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Factors Influencing Women's Optimum Health in Zambia

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Introduction

This article discusses the factors that influence health status of women in Zambia. The factors that influence the health status of women include educational level, unemployment, poverty, nutrition status, violence against women, gender inequality, Health seeking behaviour, representation in leadership positions, marital obligations and early marriages, socio-cultural factors, reproductive health and maternal morbidity and mortality. The aim of this review is to analyse factors that influence women's health and suggest strategies for improvement.

Educational Level

Education is shown to have the strongest and most direct impact on health status of girls and women [1, 2]. For instance, the more educated a woman is the more likely she is to seek medical care and to use family planning services [3]. Education gives a woman confidence, status and ability to participate in decision making both in the home and in the community [4]. In Zambia, however, 16% of females have never been to school and 46% have some primary education [3]. This situation has adversely affected their health status as they have limited knowledge and poor attitude towards health issue however; Zambia is addressing poor access to education through the Millennium Development Goal 2 by providing free basic education, providing more domestic resources to education.

Unemployment

In Zambia women have limited access to education and employment opportunities and in most cases are engaged in labour intensive, poorly paying work for long hours in order to feed their families for instance, many Zambian women (65%) derive their livelihood from Agriculture [5]. This saps away their energy and undermines their health and reduces their resistance to infections. Only ten percent (10%) of Zambian women are in skilled employment, while the majority are in agriculture and sales services [3]. Due to economic hardships, some women engage in risky activities such as prostitution to obtain favours and financial payments to make ends meet [6]. As a result they may contract HIV and sexually transmitted diseases. Others end up with unwanted pregnancies which increase their responsibilities and undermine their health further. Such problems are even more pronounced in female-headed households [7].

Poverty

In Zambia 64.38% of the population live on less than 1.90 US dollar a day [8] and 27% of households are headed by females [3]. Although poverty levels affect men and women, women are more vulnerable because they have lower education than men and have a very small share in formal employment [6]. They have to work very hard to meet the family requirements and, as a result, they neglect their own health needs. Measures to alleviate poverty have not matched the worsening situation of the poor due to limited funding, cumbersome procedures and lack of awareness of the existence of these programmes by the women in need. Poverty reduces women's access to food and health services which ultimately worsens their health status.

Nutrition

Poor nutrition is a serious concern in Zambia. According to the 2013-20014 Zambia demographic health survey, 10% of women 15-49% are under weight, that is they fall below the body mass index cut off of 18.5 [3]. A woman's nutritional status is related to her level of education and residential area, for instance, women who are educated are better able to get food on table, know the importance of nutrition and mostly live in urban areas and nutrition is also closely linked to patterns of mortality and morbidity. In Zambia the levels of malnutrition are more in rural areas than in urban areas. There is also sex bias in favour of men when it comes to the serving of meals in households. Men are given the first priority and the best food available in the home

while women and children eat last and least. Women's poor dietary intake leads to micro-nutrient deficiency, for example, vitamin A, iron and iodine deficiency all have a tremendous effect on the total health of a woman [6]. In addition, poor nutritional status of women has a negative effect on pregnancy outcomes [9].

Violence against Women

This has been in existence in Zambia for a long time and it continues to be the social norm in many Zambian societies. Violence against women is perpetuated by cultural orientation; initiation ceremonies and payment of bride price which makes men feel superior over women [10]. Women become submissive and obedient even when they are physically, sexually and mentally abused. For instance, the 2013-2014 Zambia demographic survey reported that 47% of the women interviewed said that a husband is justified in beating his wife if she burns food, urges with him, goes out without telling him, neglects children and refuses to have sex with him.

Physical violence (wife battering) is a major cause of injury to women ranging from minor cuts and bruises to permanent disability and death. In Zambia, 43% of women aged 15-49 have experienced physical violence [3] since the age of 15 and the perpetrators of physical violence among the ever married are husbands or partners (63%).

Sexual abuse results in unwanted pregnancy, sexually transmitted diseases including HIV, undermines women's sexual autonomy and jeopardizes their health. Apart from physical injury women also develop mental health problems which include depression, anxiety and substance abuse, for example, alcohol and some even attempt suicide. Evidence of sexual violence has also been reported, 17% of women have ever experienced sexual violence and 10% experienced it in the past 12 months before the survey [3]. Sexual abuse involving adolescents is also a major problem in Zambia. The most common types of sexual abuse among adolescents include defilement, rape and forced marriage [11].

Gender Inequality

Gender inequality damages the Physical and mental health of millions of girls and women across the globe and also of boys and men despite the many tangible benefits it gives men through resources, power, authority and control. WHO further states that because of the numbers of people involved and the magnitude of the problem, 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 and ensure effective use of health resources.

Gender inequality still exists in Zambia like in other developing countries. For instance, women have less land, wealth and property [3] and yet have higher burdens of work in the economy of care and ensuring survival, reproduction and security of people including the young and old [12]. Girls are less educated and more physically restricted and women are employed and segregated in lower paid, less secure informal occupations [12]. Women are seen as objects rather than subjects in their own communities and this is reflected in norms and behaviours, codes of conduct and laws that perpetuate their status as lower beings and second class citizens. Furthermore, women have less access to political institutions from the local municipal council or village to the national parliament and international arena [10].

Health Seeking Habits

Very scanty information is available on utilization of health services by women. A woman may make several trips to health facilities taking other members of the family for treatment, but when she is sick, she may be too tired to go to the clinic or she may postpone the visit due to other pressing needs of the family. In most cases this is also compounded by distance from health facilities and unreliable transport. By the time she seeks medical care, it may be too late [13]. Access to health care improves when individuals have health insurance cover; however 97% of the Zambian population do not have any health insurance [3].

Poor Representation in Leadership Positions in the Public Sector

Leadership is needed to make sure that all women reach their full health potential [14]. This is because the health status of women is also related to policy decisions and investments in key programme areas. In Zambia there are still very few women in leadership positions in the public sector. This makes it difficult for women to participate in or influence policy making, matters pertaining to the health of women lack representation from those who are directly affected by the problems and these are the women themselves.

According to WHO [14] bold, participatory leadership with a clear and coherent agenda for action is key to moving forward and that leadership must take into account the range of issues that affect women's lives and must deliberately address problem areas where progress is inadequate or inequities are growing. The participation of civil society, and particularly women's health advocates and leaders, is critical. Their meaningful engagement at all levels of assessment, priority setting and implementation should be championed and their ability to bring decision-makers to account strengthened.

Marital Obligations and Early Marriages

Marriage is almost universal in Zambia and polygamy is an accepted practice which is common in rural areas [15]. In the past polygamous marriages had a potential to limit the sexual transmitted infections as usually a man and his wives lived together [10]. They had strong ties and trusted each other. Nowadays a man maintains mistresses in different towns or villages. This acts as a vehicle for transmission of HIV and sexually transmitted infections.

Marriage does not appear to prevent a man from seeking casual sex from other women [10]. A married woman is also obliged to have sex with her husband even when she knows that he is engaged in extramarital affairs and may not use condoms. This exposes her to ill health. In cases of death of her husband some customs require her to undergo a ritual called sexual cleansing which exposes her to infections.

Early marriages are quite common in Zambia. According to Zambian law the legal age of marriage is 18 years for girls and a couple is expected to start bearing children soon after marriage. Most of the women in Zambia have had a baby by the age of 19 years [15]. Thus, early marriage leads to early child bearing, short birth intervals and many births. Girls who marry early are also less able to contribute to the productive sector of the economy [6]. Some reasons for early marriages include:

- Avoiding promiscuity, HIV/AIDS and sexually transmitted infections.
- Desire by parents for dowry (Lobola).
- Avoiding embarrassment if a girl is pregnant out of wedlock.
- Inability for the family to pay school fees for the children, so parents opt to withdraw the female child from school.
- For the woman to gain respect in the community [6].

Socio-Cultural Factors

There are certain traditional beliefs and practices that are embedded in Zambian society that affect women's health. However, it is important to remember that not all traditional beliefs and practices are harmful. The traditional beliefs and practices are divided into three groups.

Food-related beliefs

These include what to eat, what should not be eaten and how to cook. For example, anecdotally a pregnant woman is not expected to eat eggs because she will have a baby without hair; a pregnant woman should not eat red bream fish because she it will cause bleeding during labour and delivery.

In most communities there are particular beliefs and practices a woman should follow after delivery. For instance, a woman who has just delivered should not prepare food for other people or put salt in food until she is cleansed with traditional medicine, otherwise the people who eat such food will have a chronic cough. A woman who has just delivered is not allowed to cook until the baby's umbilical cord drops off and the stump is healed this allows the woman more rest so is a good thing.

Sex-related beliefs

Both the pregnant woman and her husband must not have extra-marital affairs because it will bring misfortune to the pregnant woman, for example, if the pregnant woman's husband engages in sex with other women, it is believed that delivery will be obstructed or prolonged and she may die. However, if she confesses she is cleansed with traditional medicine or given traditional medicine to drink, then both she and her baby will survive. If a pregnant woman has sex in the last trimester of pregnancy, it is believed that the baby will be covered with sperms at birth or will have large or depressed fontanels.

Behavioural-related beliefs

Most communities, in the author's experience, believe that witchcraft does exist and is responsible for most of the pregnancy-related problems. In order to prevent witchcraft, pregnant woman are required to take traditional medicines such as herbs, leaves, roots or barks of trees either by mouth, scarification or by inserting into the vagina.

A pregnant woman is also required to take traditional medicine to quicken labour [16, 17]. All these practices may have adverse effect on the mother and her unborn child. After delivery, most communities believe that women are not supposed to engage in any form of hard work for some time after delivery because they would fall sick and hot compress should be applied on the woman's stomach to prevent blood clots and help the uterus to contract.

Reproductive Health

Use of reproductive health services by women is not consistent. This is discussed below:

Antenatal care

Antenatal care is a service provided to women to ensure a healthy pregnancy before delivery and it is the opportunity for health workers and the pregnant woman to check the condition of the pregnancy and screen/treat possible pregnancy related dangers [6]. Zambia developed safe motherhood guidelines for antenatal care provision. For normal pregnancies, antenatal clinics visits are recommended as follows: the first visit is by the end of 16 weeks of pregnancy, the second visit at 24 weeks, the third at 32 weeks and 4th at 36 weeks [6]. However, women who experience discomfort, danger signs or have special needs or conditions beyond the scope of basic care may require additional visits. Evidence show that 56% of pregnant women make 4 or more antenatal care visits during pregnancy and 24% had their visits in the first trimester of pregnancy [3].

There has been a marked increase in the use of antenatal care facilities. According to the Zambia Demographic Health survey (2013-2014), 96% of women received antenatal care from a skilled provider (Doctor, Midwife, Clinical officer or Nurse). However, most of the bookings take place in the second or third trimester of pregnancy. This could be attributable to the negative attitude of midwives, long distance and non-availability of female midwives at the health facilities.

Delivery and postnatal care

More than half (42%) of the births occur at home while less than half are assisted by trained medical staff [3]. In addition, home deliveries pose a danger of infection and late reporting to hospital in case of complication. Postpartum period is a critical time for the women and her baby because life threatening complications such a postpartum haemorrhage can occur. Zambia's safe motherhood guidelines recommend that women should receive at least 4 postnatal checkups, the first within 6 hours, the second two days after delivery, the third 6 days and the last visit is 6 weeks after delivery [6]. Evidence shows that 63% of the women receive postnatal care within the critical first two days following delivery [3].

Reasons for low utilisation of postnatal care include

Lack of transport and distance to a health facility, not wanting to go alone, concern that there may not be a female health provider, concern that there may not be any health provider, concern that there may not be drugs available for treatment, and concern about rude attitudes among health providers.

Family Planning

Family planning plays a critical role in influencing the health status of women. Most women in Zambia know at least one method of family planning, however, current use of a modern method stands at 49% for married women in Zambia, which shows an unmet need for family planning in the country [3].

The average number of children per women is 5.3% and in the rural areas, children are still visualized as a symbol of prestige [3]. In most cases women have to obtain consent from their spouses to use a contraceptive method. Myths about family planning, for example that it causes lumps in the abdomen, have prevented some women from using contraceptives. Lack of adequate information has also contributed to the problem. As a result women in rural areas continue having a lot of children, leading to ill health and complications during pregnancy and delivery.

Sexually Transmitted Diseases and HIV/AIDS

Since the first case was identified in 1984, the pandemic has impacted on the entire population. The majority of women provide care to their family and relatives in hospitals, hospices and homes [6]. This has increased their workload and undermined their mental and physical health. Protective measures are not adequate and risk of infection is very high [6]. Despite this heavy burden, women have to continue with other chores such as cooking, fetching water and caring for the other members of the family. The pandemic has also outstretched the women's capabilities as they have to care for orphans and frequently spend time at funeral houses, leaving them with little time for rest. According the Zambia Demographic and Health survey, HIV/AIDS is spreading rapidly and women are the most affected group compared with men. Women are found to be at higher risk of being infected with HIV infection than men (15% vs. 11%). Sexually transmitted infections are an important reproductive health concern in Zambia. Surveys in antenatal clinics have shown that 10% to 15% of expectant mothers have syphilis [6].

Unsafe abortions

Unsafe or illegal abortions have an adverse effect on the woman's health because of high rates of infections, psychological trauma and sometimes permanent physical damage which affects fertility. Abortion is legal in Zambia but for a woman to qualify for abortion she requires approval from three different doctors [6]. This discourages women from seeking legal abortion and most end up using unofficial means to terminate unwanted pregnancy and a large number of women die every year from complications arising from such abortions.

Barriers to abortion services

Adolescent sexuality

In Zambia by the age of 18 years about 56% of girls are reported to have had sex and only about one quota of adolescents aged between 15-19 years used a condom at first sex [6]. Urbanization and transition from traditional to modern culture are giving rise to new patterns of sexual behaviour in adolescents [15]. This includes unprotected sex leading to early pregnancy, induced abortions, and sexually transmitted infections and HIV infection. Adolescent pregnancy carries a higher risk of obstetric problems [11]. These young mothers shun attending antenatal clinics due to unsympathetic attitudes from adults and are therefore putting their health at risk because complications are not detected early. Currently, in Zambia, there are no adolescent tailored sexual and reproductive health services [11].

Maternal Morbidity and Mortality

Over the past decade, steps have been taken by Governments towards improving the health status of women in line with commitments made at the United Nations Millennium summit in 2000. Substantial progress has been made by the Government of the republic of Zambia in reaching the Millennium Development Goal (MDG) Number 3; to promote gender equality to empower women and MDG number 5; to reduce the maternal mortality ratio by three quarters from 1990 to 2015. Despite the progress made, the health status of women continues facing challenges. According to the World Health organisation [18], the major cause of maternal mortality and morbidity include haemorrhage, infection, high blood pressure, unsafe abortions and obstructed labour.

In Zambia, the leading causes of maternal morbidity among women of reproductive age group are malaria, anaemia, HIV/AIDS and sexually transmitted infections, tuberculosis, hypertension and malnutrition [6]. The maternal mortality ratio in Zambia is very high especially in rural areas. It was estimated at 729 per 100000 live births in 2001 to 2002 but has declined to 398 per 100000 live births [3]. Most of the maternal deaths that occur during pregnancy are due to eclampsia, pre-eclampsia, anaemia and abortions [6]. During the intrapartum and postnatal period deaths are more commonly attributed to eclampsia, haemorrhage, obstetrical labour, ruptured uterus and puerperal sepsis [6].

According to WHO almost all maternal deaths (99%) occur in developing countries. More than half of these deaths occur in sub-Saharan Africa. The maternal mortality ratio in developing countries in 2015 is 239 per 100 000 live births versus 12 per 100 000 live births in developed countries. There are large disparities between countries, but also within countries, and between women with high and low income and those women living in rural versus urban areas. The risk of maternal mortality is highest for adolescent girls under 15 years old and complications in pregnancy and childbirth is a leading cause of death among adolescent girls in developing countries [19].

Factors that affect maternal mortality are divided into two categories: medical and personal factors.

Medical factors

- Inadequate supplies and equipment for antenatal, delivery and postnatal facilities. This has made it difficult to detect risk factors during pregnancy, to manage labour adequately and offer efficient postnatal care. This is more pronounced in rural areas.
- Human resource constraints. Most of the health facilities do not have trained and competent personnel to deal with pregnant women and detect complications.
- Low number of supervised deliveries. Most of the women deliver at home and this exposes them to a lot of complications and mismanagement. Only 47% of women deliver in medical facilities.
- Poor referral system. Women are referred to higher health institutions very late. The referral system is weak, especially in rural areas. Most rural health facilities lack radio communication equipment and ambulances to take referred cases to the next level of care. Clients are therefore compelled to mobilize their own transport and financial resources for travelling. Additionally the health facilities in rural areas are poorly staffed and the available health care professionals lack skill in early detection of maternal complications.
- Infrastructure limitations. Most rural health facilities in Zambia have no delivery rooms and this limits privacy for deliveries. Clean and safe water and electricity to aid provision of essential obstetric care are non-existent [6].

Personal factors

- Most of the pregnancies happen in the teenage period which predisposes girls to prolonged and obstructed labour and because of dropping out of school early; most women do not understand the danger signs in pregnancy and have little or no understanding of the importance of seeking medical help early.
- Poorly spaced pregnancies and high parity. High parity predisposes a woman to ruptured uterus and postpartum haemorrhage. When the children are closely spaced, the mother doesn't have enough chance to recover from the effects of pregnancy and can die from anaemia.
- Lack of knowledge about risk factors of pregnancy, labour and delivery. Most women are unable to identify danger signs of pregnancy or in the postpartum period and this could contribute to delays in seeking health care.
- Poor socio-economic status. They are not able to raise money to pay for medical fees and transport to health facilities.
- Distance to health facilities. Most rural populations are situated far away from health facilities, coupled with poor road network; it makes it difficult to transport a woman in labour to a health facility.
- Harmful traditional practices during labour and pregnancy. These undermine the woman's health [6].

Human Immune deficiency Virus (HIV) is the leading cause of death amongst women of reproductive age and sub-Saharan Africa has the highest HIV disease burden among women of child bearing age. Evidence shows that women acquire HIV and sexually transmitted diseases easily because of their biological make up and gender inequality [6]. It has been proved that women can acquire the virus more easily than men due to cultural practices that are harmful such as dry sex. In addition, the inability of women to negotiate condom use for safer sex also puts women at risk of acquiring the virus [6].

In Zambia women's cancers especially breast and cervical cancer result in high rates of mortality and morbidity. There are inequalities in access to early detection and screening which lead to large variations in clinical outcomes and survival after treatment. Efforts have been made by the Government to avail cervical cancer screening in health facilities in Zambia. This has led to early detection of cervical cancer and early treatment. Women are taught breast self-examination by health Care workers in order to detect breast lumps which could be cancerous.

Strategies to Improve the Health Status of Women

To improve maternal health, a multi-sectorial approach is required. Barriers that limit access to quality maternal health services must be identified and addressed at all levels of the health system. The Government should provide voluntary family planning information, products, and services to support women's and couples' ability to make and act upon informed reproductive decisions about the timing and spacing of their pregnancies. There is need to improve maternal and child health through key interventions such as iron supplementation, access to a skilled birth attendant and health facility, and prevention and treatment of obstetric and new-born complications. The other action to be taken by the Government is to ensure that HIV and AIDS prevention and treatment programs focus on women's unique vulnerabilities to infection and support critical health programs that address women's needs, including reproductive health, nutrition, malaria, and pandemic disease programs.

Conclusion

Improving the health status of women in Zambia still remains a great challenge. Illness or death of a woman has serious and far-reaching consequences for the health of her children, family and community. Therefore the government, through the Ministry of Health, should work closely with the community, collaborating partners and other concerned stakeholders. Furthermore, providing a woman access to quality basic health care, family planning and obstetric services is a basic human right.

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