increase girls' access to education, improve women's equitable access to productive resources, and encourage men's increased contribution to reproductive work, including caring for children. Ensuring sufficient resource allocation, nationally and internationally, to guarantee the availability and accessibility of good quality, patient-centred maternal and child health care, (including obstetric services) requires committed advocacy for improving geographically equitable provision of services (Tolhurst, Raven and Theobald 2009). Policy-level approaches to improve access to services include removing user charges, including services in social or community-based health insurance schemes, and providing free emergency transport to health facilities.

The activity of organised women's groups is also important for realising reproductive health and rights worldwide (Tolhurst, Raven and Theobald 2009). Involving such groups in policy and its implementation is a key strategy for improving both participation of and accountability to different groups of women. Such groups can lobby for relevant legal changes, as well as for greater commitment to and resources for ensuring safe motherhood. They can engage in dialogue with health service providers over quality of care issues on behalf of patients.

As most women in resource-limited settings give birth at home priority is given to having a skilled birth attendant present when women are giving birth (Nour 2008). Skilled birth attendants are important because they are able to prevent, detect, manage or refer women with major obstetric complications (Wirth 2008). In *Figure 8* the proportion of births attended by a skilled birth attendant in the 16 countries is presented.

The figure shows that there is a wide disparity between the 16 countries. In Mauritius, a skilled birth attendant attends 99% of births. This disparity is inverse to the maternal mortality ratios presented earlier, where, for example, Mauritius has the lowest rates. Addressing the barriers to access to maternal health services are thus a key issue for gender equity.

Figure 8: Proportion of births attended by a skilled birth attendant

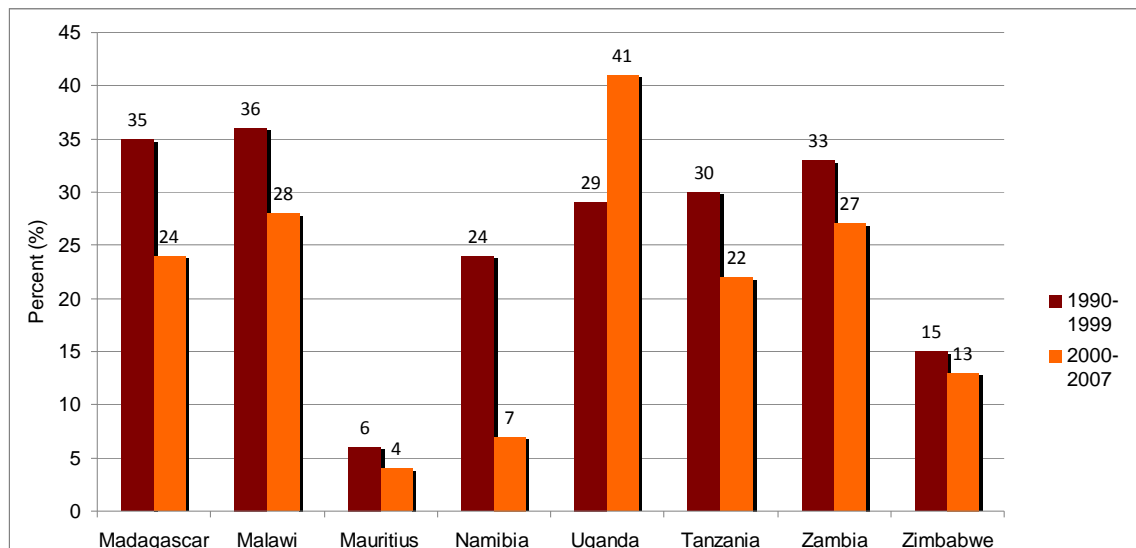


Source: United Nations, 2009

4.4 Unmet contraceptive needs

Unmet contraceptive needs can be used as a proxy measure for access to family planning services (Ortayli and Malarcher 2010). This is because most unplanned pregnancies in the developing world are due to lack of access to family planning services. As seen in *Figure 9* below, where data are available, there is a gap in unmet family planning needs.

Figure 9: Proportion of women with unmet family planning needs, 1990-1999 and 2000-2007



Data missing for Angola, Botswana, DRC, Kenya, Lesotho, Mozambique, South Africa, Swaziland.
Source: WHO, 2011

This is particularly pronounced in Uganda where unmet need has increased from 29% in 1990-1999 to 41% in 2000-2007. Meeting women's family planning needs is vital for empowering women. In countries where abortion is restricted, as shown in Table 3, unmet needs can mean women are more likely to have unsafe abortions. It can also mean that women are at an increased risk of maternal mortality

As discussed above in relation to intervening to prevent maternal mortality, it is critical to ensure that sexual and reproductive health services are accessible for all. In ESA countries this means improving the coverage of family planning services to widen their availability, particularly for hard-to-reach populations, as well as improving their accessibility and responsiveness to the needs of users. Ostlin (2009) argues that in some countries the introduction of women- and adolescent-friendly services has helped to counteract judgmental attitudes of providers, and lack of privacy and confidentiality. Adapted services may include youth-only and men-only clinics women-only services within existing services, or out-reach and community-based services (ibid).

4.5 Gender-based violence

While gender-based violence is pervasive in many ESA countries, it is often under-recognised as a public health challenge. The extent to which women are exposed to violence varies across countries. The data indicates, however, that violence against women is widespread and that women are subjected to different forms of violence – physical, sexual, psychological and economic – both within and outside their homes. Violence limits women's autonomy and their ability to make decisions about their bodies. It can also have a wide ranging impact on the short- and long-term physical, mental and sexual health problems of women (Heise and Garcia-Moreno 2002). These health problems can range from physical injuries to depression and suicide.

According to Duggan (2011), perpetrators of violence against women are most often their intimate partners, and violence may be considered one of the 'most graphic expressions of unequal household power relations' (ibid: 107). Women are abused physically and sexually by intimate partners at different rates throughout the world – yet such abuse occurs in all countries or areas, without exception. There is limited data available on the occurrence of violence against women in sub-Saharan Africa, but the United Nations Children's Fund estimates 13–49% of women reported having been physically assaulted by an intimate male partner (UNICEF 2011). Studies on sexual violence in Ethiopia, Kenya, Namibia, Tanzania, Zambia, and Zimbabwe estimate that 14–59% of women have experienced sexual violence at some point during their lives (UNICEF 2011). Pregnancy can also be a trigger for violence with 10% of ever-pregnant women in Zimbabwe and 7% in South Africa having been attacked during pregnancy (UNICEF 2011).

South Africa has one of the highest rates of rape in the world and in a recent study 27.6% of men interviewed admitted raping a woman (Jewkes et al. 2011). This was an intimate partner, stranger or acquaintance, and the rape was perpetrated either alone or with accomplices. Further, 4.7% men admitted raping a woman in the last 12 months. In the DRC, there have been reports of rebels using rape as a weapon of war to humiliate women and girls as well as to humiliate the women's spouses. It has also been used as a tool to terrorise and demoralise whole communities (Mukwege and Nangini 2009).

Taking action on gender-based violence is vital and required at all levels, including community, legal and health system levels. *Box 6* lists 15 recommendations by WHO for preventing violence against women.

Box 6: WHO's 15 recommendations on action to prevent violence against women

| | |
|-----|--|
| 1. | Promote gender equality and women's human rights. |
| 2. | Establish, implement and monitor multisectoral action plans to address violence against women. |
| 3. | Enlist social, political, religious, and other leaders in speaking out against violence against women. |
| 4. | Enhance capacity and establish systems for data collection to monitor violence against women, and the attitudes and beliefs that perpetuate it. |
| 5. | Develop, implement and evaluate programmes aimed at primary prevention of intimate-partner violence and sexual violence. |
| 6. | Prioritise the prevention of child sexual abuse. |
| 7. | Integrate responses to IPV in existing HIV and AIDS prevention/adolescent health promotion programmes. |
| 8. | Make physical environments safer for women. |
| 9. | Make schools safe for girls. |
| 10. | Develop a comprehensive health sector response to the various impacts of violence against women. |
| 11. | Use reproductive health services as an entry point for identifying and supporting women in abusive relationships, and for delivering referral or support services. |
| 12. | Strengthen formal and informal support systems for women living with violence. |
| 13. | Sensitise legal and justice systems to the particular needs of women victims of violence. |
| 14. | Support research on the causes, consequences, and costs of violence against women and on effective prevention measures. |
| 15. | Increase support to programmes to reduce and respond to violence against women. |

Source: WHO, 2005

Box 7 contains case studies from South Africa and Kenya that show ways in which health providers can work with communities to address domestic violence, as well as improve health systems to provide better services to survivors of gender-based violence.

Box 7: Working with communities and improving health services for survivors of gender-based violence: Case studies from South Africa and Kenya**Working with communities: Soul City, South Africa**

The Soul City intervention in South Africa operated at multiple and mutually-reinforcing levels (individual, community and socio-political) to address domestic violence by increasing knowledge about domestic violence and shifting perceptions of social norms on this issue. The programme is on-going but the intervention used during this evaluation ran from July to December 1999.

The evaluation showed that the Soul City intervention successfully reached 86%, 25% and 65% of audiences through television, booklets and radio, respectively. The evaluation suggests that the intervention played a role in enhancing women's and communities' sense of efficacy, enabling women to make more effective decisions around their health. It concluded that the implementation of the Domestic Violence Act in South Africa can largely be attributed to the success of the intervention.

Improving health systems' responses to survivors of gender-based violence: Kenya

An assessment in 2003 in Kenya revealed limited post-rape services, lack of policy and tensions between HIV and reproductive health staff at service delivery points. Facilities lacked protocols and confidential spaces for treatment. In response, a standard package of care was developed with Liverpool VCT (LVCT). This included the provision of HIV post-exposure prophylaxis (PEP), psycho-social support and gender-sensitive counselling for survivors. By June 2007, there were 13 health facilities providing post-rape care services in Kenya including the national referral and teaching hospital. Between them they had delivered services to over 2,000 adults and children, with 96% of those eligible initiating PEP at presentation.

Sources: Usdin et al, 2005; Goldstein et al, 2005; Kilonzo et al, 2009; Sen et al, 2007

4.6 HIV and gender equity

Globally the response to HIV and AIDS has triggered an unprecedented focus on gender inequality and how this shapes women's vulnerability (Gupta, Ogden and Warner 2011). This response is unprecedented because it has not been mirrored in other aspects of disease prevention or within health systems more generally. One of the reasons for this unparalleled response is the statistics relating to HIV. Of the estimated 34 million people living with HIV worldwide (UNAIDS 2011) women constitute half of all adults living with the disease. However, in sub-Saharan Africa, there are 14 HIV-infected women for every 10 HIV-infected men (UNAIDS and WHO 2008). Seventy-five percent of new HIV infections occur among young girls and female adolescents in Southern Africa (UNAIDS and WHO 2008). Women aged 15-24 are twice as likely to be infected with HIV than boys of the same age in the region (UNAIDS and WHO 2008). This is due to sociological and physiological risk factors, since young women have immature genital tracts but are more likely to have older sexual partners partly due to gendered expectations of men's and women's roles as men are expected have younger sexual partners (Shisana and Davids 2004).

As can be seen from *Table 4*, HIV prevalence in the 16 EQUINET focal countries varies widely from 0.2% for Madagascar and 1% for Mauritius to 25.9% for Swaziland and 23.6% for Lesotho. Southern Africa has borne the brunt of the HIV epidemic globally. Likewise, anti-retroviral (ART) coverage varies significantly, with Botswana (93%) and Namibia (90%) performing best, and Madagascar worst (1%). South Africa scored a disappointing 55%, despite having third-highest HIV prevalence in the region (17.8%).

Women are more biologically susceptible to HIV than men, with male-to-female transmission of HIV between two and four times more efficient than female-to-male transmission (Türmen 2003). The presence of sexually transmitted diseases also increases risks of transmission and acquisition of HIV by up to tenfold (ibid).

Table 4: Prevalence of HIV and percentage of ART coverage, 2010

| Country | Prevalence % | ART coverage % |
|--------------|-------------------|-------------------|
| Angola | 2 | 33 |
| Botswana | 24.8 | 93 |
| DRC | No data available | No data available |
| Kenya | 6.3 | 61 |
| Lesotho | 23.6 | 57 |
| Madagascar | 0.2 | 1 |
| Malawi | 11 | No data available |
| Mauritius | 1 | 16 |
| Mozambique | 11.5 | 40 |
| Namibia | 13.1 | 90 |
| South Africa | 17.8 | 55 |
| Swaziland | 25.9 | 72 |
| Tanzania | 5.6 | 42 |
| Uganda | 6.5 | 47 |
| Zambia | 13.5 | 72 |
| Zimbabwe | 14.3 | 59 |

Source: UNAIDS, 2011

Gendered roles and relations often place women in a subordinate position to men and promote models of masculinity that justify and reproduce men's dominance over women (Greig et al. 2008). As Grieg et al argue, 'notions of masculinity prevalent in many parts of the world that equate being a man with dominance over women, sexual conquest and risk-taking are associated with less condom use, more sexually transmitted infections, more partners, including more casual partners, more frequent sex, more abuse of alcohol and more transactional sex' (ibid: s35). Women's economic dependence on men can mean that they are also less able to negotiate the terms of sexual exchange (Côté et al. 2004). In many

ESA countries, masculinities are closely linked in the sexual prowess of men through multiple sexual partnerships, but frowned on women who do the same (Kaler 2003).

Wealth, migrant labour and social networks are related to engagement in extra-marital relationships (Clark 2010; Luke 2005). In Malawi, for example married men are four times more likely to be engaged in extra-marital sexual relationships than women (Schatz 2005). There is a relationship between levels of urbanisation and HIV infection and the higher the level of migration the higher the HIV prevalence and through migratory interaction between the rural and urban, HIV infection in rural areas is increasing (Dyson 2003).

While the relationship between poverty and HIV is greatly contested, there is agreement that poverty has potential to put poor people at greater risk of infection (Parkhurst 2010). Studies have documented that HIV has been concentrated among better-off, wealthier populations in sub-Saharan Africa, however there seems to be a shift of increasing transmission among the poor due to their social position, which leaves them less empowered to change their sexual behaviour (Parkhurst 2010; Piot, Greener and Russell 2007). Poor people often risk their lives to survive and provide for their family, including by engaging in transactional sex (Mbirimtengerenji 2007).

The gendered differences in financial inequality, authority relations and social identities of men and women influence how families, communities and health care systems react towards HIV infection among men and women (Mbonu et al, 2010). Views of blame and accusation have in some societies been directed more towards female people living with HIV (PLWHIV) than male PLWHIV (Mbonu, Van den Borne and De Vries 2010).

Recent work has identified violence against women as an independent risk factor for HIV in South Africa (Jewkes et al. 2010; Türmen 2003). A study in South Africa conducted among women attending antenatal clinics showed that women with violent partners were at more risk of HIV infection (Dunkle et al. 2004). Within a sexual relationship the threat of violence can influence women's power and their ability to negotiate conditions of sexual intercourse, especially condom use (Gupta 2002).

Women who face violence within their relationships may be less likely to access HIV testing services because of the fear of disclosing their sero-status (Dunkle and Jewkes 2007). Dunkle and Jewkes present research from India, South Africa and the United States suggesting that 'men who are violent towards their female partners or commit rape are more likely to have sex more often, to have sex with concurrent and/or casual sexual partners, to have higher total numbers of sexual partners, to practice anal sex, to participate in transactional sex, to father children, and to use alcohol and drugs' (ibid: 173). These are all factors that increase risk of HIV.

Strebel et al (2006) found in South Africa that shifting gender dynamics between men and women have meant that more women are entering paid employment – this competition is making some men uneasy and they blame women, leading to increased gender-based violence, with both men and women being perpetrators and victims of abuse (Strebel et al. 2006).

Prevention of HIV

The initial global public health prevention response to HIV was to focus on the ABC approach (Abstinence, Be Faithful and Condomise). This focus relies on the underlying assumption that individuals are able to change their behaviour and they just require knowledge about how to change the behaviour to do this. However, these messages are gender-blind and assume that women and men have equal power to decide the terms of sexual engagement. In reality, gender power relations and economic vulnerability mean that women are often unable to change their behaviour.

A study in a peri-urban area in Malawi found that women can do very little to influence condom use by their husbands to protect themselves from HIV due to the perception that condom-use implies infidelity, nor can they space or stop having children without their male partner's permission (Ghosh and Kalipeni 2005). Studies in Kenya and South Africa have found men are in control of condom use (Bühler and Kohler 2003; Maharaj and Cleland 2004).

Boxes 8 and 9 present two promising case studies of HIV prevention working with both women and men. Both studies were conducted in South Africa. An important aspect of the Stepping Stones trial was that it worked with men and boys. The IMAGE study used microfinance as part of the intervention. Microfinance has been promoted as a tool to increase women's empowerment. However, a study in Bangladesh found that when women received loans, their husbands used the funds instead of the women themselves (Goetz and Sen Gupta 1996).

Box 8: Stepping Stones: A participatory HIV programme from South Africa

Stepping Stones is a participatory HIV prevention programme that aims to improve sexual health through building stronger, more gender-equitable relationships by working with community members, including men and boys. The curriculum is delivered using participatory learning and action methodology and emphasises the inclusion of all members of the community (HIV interventions have often only worked with women or younger men and girls). The intervention was developed more than a decade ago and has been used in over 40 countries, adapted for 17 settings, translated into 13 languages and delivered to hundreds of thousands of individuals on all continents.

In South Africa the intervention was evaluated with a group of rural youth using a randomised controlled trial. The trial found that with two years follow-up, Stepping Stones lowered the incidence of herpes simplex virus 2 in men and women by approximately 33%, and men reported less perpetration of intimate partner violence across two years of follow-up, as well as changes in several other HIV risk behaviours. This is the first HIV behavioural intervention in Africa to be evaluated in a randomised trial and shown to reduce sexually transmitted infections.

The evidence suggests that Stepping Stones may have been particularly effective as an HIV preventive intervention because it addressed gender norms and provided communication skills that could be used to build better relationships, which was seen as a valued outcome by both men and women. This project also highlighted the role of interventions with women and girls that empower them with relationship skills and challenge the acceptability of gender-based violence, and help them navigate a safer route between ideals of femininity predicated on subservience to men and empowered femininities that celebrate having multiple partners and engaging in transactional sex, all of which entail considerable risk of acquiring HIV.

Source: Greig et al, 2008

Box 9: Intervention with Microfinance for AIDS and Gender Equity (IMAGE): A case study from South Africa

The IMAGE study sought to reduce HIV prevalence through intervening structurally at community and individual levels. The study offers some important insights into the challenges of assessing a structural approach by use of conventional methods (i.e. a randomised community trial which is used extensively within the public health and bio-medical fields of study). The study was developed from evidence that the rising prevalence of HIV in South Africa was due to prevalent migrant labour, widespread poverty, and entrenched gender inequalities. The study combined a microfinance initiative with a participatory learning and action curriculum on gender and HIV education. IMAGE sought to determine whether the involvement of women in the programme would improve household economic wellbeing, social capital, and empowerment and thus reduce vulnerability to intimate partner violence a known risk factor for HIV.

The project also sought to assess 'whether such measures could raise levels of communication and collective action on HIV and gender issues within communities and reduce the vulnerability of 14–35-year old household and village residents to HIV infection'. A key feature of this study was

that it also hoped to prove a direct link between action around these specific structural factors and HIV incidence.

The study team estimated that over two years, levels of intimate partner violence were reduced by 55% in the intervention group (who had access to microfinance services and the gender training programme) relative to the control group. Additionally, there was evidence that the intervention improved household wellbeing, social capital, and empowerment. They did not however, find a reduction in prevalence of HIV within the two groups.

Source: Gupta et al, 2008

Accessing ante-retroviral treatment

A systematic review of literature investigating the gender distribution of patients accessing highly active antiretroviral therapy (HAART) in Southern Africa found that in most countries in the region there was proportionally more females than males on treatment (Muula et al. 2007). This differential in treatment access could be explained by a number of factors. Women are offered a HIV test at the antenatal clinic. They are often primary care givers in most ESA countries and thus present and are familiar with primary health care facilities (ibid). They are thus likely to feel more comfortable in the setting and return for a HIV test. Men may also view these spaces as women's spaces, putting them off attending.

In a study from a rural South African ART treatment programme, men initiated treatment at a more advanced stage of illness than women (MacPherson et al. 2009), reflecting other studies showing that men delay testing and accessing care for HIV (Cornell et al. 2009). They suggest that masculine norms associated with hegemonic masculinity prescribe not only an avoidance of the sick role, but also discourage men from seeking care and out of fear of being labelled weak. The changing social and economic environment in the context of globalisation impacts profoundly on the social constructs of men and women and their respective roles in the household with broader implications for gender equity (Brown, Sorrell and Raffaelli 2005).

There is evidence of economic factors playing an important role in HIV treatment seeking patterns. In Malawi prior to the introduction of free treatment, the economic cost of seeking treatment was seen as the key barrier in accessing treatment (Nyirenda et al. 2006). Cornell et al (2009), found that having a monthly income meant people were less likely to drop out of treatment programmes. In Lilongwe, Malawi, prior to the introduction of free highly active anti-retroviral therapy (HAART) services more males than females accessed the services (Hosseini-pour et al. 2004). Once free treatment was rolled out women were then able to come forward. Although treatment is free there are still associated costs, such as of transport and loss of opportunity for earnings.

Gender, care and HIV

Within the health system there has been a gradual shift away from providing care to HIV positive people within the hospital to home-based care (Akintola 2004). This move has been in response to the burden placed on the health system by HIV positive patients (ibid). In South Africa, the national government's policy has been to promote home-based care models. These models of home-based care have ranged from home-visiting to home-based palliative care, to comprehensive treatment, care and support programmes (ibid).

In South Africa women from the community where the affected patient lives have provided most of the care required for the programmes and have done so mostly on a volunteer basis, occasionally receiving a small stipend for transport (ibid). Home-based care can benefit the person living with HIV and AIDS because it allows the person to be treated in a familiar environment. However, this model of care relies on women's unpaid labour to provide the care thereby increasing the workload, economic hardships and psychological distress of women who sometimes might themselves be living with HIV or widowed (Kipp et al. 2007; Newman et al. 2011; Tarimo et al. 2009). This situation reinforces the stereotype that women are responsible for the care of the sick and that work of this nature should not be paid.

5. Gender equity in health systems

As discussed earlier, societal expectations around masculine norms, values and identities may inhibit men from accessing health services. However, within the health system gendered norms of behaviour are also reproduced. This can manifest in gender biases and discrimination on the part of health care providers which may in turn discourage men and women from seeking care. Research from Botswana suggests that policy-makers have failed to target men for prevention programmes, while their wives and partners may access services but be unable to initiate HIV and AIDS prevention strategies without the support and collaboration of their husbands who remain uninformed (Phaladze and Tlou 2006).

Men interviewed in South Africa about their use of HIV services identified confidentiality as an extremely significant issue in their ability to continue using services. Where these men felt that their trust in their health care providers was betrayed, they were likely to stop attending the services (Fitzgerald, Collumbien and Hosegood 2010). In other evidence from research on treatment-seeking for HIV one of the barriers to men accessing ART services was linked to the locating of such services largely in clinics dealing with maternal and reproductive health, largely identified as spaces inhabited by women and children (Bila and Egrot 2009, Skovdal et al 2011). This has led some researchers to suggest that men-only clinics could enable access to ART services (Bila and Egrot 2009).

Health service providers are themselves influenced by their gendered positions in society. Research from South Africa found that primary health care nurses (women and men) displayed attitudes about gender-based violence which largely reflected prevailing cultural and social norms about gender-based violence. The research also found that among the 36 female nurses interviewed, 25 had themselves experienced violence (Kim and Motsei 2002).

The politics of who provides health care and how it is funded may exacerbate inequitable access to care. In the past two decades there has been an increased focus on market-based solutions to health sector reform, rooted in the structural adjustment policies (SAPs) of the International Monetary Fund (IMF) and the World Bank. From the early 1980s onwards, the IMF and World Bank introduced these so-called 'austerity programmes' as conditions attached to financial loans to governments, from both developed and developing nations (Chossudovsky 2005). SAPs required governments to undertake neoliberal economic reforms in return for financial assistance (Beneria 2005). In the health sector, such reforms increased women's burden of care by forcing governments to cut back on social spending – for example by cutting government funding for health services – and promoting privatisation, for example by increasing private sector involvement in public health systems in the form of public-private partnerships.

The era of structural adjustment may have ended (within the World Bank and IMF), but the earlier damage continues to have fundamental consequences for women and girls. Reforms in Africa included the introduction of new financing mechanisms such as user fees, revolving drug funds and other community-run financing schemes, as well as the use of essential drugs lists to ensure cost-effective use of resources.

Committing to the reduction of debt and the increase in public expenditure is important for improving gender equity. However, health budgets are not gender neutral and require input to ensure they respond effectively to men's and women's different health needs. Given the gendered nature of health work the retention and support of female health workers is vital, particularly as women in lower positions often make up for gaps in services by, for example, providing free home-based care.

In this section we examine how health systems reflect or confront gender inequalities in health using as illustrative examples:

- i. allocation of health resources for men and women – with examples of gender budgeting, how it has worked and what they have done
- ii. the policies and payment of health workers and how they support women's reproductive and productive role within the household
- iii. user fees in health systems, and
- iv. the voice and representation of community members in the design of health systems.

5.1 Allocation of health resources for men and women

It is commonly assumed that government budgets, including health budgets, involve gender-neutral methods of raising and spending funds and that they equally affect men, women, boys and girls. However, government budgets affect not only women and men differently but may be further influenced by a number of other factors, including race, age and ability. Gender responsive budgets (GRB) have been developed as a tool to analyse and transform governmental budgets to contribute to the advancement of gender equality and the fulfilment of women's rights (UNWomen 2011a). This entails identifying and reflecting on needed interventions to address gender gaps in government policies, plans and budgets. GRB also aims to analyse the gender-differential impact of revenue-raising, policies, and the allocation of domestic and Official Development Assistance (UNWomen 2011a).

Policies for gender equity policies do not allocate equal funds for men and women. They rather take into account women's needs relative to men's and allocate accordingly. For example, due to the greater needs of women in terms of reproductive health, a budget for health care would necessarily allocate more than 50% of the funds to women. See *Box 10* for a case study of GRB in Mozambique.

Box 10: Gender-responsive budgeting in Mozambique

Since 2000 UNICEF has been working in collaboration with the Government of Mozambique to promote the application of gender responsive budgeting in the national planning and resource allocation. The second phase of the project began in 2005 and has focused on three key priorities: violence against women, maternal mortality and HIV and AIDS. These priorities were developed with women's organisations working in Mozambique.

Funding for programmes addressing violence against women have been strengthened. These funds have been used to create facilities for survivors of domestic violence in police stations in all 129 districts. Public expenditure related to health and violence against women is now tracked by applying a gender perspective. The budgets for the Ministry of the Interior and the Ministry of Health indicate an increase from US\$15,000 in 2006 to an expected US\$51,000 in 2009 for gender-related actions.

Sources: UN Women, 2011a; Romão et al, 2007

The financing of health systems is an important determinant of the availability of health care (WHO Europe 2005). Financing mechanisms affect who is able to access the available care and the degree of financial protection provided to individuals when they do have health needs (ibid). However, there are important gendered aspects to health financing. As discussed later, user fees can have a greater impact on women, particularly poor women, due to their limited access to income.

Gilson and Mills (1995) argue that in the absence of a robust tax base, social health insurance systems may be one of the most equitable funding mechanisms (Gilson and Mills 1995). However, in many African countries this may be inequitable for women. Women are less likely to be in paid jobs, they are disproportionately concentrated in informal and precarious employment, and they are paid less (Arbache, Kolev and Filipiak 2010). This may be due to women in Africa having on average fewer educational opportunities (such as schooling or training) and less available time for paid work due to their domestic chores (ibid):

9). Therefore women's access to social health insurance schemes may be compromised by their less equal employment opportunities and practices.

Private health insurance also includes discriminatory and inequitable practices, such as refusing to cover pre-existing health conditions or providing limits on the amounts of funds available for a specific condition. Women's reproductive health roles can mean that women require more funding. When private health providers calculate risk women are likely to be seen as more risky and therefore might not receive adequate health coverage. Furthermore, private health insurance schemes are often linked to private sector employment and women are under-represented in this sector in sub-Saharan Africa, as discussed above.

5.2 Health workers and gender

Gender power relations within the health system do not only impact women as users of health care but also as providers of healthcare (Ostlin 2009). Globally, more than half the health workforce are female and women also contribute significantly to care provided within the home.

Despite their significant contribution, women in the health sector are more likely to be found working in positions that require fewer years of education, and where they earn less and enjoy less employment security (George 2008). George (2008) examined the experiences of nurses, community health workers and home carers in health systems and found that female frontline health workers compensate for the shortcomings of the health systems through taking on health care responsibilities beyond their defined roles in ways that are not recognised or supported by the health system they work in.

Within the health system community health workers make an important contribution to health, particularly of hard to reach and poor communities. There are important gendered dimensions to these roles because they are often occupied by women. These women often provide their time for free or are given irregular pay for their work (UN Millennium Project 2005b). In their roles they are provided with little supervision and have almost no job security.

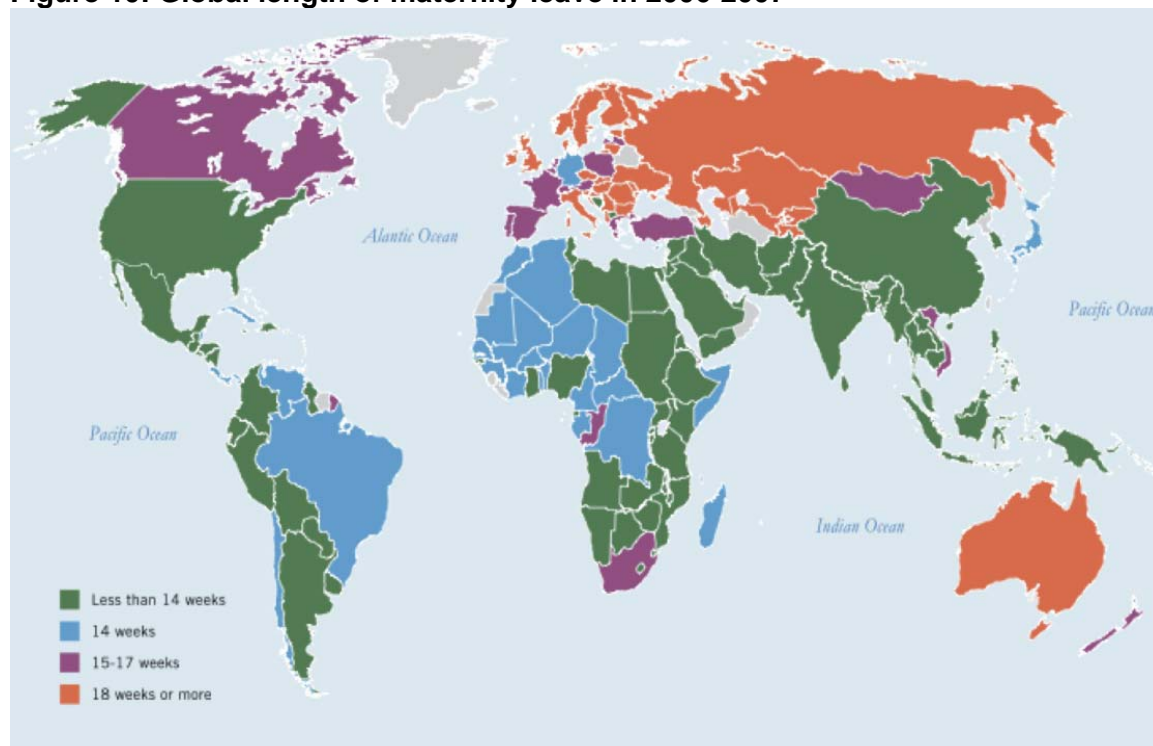
In 2000 the World Health Organisation estimated that, globally, up to 90% of care for the ill was being provided at home (Ogden, Esim and Grown 2006). Care in this setting is overwhelmingly provided by women and girls and virtually invisible in health systems. Yet, this external support is vital to the functioning of the health system. This care is provided for free and limits women and girls' free time to pursue both educational as well as formal work opportunities. As discussed above women are often clustered in the informal work sector and providing support to the health system is a significant component of this.

Despite the gendered nature of much health work, there has been limited focus on the gendered implications of human resource policies. The blindness to gender in some of these policies has negatively impacted on women, particularly in relation to the deployment of staff (Standing 2000). Maternity leave is one support for gender equality within the workplace. It enables women to balance their reproductive and productive roles. *Figure 10* illustrates estimates of length of maternity leave for countries around the world.

As can be seen in *Figure 10*, there is a wide range globally in the amount of maternity leave provided to women. In most ESA countries women are given less than 14 weeks' maternity leave.

The lack of awareness and failures of the health system to recognise women's specific health needs are largely due to gender bias within the health system, which leads to neglect of these issues (Ostlin 2009). One way of overcoming this is by building capacity of women and men working in the health system so they can understand and apply gender perspectives to their work (ibid).

Figure 10: Global length of maternity leave in 2006-2007



Source: ILO, 2008

Box 11 outlines the actions for human resource policies identified by the United Nations for improving gender equity in health systems.

Box 11: Five actions in human resource policy to improve gender equity in health systems

To achieve greater equity for women in health systems, government and other stakeholders must:

- Develop gender-sensitive career paths that allow all women to move in and out of the labour market if they have children.
- Provide adequate maternity leave allowing flexibility once women return to work.
- Ensure the personal security of women while they are working, particularly ensuring they are not vulnerable to physical attack.
- Create non-discriminatory working conditions.
- Increase availability of promotions, particularly for women.

Source: UN Millennium Project, 2005

Transforming medical curricula is another approach. Ostlin (2009) cites the example of Kerala State, India, where a three-year programme on gender sensitisation for medical college teachers was developed. This complements the traditional medical texts that have already been published (ibid).

In South Africa in the 2000s, primary health care nurses provided support for gender-based violence survivors. The work was in two phases – the first focused on dealing with the attitudes and experiences of the nurses as individuals, and to begin a process of self-awareness and sensitisation (Kim and Motsei 2002). The second stage was to train the nurses in a professional capacity to be more responsive to gender-based violence survivors (Kim and Motsei 2002). Following the training none of the female nurses felt that it was acceptable to beat a woman. The female nurses also felt that the greatest impact from the

training was to raise awareness of their own oppression and to acknowledge – sometimes for the first time – their own experiences of abuse (ibid).

5.3 Gender and financial protection in health systems

In 1987, an influential World Bank report argued that user fees would solve the funding crisis for health care that many developing countries were facing (Yates 2009). The report put forward the case that the introduction of user fees would be effective in raising additional funds and improving efficiency within the health system (ibid). However, a number of studies have highlighted that user fees are in fact ‘an ineffective, inefficient and inequitable funding mechanism that has been ineffective at raising substantial funds (ibid: 2078).

User fees proved inequitable because poor and vulnerable people were most adversely affected, as having to pay fees reduced their use of services and impoverished them further when they had to pay for unexpected and expensive treatment (i.e. high catastrophic health expenditures) (ibid). User fees are also inequitable because the poor pay a larger portion of their income than people with larger incomes.

The impact of user fees has not been gender neutral. According to UNWomen some estimates find women representing 70% of the world’s poor (UNWOMEN 2011b). As a consequence, women’s limited access to resources and decision-making about health within the household reduces their demand for services (Nanda 2002). Nanda cites the case in Kenya of the introduction of user fees affecting demand for services. ‘[T]he introduction of user fees (amounting to half a day of pay for a poor person) in government outpatient health facilities led to a dramatic reduction in utilisation of sexually transmitted disease services by both men and women, but at significantly greater rates for women. Before the introduction of user fees, there were fewer women than men attending. Nine months after their introduction, the fees were revoked, and women’s utilisation rose to a greater level than the pre-fees level’ (ibid: 129).

A study in Kenya demonstrated the impact made on demand by charging women. The randomised control trial, conducted by the Poverty Action Laboratory, found that charging pregnant women US\$0.75 for an insecticide-treated bed net lessened demand by 75% (Yates 2009).

Due to their reproductive health needs, women also require more access to preventative reproductive health services, as well as to obstetric and gynaecological services. Given that prevention of maternal mortality is strongly linked to women being able to access hospital-based facilities, user fees introduce a further barrier to access. *Box 12* illustrates how scrapping user fees improves utilisation of health services.

Box 12: Abolition of user fees: A case study from Uganda

In 2000, cost sharing was abolished for the whole of the public health system in Uganda (although paying wards were maintained at the hospital level). Prior to this, several modes of cost sharing co-existed including charges levied per illness episode, fees for services and small-scale schemes designed to address local health-care financing problems. Empirical work found that the abolition of user fees improved utilisation. The increase in utilisation varied from 26% in public referral facilities in 2001, rising to 55% in 2002 compared with 2000. The corresponding figures from the lower level facilities were 44% and 77%, respectively. Improvements in access were most marked amongst the poor, and days of work lost to illness were reduced.

Sources: Deininger and Mpuga, 2004; Nabyonga et al, 2005

While eliminating user fees is an important step to improving gender equity within the health system, even free services can incur costs for users. Poor men and women experience these external costs differently. A study by the Liverpool School of Tropical Medicine and REACH Trust in Malawi investigated the costs of accessing free tuberculosis (TB) services, in a setting where public health services are nearby and provided free of charge (Kemp et al.

2007). The costs of care seeking for symptoms of TB before diagnosis included direct costs (drugs and fees paid at private practitioners or pharmacies, transportation and food) and indirect costs (the opportunity cost or value of resources lost, such as the number of working days lost multiplied by estimated daily income). The study found that the cost of diagnosis for the patient is high. TB patients spent on average US\$13 (18 days income) and lost 22 work-days obtaining a diagnosis. The total diagnosis cost for poor patients was 248% of their total monthly income (574% after food expenses), versus 129% of total monthly income for non-poor patients (184% after food expenses). The household opportunity costs were found to be greater for poor households, or if a woman is sick. The study found that cost of a TB diagnosis is prohibitively high for patients and households, even if the service is provided free. It is likely to be a barrier for people with TB, especially the poor who do not access health care at all (Kemp et al. 2007).

Accelerated action to increase TB case-finding among the poor is needed if TB targets and MDGs are to be achieved. The study recommends the following:

- Cost-effective TB diagnosis strategies for the poor and their households must be identified urgently in the scaling up of TB services to achieve the MDGs.
- These strategies must go beyond the removal of, or exemption from, user fees and transform the way TB diagnostic services are delivered.
- The diagnostic pathway needs to be shortened to a 'one-stop' diagnosis, and diagnosis should be brought closer to where people live. These initiatives could complement wider social welfare and public health initiatives aimed at the poor. As gendered norms often prohibit women from accessing economic resources shortening the diagnostic pathway is likely to have important implications for women (and poor men's) access to health services.

A study by Mavhu et al (2010) found that men in Zimbabwe delayed care-seeking for TB for various reasons, including as a way of deferring costs; from fear that a positive TB diagnosis would automatically mean an HIV-positive diagnosis; from negative perceptions of health facilities as places where you receive discourteous treatment as well as risk contracting HIV and TB by attending, and from expectations that men should be in control of their bodies and therefore only seek care when their body can no longer hold out.

These studies indicate that economic barriers exist for both men and women even when services are provided for free. Women have less access to income within the household and therefore may delay seeking treatment even when it is free because they are faced with other unaffordable costs such as transportation to the facility. Both studies highlight that bringing services closer to vulnerable community members is important. However, subsidising travel and drugs would also be important interventions. Improving the attitude of staff towards patients is an important intervention that could encourage men and women to seek treatment. The study in Zimbabwe highlights that men's gendered identities are also a factor in preventing them from seeking treatment – with men waiting until they are very sick before coming forward. Interventions targeting men particularly for TB treatment would also be an important intervention.

5.4 Voices and representation of community members in the design of health systems

Empowered communities have greater influence on the organisation and provision of health resources. However, communities are not homogenous and women's voices can often get lost, particularly during community discussions where more powerful, often male, community members can dominate the discussion (Cornwall 2003). The voices of women need to be especially sought out, as demonstrated by Mozambique's gender focal points, a mechanism for incorporating women's voices into its health system (*Box 13*).

Box 13: Incorporating women's voices into health systems: Gender focal points in Mozambique

In Mozambique, gender focal points (GFPs) are situated within the Ministry of Health. There are 11 provinces with six departments and each department has at least one GFP. GFPs meet with national and provincial health officers, health workers and community representatives on a monthly (at national level) or trimestral (at provincial level) basis to discuss the implications of the disaggregated data sets. This enables the team to embed the findings within the local context, to discuss important intersections such as how gender and cultural norms, literacy and age may be interacting to shape women's and men's health and service access for malaria, HIV, other diseases, and following violence. These discussions develop ownership over the data and enable the team to critically develop context embedded approaches to address the challenges and inequities uncovered. The role of health providers to improve health status based on these findings and approaches to involve men in gender equitable change are among the broader strategic issues discussed.

Source: Tolhurst et al, 2011

While not exhaustive, the discussion of these areas highlights that even in redistributive health systems, gender equity cannot be assumed. There is need to audit the functioning of the health system from a gender lens, to examine its functioning both for health workers and clients, and to identify how the institutions, processes and governance affect gender inequalities and the norms and roles that produce them. *Box 12* provides recommendations from the Women and Gender Equity Knowledge Network for improving gender equity within health systems.

Box 12: Policy steps for improving gender equity in health systems

The Women and Gender Equity Knowledge Network has proposed the following policy steps to improve gender equity in health systems:

- Transform the gendered politics of health systems by improving their awareness and handling of women's problems as both producers and consumers of health care, improving women's access to health care, and making health systems more accountable to women.
- Provide comprehensive and essential health care, universally accessible to all in an acceptable and affordable way with the participation of women: ensure user fees are not collected at the point of access to the health service, and prevent women's impoverishment by enforcing rules that adjust user fees to women's ability to pay; offer care to women and men according to their needs, their time and other constraints.
- Develop skills, capacities and capabilities among health professionals at all levels of the health system to understand and apply gender perspectives in their work.
- Recognise women's contributions to the health sector, not just in formal health work, but also in delivering informal care. Women as health providers in auxiliary, volunteer and informal care need multiple linkages to formal and professional sectors: training, supervision, acknowledgement and support, functioning referral systems linking them to drugs, equipment and skilled expertise.
- Strengthen accountability of health policy makers, health care providers in both private and non-private clinics to gender and health. Incorporate gender into clinical audits and other efforts to monitor quality of care.

Source: Ostlin, 2009

6. Acting on gender equity in health

Taking action on gender equity and health requires intervention both within and outside the health system.

Sexual and reproductive health is central to gender equity in health in the region. Women's and men's access to these services remains sub-optimal and poor access has serious health consequences for both men and women. Access to these services is particularly important in ESA countries where HIV prevalence remains unremittingly high.

There are a range of actions that should be part of the essential health benefit/ entitlement in all ESA countries. Quality youth and gender friendly sexual and reproductive health services should include in all ESA countries:

- i. Universal access to family planning services;
- ii. Access to safe abortions to strengthen women's control over their reproductive health;
- iii. Strengthened health system capacity to deal with unanticipated medical complications associated with pregnancy;
- iv. Staff trained in midwifery skills at various levels of the health system, particularly at the primary care level, and well functioning accessible facilities equipped with essential obstetric drugs and supplies; and
- v. Reliable emergency transportation to access health facilities and referral services. .

To strengthen gender equity in responses to HIV and TB, stakeholders should:

- i. Ensure access to HIV testing and treatment for all.
- ii. Target men for HIV testing to ensure they do not come forward too late for testing.
- iii. Support women and girls who provide a large amount of care to HIV positive patients.
- iv. Provide home-based carers support through training and reimbursement for their time.
- v. Support strategies which bring ART and TB treatment close to communities to reduce the costs and opportunity costs associated with travel to health centres.
- vi. Support prevention interventions which work to change the broader structures of HIV vulnerability.

The report highlights areas of gender inequity and actions that can be taken within health systems to strengthen gender equity. In the international debate on universal health coverage, there is need for specific measures to enhance equity, including improving adequacy of public and progressive tax based health financing to provide universal access to health service entitlements. However the report provides evidence that this is necessary but not sufficient to address gender equity.

Given the burdens on women, there is need to remove user fees and introduce funding for transportation to ensure the poorest and most vulnerable men and women can seek health care. Private health care providers and the commercialisation of services should be regulated given its particularly negative consequences for women in cost barriers and increased burdens of home caring. Insurance schemes should cover all illnesses, including women's reproductive health. Given the nature of women's employment, specific measures should be found to fund health services and social support for those working within the informal sector or within the home, and to use gender responsive budgets to ensure that governmental policies take into account and allocate resources to address women's needs. The policies for payment and work organisation of health workers should recognise and adequately pay for or support the role that women play, including those who provide care voluntarily within the home and in the community. Women as health providers in volunteer and informal care settings need links to training, supervision, acknowledgement and support, and to functioning referral systems to access drugs, equipment and skilled support.

Beyond these technical and service measures, there is need to improve the awareness and handling of women's problems as both producers and consumers of health care, improving women's access to health care, and making health systems more accountable to women.

Health policy makers, managers and providers should implement institution and systems level gender audit of health systems, incorporate gender into clinical audits and other efforts to monitor quality of care, and make changes to the functioning of systems, including the decision making processes, to take into account the gender differences in access to and experience and benefits of health systems. Specific attention should be given to services that protect or provide support to women and female children affected by gender violence. This includes integration of post-rape services so that women receive post exposure prophylaxis, psycho-social support and gender sensitive counselling

Beyond the health system, there is need to address the structural drivers of gender inequality. This includes addressing the features of living and working conditions that widen gender inequalities, particularly by improving access to water and sanitation in homes, schools, public settings and ensuring that working conditions are more responsive to women, and in particular ensuring that maternity benefits are available. Education is an important positive contributor to closing gender inequalities and measures should be taken to improve women's and girls' access to education and post-primary education opportunities.

The causes of gender-based violence point to deeper areas that need to be addressed, including: action at the community level to change cultural norms about the acceptability of violence against women and girls; and improving linkages between the health system and the legal system.

Changing such norms calls for political, civil and social leadership to change social norms and institutional practice. A common indicator of changing governance is the increase in women's participation in all levels of decision-making including at the household and community levels and in national legislative bodies. However, wider changes are needed to strengthen institutional functioning to address gender equity.

For example it is important to build the evidence base to support gender equity in health, and to support and share promising practices in the region. This includes:

- Advocating for gender disaggregated health information systems, and attention to other important factors that shape vulnerability and resilience to ill-health (poverty, age, literacy, dis/ability);
- Encouraging programmes to use the results of gendered evaluations (plus consultations and feedback from women and men community members) to improve interventions to better meet the needs of all groups of women and men;
- Further sharing and discussing promising gendered actions across different contexts and encourage adaptation and implementation in other countries; and
- Advocating for further resources and skills to support gender equity within and beyond the health sector.

7. Glossary of gender terms

Gender is: how a person's biology is culturally valued and interpreted into locally accepted ideas of what it is to be a woman or man. 'Gender' and the hierarchical power relations between women and men based on this are socially constructed and not derived directly from biology. Gender identities and associated expectations of roles and responsibilities are therefore changeable between and within cultures. Gendered power relations permeate social institutions so that gender is never absent (Reeves and Baden 2000).

Gender power relations are: hierarchical relations of power between women and men that tend to disadvantage women. These gender hierarchies are often accepted as 'natural' but are socially determined relations, culturally-based, and are subject to change over time. They can be seen in a range of gendered practices, such as the division of labour and resources, and gendered ideologies, such as ideas of acceptable behaviour for women and men (Reeves and Baden 2000). Gender relations of power constitute the root causes of gender inequality and are among the most influential of the social determinants of health (Sen, O'stlin and George 2007). However, all men do not exercise power over all women; gender power relations intersect with age and life-cycle as well as other social stratifiers, such as economic class, race or caste (Sen and Ostlin 2011).

Gender equity refers to fairness and justice in the distribution of benefits and responsibilities between women and men. The concept recognises that women and men have different needs and power and that these differences should be identified and addressed in a manner that rectifies the imbalance between the sexes (WHO 2002).

Gender equity approach in health is concerned with the role gender power relations play in the production of, and vulnerability to, ill health or disadvantage within the health system. 'Achieving **gender equity in health** implies eliminating unnecessary, avoidable and unjust health inequities which exist as a result of the social construction of gender. It means that women and men have the same opportunity to enjoy living conditions and services that enable them to be in good health, without becoming ill, disabled or dying by causes that are unjust and avoidable' (Pan American Health Organisation).

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled (WHO 2006)

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Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

EQUINET implements work in a number of areas identified as central to health equity in east and southern Africa

- Protecting health in economic and trade policy
- Building universal, primary health care oriented health systems
- Equitable, health systems strengthening responses to HIV and AIDS
- Fair Financing of health systems
- Valuing and retaining health workers
- Organising participatory, people centred health systems
- Social empowerment and action for health
- Monitoring progress through country and regional equity watches

EQUINET is governed by a steering committee involving institutions and individuals co-ordinating theme, country or process work in EQUINET from the following institutions: TARSC, Zimbabwe; CWGH, Zimbabwe; University of Cape Town (UCT), South Africa; Health Economics Unit, Cape Town, South Africa; MHEN Malawi; HEPS Uganda, University of Limpopo, South Africa, University of Namibia; University of Western Cape, SEATINI, Zimbabwe; REACH Trust Malawi; Min of Health Mozambique; Ifakara Health Institute, Tanzania, Kenya Health Equity Network; and SEAPACOH

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