AFRICAN WOMEN'S DEVELOPMENT FUND

Health and Reproductive Rights Portfolio:

A look back at the last 14 years of thematic grantmaking and recommendations for moving forward

Henrietta Awo Osei-Anto

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Contents

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Zeytuna Abdella Feyissa-Azasoo
Monitoring and Evaluation Specialist

AWDF BACKGROUND[1]

The African Women's Development Fund (AWDF) was launched in June 2000 to support the work of women's organisations that promote women's rights in Africa. AWDF is the first Africa-wide feminist grantmaking organisation of its kind.

The vision of AWDF is for women to live in a world where there is social justice, equality and respect for women's human rights.

The mission of AWDF is to mobilise financial, human and material resources to support African women and the work of the African women's movement to advance women's rights and gender equality in Africa. We believe *if* women and women's organisations are empowered with the skills, information, sustainable livelihoods, opportunities to fulfill their potential, plus the capacity and space to make transformatory choices, *then* we will have vibrant, healthy and inclusive communities.

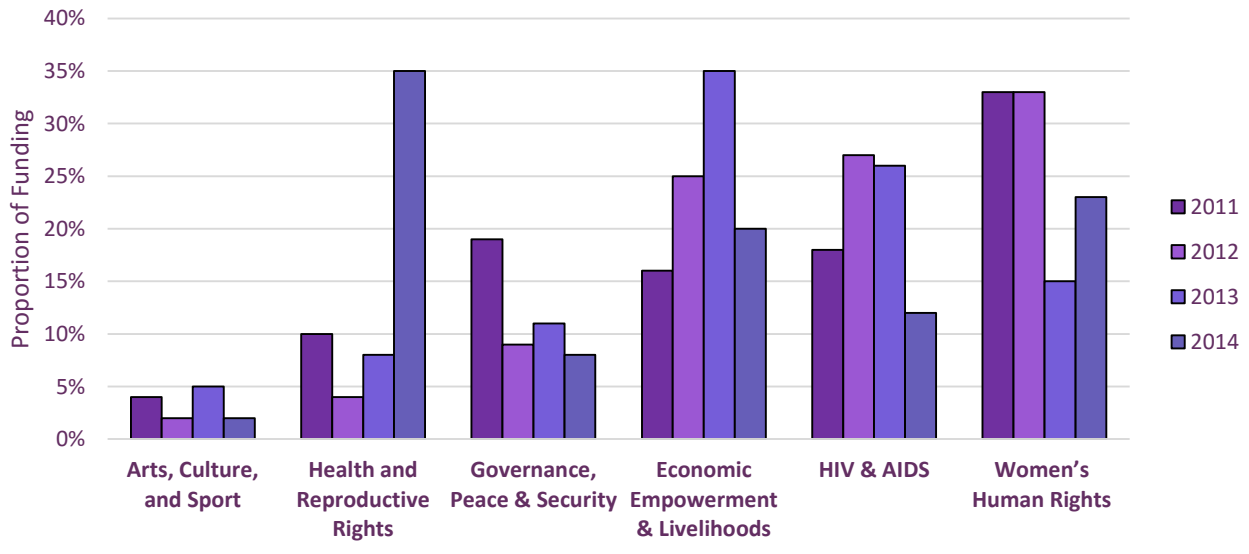
AWDF GRANTMAKING

Since inception, AWDF has provided over USD 26 million in grants to over 1200 women's organisations in 42 African countries. To make this possible, AWDF draws resources from individuals, corporations, foundations and governments and provides financial and capacity building support to women's organisations across Africa.

Health and Reproductive Rights (HRR) thematic Grants

In the area of Health and Reproductive Rights (HRR), AWDF has supported 181 organisations across 26 countries since 2001. The total amount awarded in grants for HRR is USD 1,699,532, representing 6.15% of AWDF's total grantmaking efforts over the period under review (2001-14).

Figure 1: Distribution of AWDF Funding by Thematic Areas, 2011-2014



[1] AWDF website: http://awdf.org/who-we-are/#vision_mission. Accessed on November 2, 2015.

AWDF prioritises funding to small scale, lesser-known organisations that work directly with women at the community level and actual rights-holders directly affected by an HRR issue themselves. With the exception of a recent spike in 2014, grantmaking in the HRR thematic area has consistently ranked low in grantmaking, as shown in Figure 1; second only to Arts, Culture and Sports (a new thematic area introduced in 2011).

AWDF's Six Thematic Areas

- Arts, Culture, and Sports
- Economic Empowerment and Livelihoods
- Governance, Peace, and Security
- Health and Reproductive Rights
- HIV & AIDS
- Women's Human Rights

Topics Prioritised/Funded Under the HRR Theme

AWDF has funded women-led initiatives and organisations that have prioritised the following issues under the HRR theme:

- Mental health and well-being
- Maternal health issues including family planning, ante-natal care, safe delivery and post-natal care services
- Safe delivery and reduction of maternal mortality rates particularly in rural and marginalised communities
- Breast and cervical cancer; prevention and management
- Sexually Transmitted Infections (excluding HIV), education and treatment of reproductive tract infections
- Protection of women's reproductive health rights, including the right of a woman to decide to be sexually active or not and whether or not to have children
- Harmful traditional practices, such as Female Genital Mutilation (FGM)

IMPORTANCE OF HRR FOR AFRICAN WOMEN

Women's health as a standalone issue is currently not prioritised in many African countries, unless it is connected to women's reproductive roles, safe motherhood or the well-being of their children. While these issues are important, framing African women's healthcare through only these roles neglects other aspects of well-being. Specifically, it fails to recognise that incidences of communicable and non-communicable diseases are on the rise among African women. Breast and

cervical cancers, hypertension, diabetes, fistulas and mental health problems are all common health problems that affect African women and girls, but do not receive adequate attention.[2]

Multiple barriers have contributed to the lack of appropriate attention given to women's issues in Africa. First, women's health priorities are determined globally by factors and stakeholders outside of the African continent. The Millennium Development Goals (MDGs) is a prime example of this phenomenon. While the MDGs helped to galvanise global attention to address some of the most pressing development issues, they also served to ensure that resource-constrained countries focus their resources only on the issues that are being assessed globally. None of the three health-related goals in the MDGs - improving maternal health, reducing child mortality, and combatting HIV/AIDS, malaria and other diseases - are directly related to the needs of the African woman as an individual.[3]

Global funding has also dictated the health care priorities for African countries. The influx of global funding for HIV/AIDS in African countries has led to the creation of a parallel health care system, which has weakened the public health infrastructure in African countries. This weakening of the health care system has been especially deleterious for poor women in remote rural areas and those living in urban/peri-urban areas.[4]

Another key barrier are prohibitive user fees that have prevented women from accessing much-needed health care services. In the 1980s and 1990s, most African governments abandoned social justice programs in favor of Structural Adjustment Programs recommended by the IMF and World Bank.[5] The effect of these programs have persisted to date. Even the smallest user fees can prove burdensome for a majority of poor women who have no independent or consistent source of income.

A final set of barriers has to do with long-held cultural and religious beliefs, values, norms and practices that often militate against African women enjoying good health and reproductive rights. As a result of these norms, women and girls in several African countries lack knowledge about their own bodies and sexuality, resulting in poor reproductive health for young women. Some traditional religious beliefs have taught women that their bodies are unclean. Others have falsely cast harmful practices such as female genital mutilation in a religious light. Payment of bride price, which gives

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[2] Jamison, D. T., Summers, L. H., Alleyne, G., Arrow, K. J., Berkley, S., Binagwaho, A., Yamey, G. (2013). Global health 2035: a world converging within a generation. *The Lancet, 382*(9908), 1898-1955.

[3] Millennium Development Goals and Beyond 2015. http://www.un.org/millenniumgoals/bkgd.shtml. Accessed on November 9, 2015.

[4] Hanefeld, J., & Musheke, M. (2009). What impact do Global Health Initiatives have on human resources for antiretroviral treatment roll-out? A qualitative policy analysis of implementation processes in Zambia. *Human Resources for Health, 7*(1), 8.

[5] Bond, P., & Dor, G. (2003). Neoliberalism and Poverty Reduction Strategies in Africa: Regional Network for Equity in Health in Southern Africa (EQUINET).

husbands control over their wives' bodies and sexual and reproductive choices, have all compounded these norms. Even in the health care system, women are sometimes subjected to poor treatment from health care professionals.

HRR ASSESSMENT

In an effort to ensure that the HRR thematic area remains relevant to women's needs and reflect current and emerging issues that affect health and reproductive rights of women in Africa, AWDF commissioned an independent consultant (Ms. Everjoice J. Win) to conduct an evaluation of the thematic HRR area. This report is an abridged version of the findings from that assessment. To obtain a full copy of the evaluation, please contact Ms. Zeytuna Abdella Feyissa-Azasoo, the M&E Specialist at AWDF.

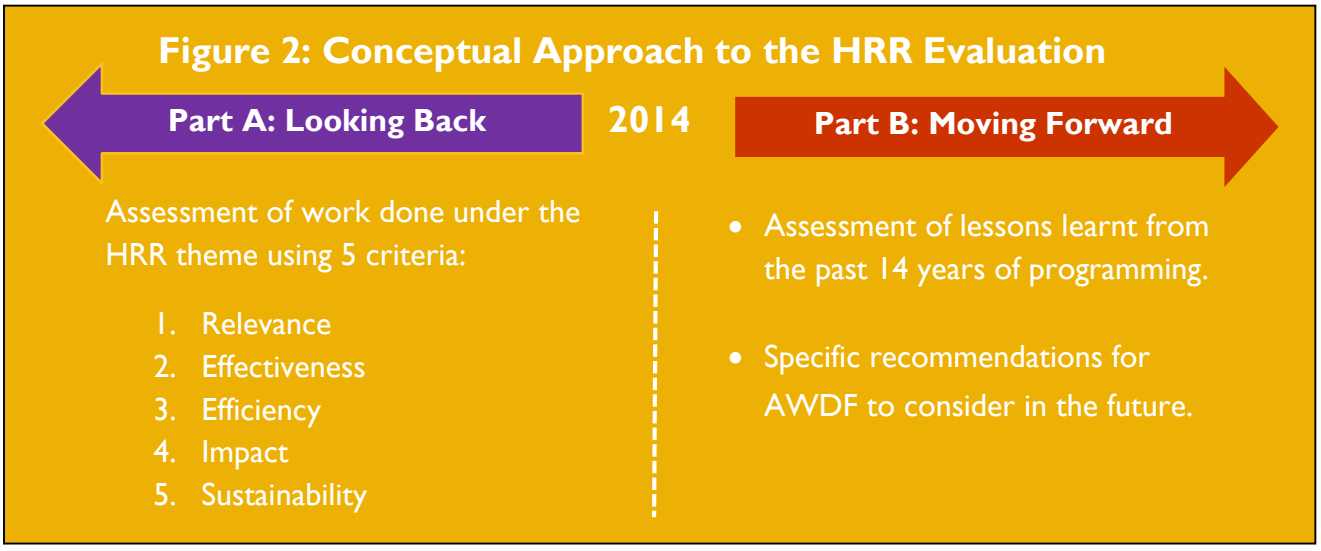
The overall objectives of the HRR evaluation were:

- To document and assess the work of AWDF in this thematic area, examining the relevance of selected priorities;
- To understand major challenges that have contributed to low patronage of the thematic area and suggest improvements;
- To identify current and emerging HRR issues of importance to African women.

Methodology

To complete the assessment, the external evaluator conducted extensive interviews by Skype and telephone with almost 35 key individuals from AWDF and partner organisations. Interviews were supplemented with information collected through questionnaires that were distributed to AWDF-funded organisations. The evaluation was conceptualised to include two parts, as shown below.

Figure 2: Conceptual Approach to the HRR Evaluation



Part A: This first section was aimed at answering the question of "what was done", by looking back at AWDF-funded projects and also at current projects for results achieved and lessons learned.

Part B: This section answers the question of "what could be" by looking forward at how things can be improved to maximise impact.

The external assessment found that AWDF-funded projects are relevant, effective and efficient in the face of the barriers identified in the preceding section. These findings, including challenges to sustainability are discussed in-depth in the next sections of this report.

Part A: Looking Back – Findings from the Evaluation

- **HRR Projects are Relevant.** The programs funded are aligned with AWDF's goals and objectives, addressing evident gaps in African women's care identified in earlier sections of this report and contributing to the advancement of solutions to women's SRHR issues in Africa.

Figure 3: HRR Projects Addressed Relevant Needs

Providing services that are largely underprovided by public health sector	•AWDF support women's groups in Ghana and Swaziland to bring awareness to gender-specific diseases such as breast, cervical and uterine cancers, which are on the rise among African women, but largely ignored at the national level. •AWDF partners also provide screening services and in some cases, life-saving surgery to address the practical needs of women.
Reversing potentially harmful beliefs, values, norms and practices	•AWDF partners posssess a deep understanding of the socio-cultural context in which they work, thus ensuring that their programs are culturally relevant. •In addition to addressing the practical health needs of women, AWDF partners tackle the underlying socio-cultural issues that may lead women to not seek health care even when it is accessible and affordable.
Challenging role-specific contextualisation of women's healthcare	•AWDF and their partners reframe women's sexual health as a rights issue, first and foremost. •AWDF partners challenge and change some of the prevailing attitudes that stand in the way of women enjoying their own sexuality and making informed choices.
Removing financial and geographic barriers to access	• AWDF partners prioritise the needs and rights of mostly poor, marginalised and excluded women. •Programs run by AWDF partners close financial gaps and provide women with some access to affordable healthcare. • AWDF partners leverage existing relationships with beneficiaries to identify and address their most pressing needs.

- **HRR Projects are Effective *and* Efficient.** The findings from the evaluation also show that AWDF grantee partners utilise effective strategies to address the healthcare needs of the program participants. The projects have also been efficient in terms of the human resources, time and finances invested and the results achieved. Since most of the organisations work directly with the communities they serve and are located away from capital cities, they were able to minimise costs associated with reaching women and girls directly with awareness-raising activities. The strategies chosen by partners fall into two broad categories: those tackling structural barriers/meeting strategic needs and those meeting practical needs/service provision.

A. Tackling structural barriers and changing negative traditional beliefs, values and norms

In order to counter deeply-entrenched belief systems in African societies, AWDF partners utilised a set of four interrelated strategies that target individual women who benefited from planned activities, the communities and countries where participants are based as well as the key players in their region who make decisions that impact them.

Figure 4: Four Strategies for Tackling Strategic Barriers

1.

Empowering women and girls

AWDF grantees invest resources in raising awareness among women and girls. The most common activities organised under this strategy are: workshops with specific project participant groups; use of mass communication tools such as radio, television, and daily newspapers; use of ICTs - digital storytelling, mobile telephones; training of peer educators; and one-on-one awareness for women seeking services.

2.

Changing mindsets of significant others

A significant number of AWDF's partners went beyond raising awareness among women to awareness-raising amongst other individuals or groups who could potentially stand in the way of the rights holders exercising or enjoying their rights. These include men and boys in some of the communities or tertiary institutions; family members, community members, service providers as well as community leaders or opinion-leaders.

3.

Influencing policy and promoting reform at national level

AWDF partners contribute to policy and systematic change at local levels (such as influencing traditional leaders or nurses at local clinics), as well as at national levels. This strategy is effective because while women's groups can design and implement interventions, it is the primary responsibility of governments to provide healthcare, education and awareness to communities.

4.

Regional and global advocacy

AWDF grants also support initiatives at regional and international levels as demonstrated through the work of AMANITARE and the African Women Leaders' Network (AWLN) for Reproductive Health and Family Planning. **AMANITARE** is a regional network of 72 women's rights organisations that come together to reflect, learn and share strategies on SRHR and impact policies in members' countries. **AWLN** was established to represent the African woman's voice on discourses and agenda setting on SRHR at national, regional and global levels.

B. Service provision

Most governments, constrained by resources, have not prioritised the needs and rights of the marginalised who live away from political or economic capitals. The healthcare needs of women have received even less attention. A majority of AWDF's partners in HRR help fill this gap by providing direct services to women or girls who need healthcare. These organisations work in very resource-strapped, geographically-remote (away from big cities), and underserved communities. It is important to note that almost all partners who provide direct services did not see this strategy as an end in itself. Rather they utilised service provision as an entry point to influence policy or to demand wider service provision by the State following the example the organization has set.

Impact Made: Service Provision

- In Ghana, **Reach for Recovery** screened over 22,000 women for breast cancer. The same organisation provided 100 survivors with psychosocial support, post-mastectomy care kits, and temporary prosthesis.
- In Sudan, **ZENAB for Women in Development** trained 20 traditional midwives. As a result, 10 rural villages now have midwives who can conduct safe deliveries.
- **International Centre for Environmental Health & Development (ICEHD)** in Nigeria trained 45 local midwives in 2013 to provide care to poor, rural women. The organisation is now working with a selected 10 women out of these 45 to train other midwives in a bigger catchment area.
- **Swaziland Breast Cancer Network (SBCN)** increased services from 1,000 people to 4,500 people with support from AWDF.
- **ARUWE** reported that in one county, Mulagi County, Uganda, 38% of the women attended both pre- and post-natal care clinics, representing a 10% increase from the previous year. The same health centre increased the proportion of women using pills and injections from 7% to 36%.

Grantee Spotlight

In Nigeria and Zimbabwe, **Women Against Rape, Sexual Harassment and Sexual Exploitation (WARSHE)** and the **Student's and Youth Working on Reproductive Health Action Team (SAYWHAT)** work with young women in tertiary institutions to educate them about their own bodies and sexuality.

In Uganda, **Mentoring & Empowering Programme for Young Women (MEMPROW)** works with young women, training them to understand their own sexuality, whether they are heterosexual, bisexual, transgender.

In Ghana, the **Deprived Single Mothers Association (DeSMAs)** works with girls to raise awareness about female condoms. **DeSMAs** also works through the Ministry of Health to raise awareness of three health facilities offering abortion services and with school heads and teachers to support girls returning to school after having babies.

Impact Made: Policy and Structural Change

- The **SBCN** started out with the main goal of creating awareness about cancer amongst women. The group, realising a demand for screening services from the women they educated, approached the government of Swaziland to use existing health facilities that had no cancer screening or treatment centres. Under this arrangement, the government provides the physical infrastructure and pays the nurses, while the NGO runs the clinics. The government has now designated 23 health facilities as cancer screening centres and they have agreed to provide the resources. Additionally, the NGO has mobilised a corporate sector response to construct a new chemotherapy centre.
- In Nigeria, **ICEHD**'s objective is to reduce maternal deaths amongst poor women in underserved communities. The group trains traditional birth attendants (TBAs) and midwives in a one week program and provides them with obstetric kits. However, they realized they needed the support of the state health system to make the program sustainable. This meant attaching the TBAs to qualified professionals, and getting them registered with the nearest primary healthcare centres. ICEHD is now working on a National Operational Guide which will set standards for how TBAs and midwives operate and are linked to the national healthcare system.
- In Sudan**, ZENAB for Women in Development** has also been training rural midwives in order to decrease incidences of maternal mortality. This is done in collaboration with the government, which has allowed the midwives to be trained at midwifery schools. ZENAB has added FGM to the curriculum so that midwives also become champions against the practice.
- In Nigeria, **INCRESE** started their work organising LGBTIQ women following a media and police raid on a safe house where some had sought shelter. The initial response was mainly service provision; psychosocial, housing, and medical support for recovery from violence by community members against those outed in the press. The group is working with young women to strengthen the nascent LGBTIQ movement in Nigeria.

Grantee Spotlight

In Uganda, the **Better Health and Action Group (Better HAG)** works with traditional and clan leaders to stop harmful practices such as early marriage. They encourage community leaders to form 'clan committees' to monitor what is happening in their communities and to take actions to stopping them.

The **Swaziland Breast Cancer Network (SBCN)** helps dispel some myths surrounding cancers, such as beliefs that cancer is caused by witchcraft and that modern medicine can't help. Also, through their advocacy work, **SBCN** succeeded in having breast cancer prioritized in the national health plan.

In Uganda, **Action for Rural Women's Empowerment (ARUWE)**, builds the capacities of local communities to understand how state resources are collected, allocated and ultimately who is responsible and accountable for their expenditure. **ARUWE** also promotes awareness of family planning services.

LESSONS LEARNED

Several clear lessons emerged from the work that AWDF partners have conducted and the impact that they have made among various constituents. The lessons, which are categorised below, are largely encouraging and speak to the need for further investment in SRHR to provide guidance on how to improve programming.

- **Changes in consciousness, beliefs and values amongst rights holders**: With critical knowledge about their own bodies, health and reproductive rights, women and girls can enjoy their bodies, better health, and protect themselves from rights violations. Consciousness of rights, coupled with a shattering of some myths and negative beliefs that impede women and girls go a long way. AWDF and partners can leverage awareness raised to tackle other more contentious issues.
- **From awareness to action**: As a result of awareness activities, the behavior of women and girls towards health consultations has improved. For example all the partners working on breast cancer reported that women now present themselves early after discovering small lumps.

- **Peer to peer education**: Peer education potentially holds the promise of widely spreading accurate messages within communities and schools, even after the end of the AWDF funding period, thus presenting a powerful vehicle for making even more impact.
- **Strong individual leaders with expertise in health**: Although a majority of partners doing HRR work are small scale organisations, they have strong women (and some men-assisted) leadership. These leaders comprise oncology specialists, public health professionals, and university lecturers with professional networks in the health sector and government. These leaders are able to leverage their profiles, connections and technical knowledge to influence policies and structural changes at national levels.
- **Building leadership and skills in SRHR programming and advocacy**: The work done by AMANITARE and AWLN has helped to build and strengthen the leadership skills and more of younger women, and establish a new cadre of women's health advocates.
- **Building movements – from individual to collective action**: A few of the grantees see collective action as key strategies for sustaining momentum on these initiatives as well as creating new ones. INCRESE's work in Nigeria, for example, has led to the establishment of some visible LGBTIQ groups in different parts of the country.

BARRIERS TO SUSTAINABILITY

The previous sections have highlighted the immense impact made through HRR despite the relatively small size of organisations AWDF was able to support, and to a large extent, the limited geographic scope or reach of the initiatives funded in this portfolio. The outcomes can potentially be leveraged for longer-term sustainability of this work. However, there are several crucial barriers to sustainability that remain to be addressed.

First, partners identified inadequate funding as the biggest barrier to sustainability. Most of the groups rely on small grants, such as that provided by AWDF or other women's funds like the Global Fund for Women or Mama Cash. These grants are often short term (one to two years), small in size, and primarily for program activities as compared to institutional building. The small grants and limited timeframe can be a barrier to continuity of programmes.

Second, even if some of the organisations received more money, their capacity to absorb these funds would still be limited, due to their small size, which limits their ability to make an impact on the huge health problems women face in Africa. The organisations are also limited in their ability to cover the geographic scope if needed.

The final barrier is the need to balance women's practical health service needs with activities that foster lasting impact for SRHR. The former outweighs the latter, hence there is always a constant struggle within organisations (and in AWDF) between service provision and advocacy/structural change work. Practical needs require huge human, financial, and infrastructural outlays that most partners don't have. Long-term change can only be achieved through structural and policy changes. Finding the right balance between these two competing demands is the key to sustainability and meaningful change in SRHR for African women.

Part B: Moving Forward

While the work funded by AWDF has been relevant to the needs of African women, a preliminary analysis of the dominant women's issues across Africa identified several more issues of importance for women. These priorities include (in order of importance):

- **Women's participation in politics and decision making**;
- **Violence against women** (mostly domestic violence, and to a lesser extent, sexual violence);
- **Child marriage** (as part of a larger global focus on girls, girl power, but very much delinked from feminist analysis and other life cycle issues that will affect the same girls as they become women; and
- **Livelihoods/Economic empowerment**.

A concerted effort is needed by AWDF, in collaboration with other women's funds and partners, to support the growth of a continent-wide movement tacking SRHR and elevate the issue.

This section presents considerations for moving forward with the SRHR agenda for AWDF - first, by tackling potential barriers, summarized in Figure 5, followed by three strategic next steps.

Figure 5: Remaining Barriers and Potential Strategies for AWDF

Persistent Barriers	**Sexual and reproductive rights are too contentious and "illegal":** Topics pertaining to women's bodies, sexuality and sex are not common in public conversations. Fear also stems from the fact that abortion and sex in schools are illegal. Religious fundamentalism, steeped in local African traditions and values, has perpetuated a cycle of fear and conservatism.	**HIV/AIDS has dominated discussion and funding:** HIV/AIDS has severely impacted women and girls and warranted substantial intervention, however, 30 years down the road, the focus has been at the expense of other health issues affecting African women. Also, little attention has been paid to the social, economic and political drivers of the pandemic.	**Break in a global consensus on the meaning of SRHR:** Over the last two years, policy dialogues have twisted SRHR to mean only abortion or alternative lifestyles and gender non-conformity. The low patronage of AWDF's thematic funding could be a reflection of this distortion in understanding of SRHR.
Potential Strategies for ADWF	i. Partner with organisations to implement leadership institutes to develop women leaders, particularly young women in SRHR. ii. Support young women's activism. iii. Strengthen feminist organisations working on SRHR and establish learning agenda to promote cross-sectorial movement to "de-medicalise" women's health. iv. Rekindle old networks such as AMANITARE, reinsert SRHR into the agenda and leverage power across big and small organisations.	i. Reinsert HIV/AIDS into the SRHR portfolio. This would help reframe the issues and also put the spotlight on HIV causes, consequences and feminist solutions. ii. Lead global advocacy among donors to support reframing HIV/AIDS within SRHR. iii. Invest in feminist leadership of the integrated HIV/AIDS/SRHR portfolio.	i. Use the feminist spaces AWDF and partners occupy to reposition the conversation and SRHR agenda. ii. Focus on reproductive rights for women, access to safe abortion and the protection of sexual minorities.

STRATEGIC NEXT STEPS FOR HRR PORTFOLIO

Building on the activities identified above, this report concludes with three actionable steps for AWDF and its partners. These steps are meant to facilitate 'course correction' and further strengthen the operationalisation of the HRR portfolio.

1. **The What – Expand Scope of Portfolio –** The current consensus from interviewees is not necessarily for an overhaul of the HRR portfolio, but rather, for AWDF to continue to invest in the area, emphasising the rights-based aspect of SRHR and augmenting the scope of the issues that fall into this portfolio. As indicated in previous section of this report, aligning HRR with HIV/AIDS is one potential strategy. However, HRR is also inextricably linked to other women's issues such as sexual violence, gender-related mental health, sexuality education in schools, reproductive rights of young women and access to contraceptives and a host of other issues. Whatever issues are chosen, there must be a strong social change agenda, paying particular attention to the gendered drivers of these issues, rather than symptoms or individual 'diseases' or conditions.

2. **The How: Go back to the basics –** Young activists lack skills on how to raise women's consciousness around barriers identified in earlier sections of this report. Proposed suggestions to hold themed feminist leadership institutes on SRHR must develop a curriculum that teaches young leaders how to successfully engage in advocacy at all levels.

AWDF and partners also need to develop a shared theory of how change happens in SRHR. Simply put, 'theories of change' involve consideration of how change will happen and what are the strategic choices one has in designing and implementing women's rights programs. Change, therefore, happens through understanding, claiming and shifting power.

In order to maximise impact, AWDF and partners also need to effectively balance several factors in programming. The first involves balancing practical and strategic needs. There is also a need to balance action at the local and global levels. The current portfolio of grantees is heavily weighted towards the local level, which is essential for providing interventions to project participants. However, decisions that impact beneficiaries are made globally and better linkages are needed between local, regional and global efforts. In the same vein, small, scattered initiatives will need to be linked between countries, so that there is some

coherence and stronger possibilities for structural change and sharing of promising practices and approaches to programming.

3. **The Who: Necessary leadership for meaningful change –** There is a gap in regional leadership on SRHR issues. AWDF and other women's funds can play a critical role in deliberately convening women's organisations, individual leaders and scholars around a shared SRHR agenda. AWLN has been a viable initiative to help fill this gap, but this is not enough for real change. AWDF has the available resources through a network of current grantees - grantees across thematic areas such as HRR, HIV/AIDS, women's human rights - and leaders interviewed for this evaluation who could form the nucleus of the necessary leadership network needed to move the SRHR agenda forward.

CONCLUSION

Over the last 15 years, AWDF has supported innovative and potentially promising interventions in women's health and reproductive rights. The SRHR agenda continues to be a relevant one in the region as seen from current economic, political and social structure factors that remain intractable. The evaluation identified a number of valuable lessons that AWDF and partners can build on through the grantmaking process over the years.

AWDF needs to reframe the current HRR theme to be more comprehensive, including issues that are most neglected. There must be a critical mass of current or potential partners to operationalise AWDF's vision and offer entry points to tackle other issues. Finally, stronger voices are also required at national, regional and international levels to push governments and donors to address SRHR and bring about change for women's healthcare in Africa.

The African Women's Development Fund
Office: Plot 78 Ambassadorial Enclave, East Legon
Post: P.M.B CT 89 Cantonments, Accra, Ghana
Website: www.awdf.org
Email: awdf@awdf.org
Tel: + 233 28 966 9666