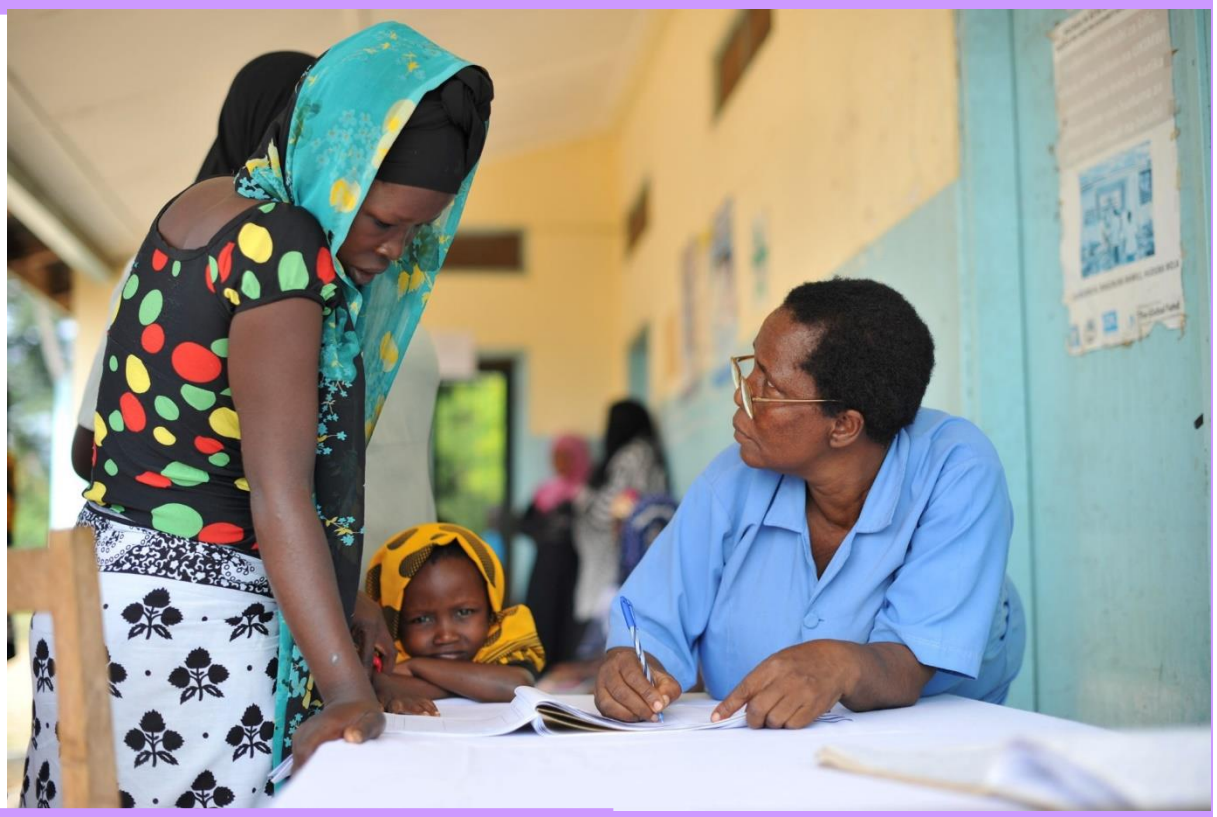
AFRICA HEALTH ORGANISATION

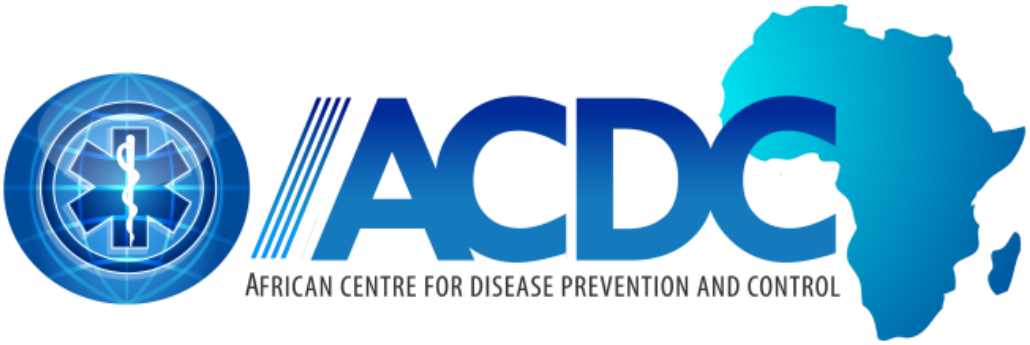
AHO Strategy and Plan of Action on Women's Health



Addressing topical women's health issues

May 2020

Partners: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African Females Empowerment & Development
EMPOWERING AFRICAN WOMEN AND GIRLS


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If you educate a man you educate one individual, but if you educate a woman you educate a family.

Fanti Proverb

Introduction

This document outlines the African Health Organisation's strategy for women's health. According to a 2012 report from the World Health Organisation (WHO), women account for over half Africa's human resources. As such, addressing women's health needs positively impacts on the socioeconomic development of societies, countries and the continent. Given the multifaceted nature of women's health, a multidimensional approach that considers all aspects of individual women's lifestyles, must be adopted.

Background

The African Health Organisation's aim is to 'help African people to attain and maintain optimum health and quality of life'. In order to achieve this aim, disparities between the sexes must be addressed to ensure equitable and accessible healthcare for all. Maternal health, though a major cause of mortality and morbidity, is often thought to be synonymous with women's health. However, women's health extends beyond reproductive capacities. Like their male counterparts, women have a variety of health needs, ranging from cardiovascular to mental health.

The health landscape across the continent has changed in recent years, with countries now facing a double burden of disease. Not only are women at risk from infectious diseases such as malaria and HIV, the prevalence of non-communicable diseases such as diabetes, stroke and cancer are on the rise. When compared to their male peers, women are oftentimes at increased risk of adverse outcomes. It is important to take into account the societal and biological differences between men and women, when addressing women's health concerns.

Many women across Africa face multiple barriers in their pursuit for good health. Gender based violence, discriminatory practices and poverty all adversely affect women's health. Girls in sub-Saharan Africa (SSA) are less likely to attend primary school than boys, which puts them at an early disadvantage and increases the likelihood of child marriage, unemployment and gender-based violence. Given the unique position women hold in many African societies, measures implemented to improve women's health oftentimes positively impact wider society. This plan of action aims to address three key health issues currently affecting women across Africa: gynaecological and breast cancers, sexual health and cardiovascular disease.

Proposal

Objective 1

To improve incidence and mortality rates of breast and gynaecological cancers.

Indicator

Cervical and breast cancers are the two most common cancers in SSA. Whilst the highest incidence of breast cancer is in higher income countries, countries in SSA have worse mortality rates. In addition, the incidence of breast cancer in SSA is gradually increasing, with the trend expected to continue.

Cervical cancer is slow growing cancer caused predominately by types 16 and 18 of the human papillomavirus (HPV). Most cases are preventable with the HPV vaccine and almost always curable, if detected and treated early. Unfortunately, the WHO state that 95% of the countries worldwide with the greatest cervical cancer burden were in SSA. The incidence and mortality rates from cervical cancer are higher in SSA than in higher income countries, with mortality rates 18 times higher in South and Eastern Africa than in West Asia and Europe.

Activities

Breast cancers

Primary prevention

1.1 Provision of education for women on the topic of breast cancer to raise awareness of the signs, risk factors, treatment and prognosis. Any stigma surrounding female gynaecological health should be addressed and the topic normalised in society.

1.2 National public health campaigns on breast self-examination. Several concurrent campaigns targeted at different age groups. Adolescent females should be taught how to self-exam by volunteers/health professionals at schools and universities. Education workshops should be delivered by suitable volunteers at places of worship, marketplaces, and local health centres. Women should be taught what to look out for and when and where they should go if the notice anything. These workshops should be delivered in a comfortable and safe environment and using language suitable for the audience.

1.3 Female community health workers should all be educated in performing accurate breast examinations to ensure those women who are unable to or struggle to carry out examinations by themselves are not neglected. With every interaction with women, community health workers should educate and remind women of the red flag symptoms for breast and gynaecological cancers and the steps to take if these are noticed. Community health workers should have strong networks with local secondary and tertiary centres, able to manage and treat any women with concerning findings, to ensure they receive prompt and effective care.

Secondary and tertiary prevention

1.4 Women should be encouraged to seek medical care should they notice anything concerning with their health. Education and health promotion advice should signpost women to the appropriate services. Health services should be accessible to all women and any potential barriers addressed, such as lack of access to female doctors/health professionals, monetary concerns, and distance. Women should be provided with the opportunity and sufficient information to make autonomous decisions regarding their health. Health services should seek government assistance to ensure financial assistance is available in the form of subsidies or loans, for women unable to access healthcare due to financial constraints.

1.5 Healthcare facilities and local communities should encourage women diagnosed with cancer to join peer support groups/meetings enable to ensure the women do not feel isolated. Survivors should be encouraged to attend some meetings to show that it is possible to survive cancer and to tackle some of the fatalistic views surrounding a diagnosis.
1.6 National healthcare expenditure should be improved to ensure suitable and effective services are available for cancer patients. Radiotherapy and chemotherapy should be made readily available to reduce the occurrence of unnecessary mastectomies or other associated surgeries.

Cervical cancers

Primary prevention

1.1 Provision of education for women about cervical cancer to raise awareness of the signs, risk factors, treatment and prognosis. Any stigma surrounding female gynaecological health should be addressed and the topic normalised in society. Educational workshops should be delivered by suitable volunteers at places of worship, marketplaces, and local health centres. Women should be taught what to look out for and when and where they should go if the notice anything. These workshops should be delivered in a comfortable and safe environment and using language suitable for the audience.
1.2 Governments should introduce a HPV vaccine programme, preferably free at the point of reception. This should be the quadrivalent vaccine, protective against HPV types 6, 11, 16 and 18, which are responsible for 80% most cervical cancers. Schools may be incentivised to cover the cost of the vaccine for their students.
1.3 Teenage girls should be encouraged to receive the HPV vaccine. Parents should be educated on the importance of the HPV vaccine and reasoning behind it. Concerns such as those regarding promiscuity, side effects and safety should all be addressed in a language and style tailored to each individual. Teenagers who refuse or parents of teenagers who refuse should be given ample opportunities to reconsider and sign posted to the necessary health centre/ appropriate professional, should they change their minds.
1.4 Vaccines should be delivered by health professionals such as community health workers, if sufficient numbers are available. Otherwise, select local individuals can be trained by healthcare workers to assist in the vaccination programme. The vaccination workshop should predominantly be delivered in secondary schools, universities and places of worship. In rural regions, vaccines can be delivered at designated stalls/sheds in the marketplace and/or at local pharmacies. Females should be provided information regarding when they will take place and given a list of future dates or nearby locations should they miss any HPV vaccination.
1.5 In areas healthcare workers may find inaccessible due to terrain or hostility, steps should be taken to ensure that safe and appropriate transport is arranged. Security should also be considered and provided by appropriate personnel in regions suspicious and/or hostile to health professionals or vaccination. Local community members can also be recruited and trained to assist with the vaccination programme to help alleviate the aforementioned issues.
1.6 National public health campaigns on gynaecological cancers and the importance of screening should be introduced. Screening and gynaecological health should be normalised. Women who are sexually active should be encouraged to attend cervical screening at an interval decided by individual governments. There should be a variety of locations available to ensure that this screening is accessible to all. Reminders could be given for the period that screening would be available through local media, i.e radio, newspapers, flyers or word of mouth.

1.7 Female health professionals should be trained on how to carry out screening tests. They should be proficient in detecting precancerous signs using HPV DNA testing, visual inspection with acetic acid as well as a Pap smear. With every interaction with women, education must be given on the common red flag symptoms for breast and gynaecological cancers and the steps to take if these are noticed. Community health workers should have strong networks with local secondary and tertiary centres, able to manage and treat any women with concerning findings, to ensure they receive prompt and effective care.

1.8 *See Breast cancer 1.4 -1.6*

Other gynaecological cancers

1.1 Despite the relative uncommonness of ovarian, endometrial, and other gynaecological cancers, women should be taught about red flag symptoms for gynaecological cancers and steps to take if these are noticed. *See Cervical Cancer.*

Objective 2

To improve accessibility and awareness of family planning methods in order to reduce maternal mortality, morbidity and sexually transmitted diseases.

Indicator

The WHO define sexual health as state of physical, mental and social well-being in relation to sexuality. In order to ensure and maintain sexual health, the sexual rights of individuals should be respected, protected and fulfilled. This is particularly pertinent to women's sexual health, which is often threatened through more avenues than their male counterparts. Family planning methods, also known as contraceptive methods, play an integral role in improving women's sexual health. Contraceptive methods reduce the risk of unplanned pregnancies, sexually transmitted infections (STIs) and allow women agency over their bodies. Unplanned pregnancies may increase a woman's risk of morbidity and mortality. Globally, 295 000 die as a result pregnancy and childbirth related causes. Two thirds of these deaths occur in SSA.

In 2010, the WHO estimated that 71% of people living with HIV were adolescent and young women. 25% of all new HIV infections were also amongst females within this age range. Women not utilising barrier contraceptive methods are at increased risk of contracting STIs. Untreated STIs pose many potential complications for women ranging from infertility to increased adverse outcomes during pregnancy and labour.

Activities

Family planning

2.1 Provision of appropriate sex education in schools for both males and females with an emphasis on safe sex practices. The topics of consent, STIs and pregnancy should be covered. This education should be age appropriate and should be built upon year on year to ensure its relevance. These sessions should be incorporated into the curriculum from late primary school and throughout secondary school.

2.2 Family planning methods should be more made more visible in society. Public health information pertaining to family planning methods should be made available utilising mass media to improve accessibility. This could gradually start with dissemination through social media and scaled up to larger platforms with the help of local governments and organisations.

2.3 Healthcare professionals including community health workers should be proficient in delivering information on safe sex practices and different types of contraceptive. Counselling and education should be available to all women, during sexual health presentations. During these consultations, women should be made to feel as comfortable as possible and any specific concerns addressed. For example, if a woman refuses hormone-based contraception but does not wish for her partner to know about her contraception use, she can be recommended the IUD or a female barrier method. The pros and cons of each method should be discussed in a language and style catered to each individual.

2.4 Contraceptives should be accessible to all women, irrespective of age, religion, marital status, social status, etc. Barrier contraceptive options should be readily available in pharmacies, shops, schools, universities and social venues. For longer acting contraception, women should be directed to health centres able to administer or fit these. Such centres should be easily accessible, safe and affordable. Governments should be encouraged and assisted to reduce the price of contraceptives, particularly for vulnerable individuals.

2.5 Attempts should be made to liaise with prominent faith leaders to try and tackle the perceived religious barriers to contraception.
2.6 Provisions should be made to improve male awareness of family planning methods. They should be educated on the risks of unsafe sex and unplanned pregnancies. This could be addressed through mass media platforms targeted at males as well as, interactions with health professionals.

STIs

2.1 Comprehensive education on various STIs should be delivered throughout schools for both males and females. Individuals should be encouraged to practice protected sex and aware of the different barrier methods. Such education must address the distinction between barrier and non-barrier contraceptive methods. Students must be taught how to use barrier contraceptive methods and where to access them.
2.2 Women should be aware of symptoms of STIs. Education programs should ensure that women are aware of where to access testing and treatments for STIs and when. Women should be made aware of the need for testing following new unprotected sexual encounters or with possible symptoms of an STI. Women with financial difficulties should not be allowed to let financial difficulties to deter them from testing or treatment and instead be offered financial assistance from governments or charities.
2.3 Fully trained healthcare professionals able to treat STIs should be easily accessible by all women. These could be within formal healthcare settings or delivered in more informal settings in rural areas by community health workers. Such consultations need to safe and confidential. Counselling should be available at such during consultations, covering risk reduction, safe sex practices and pregnancy. Governments should ensure that centres and clinics treating sexual health complaints, possess the necessary resources needed. PEP and PrEP should be readily available to at risk women, with financial barriers removed in the form of subsidies or financial assistance for those struggling. Women should receive adequate follow-up in necessary and encouraged to attend.

Objective 3

Indicator

Cardiovascular disease (CVD) refers to diseases that affect the heart and blood vessels. Globally, CVDs are the leading cause of death amongst women, despite their reputation as a predominately male affliction. Traditionally CVDs have been referred to as “diseases of affluence”, however, two thirds of deaths have occurred in low- and-middle income countries. Oftentimes, their fatal manifestations are often the presenting complaint. Risk factors for CVDs can be split into non-modifiable and modifiable. Whilst non-modifiable risks include factors such as ethnicity, age and family history are unchangeable, the majority of risk factors can be altered by behaviour change. One of the leading risk factors for CVDs is high blood pressure, an often asymptomatic condition, that currently affects approximately 20 million in Africa.

CVDs can be classified into infective and non-infective disease. In high income countries, non-infective CVDs such as coronary heart disease and cerebrovascular disease are the most prevalent. However, in SSA there is a double burden of disease, with infectious diseases such as rheumatic heart disease (RHD) and cardiac complications of HIV existing in tandem.

Activities

Non-infective cardiovascular disease

Primary prevention

3.1 Initiation of national public health campaigns to raise awareness of CVDs. Such campaigns should be as far reaching as possible and delivered through as many media platforms as possible. Such campaigns should address the symptoms of heart disease, risk factors and preventative strategies. Information on where to seek advice, if necessary, should be available. This should be delivered in a manner that is simple and easy to understand.

3.2 The importance of healthy lifestyles should be taught in schools and the message continued into adulthood. Concurrent public health campaigns should also run promoting healthy lifestyles targeted at women. Women in many societies throughout Africa play an integral role in the provision of food. As such, would be in a prime position to implement healthy dietary changes, such as reducing salt intake or buying healthier options. Women should also be taught about the importance of physical activity. Campaigns should highlight that exercise is free, can be fitted into women’s day to day lives, undertaken in the home and provide examples of these. Campaigns should also highlight the danger of smoking and excess alcohol consumption.

3.3 Governments should increase taxes on unhealthy foodstuffs increase the affordability of healthier options. Taxes should be imposed on cigarettes and alcohol making them less affordable. Salt restrictions should also be imposed on processed foods.

3.4 Healthcare professionals should be encouraged to routinely measure blood pressures, heights and weights during consultations with women, if possible, regardless of the reason for the visit. If any concerning findings are discovered, women should be given specific health education to address such findings, e.g. weight loss in cases of obesity. Any suspected high blood pressure should be identified and managed appropriately.

Secondary and Tertiary prevention

3.5 Women should be encouraged to seek medical care should they notice anything concerning with their health. Education and health promotion advice should signpost women to the appropriate services. Health services should be accessible to all women and any potential barriers addressed, such as lack of access to female doctors/health

professionals, monetary concerns, and distance. Women should be provided with the opportunity and sufficient information to make autonomous decisions regarding their health. Health services should seek government assistance to ensure financial assistance is available in the form of subsidies or loans, for women unable to access healthcare due to financial constraints.

3.6 All healthcare providers should be able to recognise the symptoms of CVD and training for unqualified healthcare providers can be provided in the form of leaflets or posters highlighting the key information.

3.7 Provision of education on the importance of adhering to any set drug regime should be provided through interactions with health professionals.

3.8 National healthcare expenditure should be improved to ensure suitable and effective services are available and accessibility to ensure gold standard treatments for CVDs. Medications and surgeries to manage CVDs should be readily available and accessible to all.

Infective cardiovascular disease

Primary prevention

3.1 *See non-infective cardiovascular disease 3.1-3.4*

3.2 RHD is caused by damage to the heart from rheumatic fever. Rheumatic fever is an abnormal complication of a bacterial throat infection, usually occurring in children. Improvements in children's health services alongside health education for parents should be provided by nations. Adolescents and young women should be encouraged to seek medical attention from health providers should they have any concerns about their or their children's health.

3.3 Cardiac manifestations of HIV should be prevented through improvements in HIV prevention and management. *See STIs 2.1-2.3*

Secondary and tertiary prevention

See non-infectious cardiovascular disease 3.5 -3.8

Financial Approximations:

Most recommendations made by this plan of action, would need to be spearheaded by national governments. However, due to the continent-wide nature and grassroots approach of most interventions, it is difficult to provide estimations of cost. Basing cost approximations on a single country would be grossly inaccurate, given the monetary disparities not only amongst countries but within them. The main costs to the AHO would be from the initiation and possible maintenance of the aforementioned workshops.

Workshops and education

Workshops and educational programmes should ideally be delivered by local health workers or trained non health professionals. Individuals could work in a voluntary capacity or agreements could be made with local charities or governing authorities to provide financial assistance.

Health professionals should possess sufficient knowledge to deliver the necessary workshops. Provision of refresher sessions can be delivered by senior health professionals or through online videos available on mobile devices. Non-health professionals' training should involve shadowing/assisting health professionals with concluding with an assessment. Again, this could be done on a voluntary basis if possible.

Materials could be provided to these centres through email, if necessary. As such, there would be associated printing costs that would vary with location.

Provisions would also need to be provided for attendees.

Summary

The recognition and improvement of topical women's health needs is crucial in improving women's health across Africa. Ensuring the incorporation of non-communicable diseases into Africa's public health narrative whilst also not neglecting infectious diseases is key in achieving this aim[1].

In summary, the AHO propose for the following:

1. An increase in health promotion workshops on sexual health, female cancers and CVDs, run by local healthcare professionals and volunteers.
2. An increase in the dissemination of health promotion on the topics of non-communicable diseases such as cancers and CVDs. These should be across as many platforms as possible and women should be encouraged to share what they have learnt.
3. Increased provision of family planning methods by governments and charitable bodies.
4. Initiation of national HPV vaccination programmes across Africa.
5. Increased training of healthcare providers, particularly community health workers and volunteers. This would allow all health providers to manage sexual health complaints, suspected cancers or CVD, or at least direct women to the centres where they would be able to receive optimal care.
6. Encouragement of governments to take a more active role in public health. A continental increase in healthcare funding should be made to ensure an improvement in healthcare facilities and an increase in accessibility. A stable economy is not possible without adequate healthcare.

[1] Although, the aim of this plan of action is to outline a few aspects in which women's health can be improved, the recommendations made for objectives 2&3 need not be limited to women.

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