

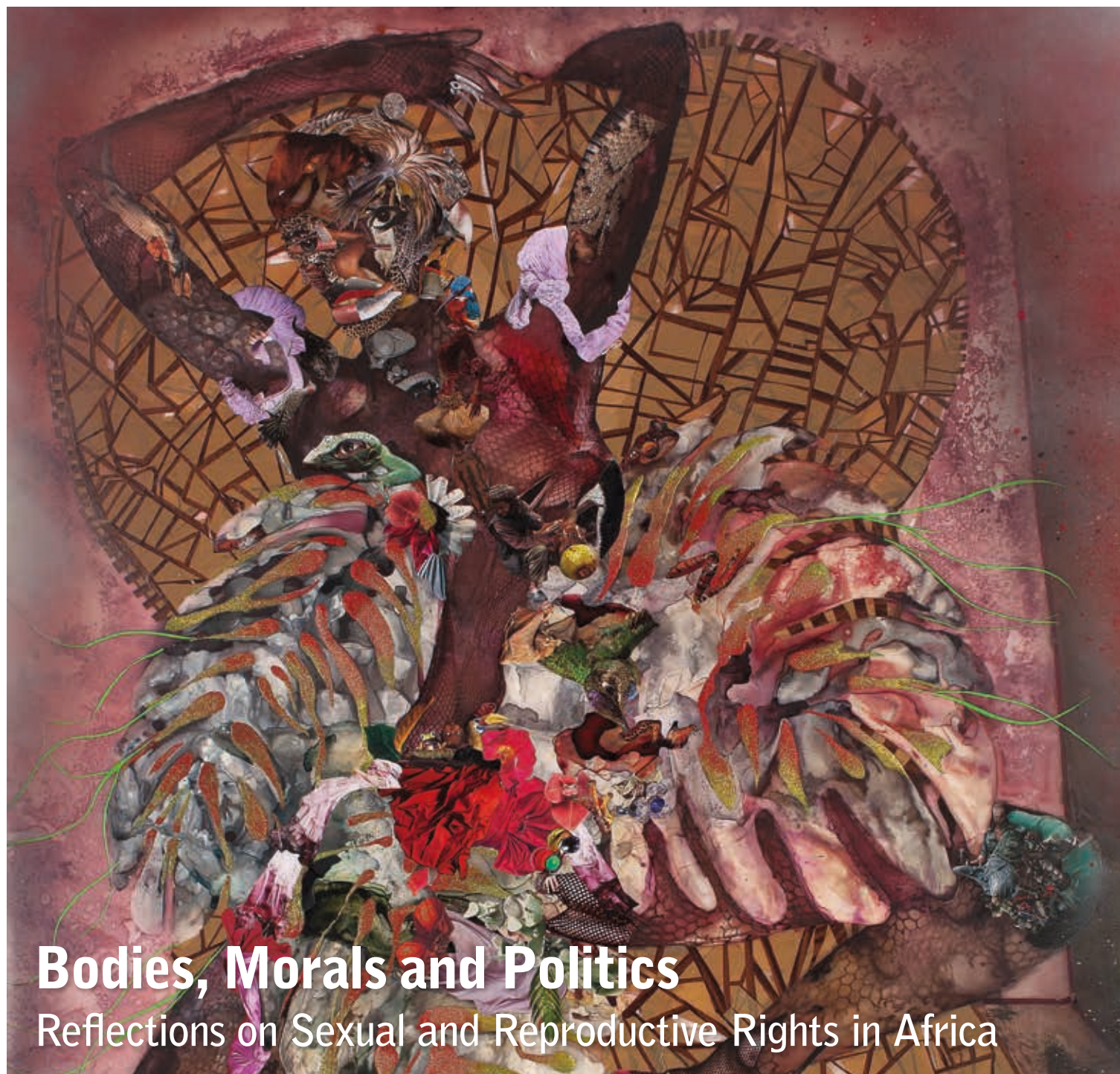
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AFRICA



Bodies, Morals and Politics

Reflections on Sexual and Reproductive Rights in Africa

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Heinrich-Böll-Stiftung

The Heinrich Böll Foundation is a publicly funded institution that is affiliated with but intellectually independent from the German Green party. From our headquarters in Berlin and 30 overseas offices, we promote civic participation in Germany, as well as in more than 60 countries worldwide. Our work in Africa concentrates on promoting civil society, democratic structures, gender democracy and global justice. Together with our partners, we work toward conflict prevention and search for solutions to the challenges of environmental degradation and the depletion of resources. To achieve these goals, we rely on disseminating information, creating a deeper understanding between actors in Africa and Europe, and supporting global dialogue.

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Editorial

Despite the formal commitment of many African states to universal human rights, the realisation of those rights remains unfulfilled for a great number of their citizens, especially women.

Root causes for the slow progress in advancing women's emancipation and gender equality in Africa can be traced, in part, to contradictions between different layers of existing value systems. On the one hand, universal human rights principles, protected through international treaties and national legal frameworks, emphasise the freedom of the individual and her or his entitlement to choice and participation in all spheres of life. On the other, values and cultural norms enshrined in African traditional concepts of community give precedence to what is defined as "the collective interest" over individual rights. The fact that many African societies are deeply embedded in religious traditions such as Christianity and Islam adds further complexity. These various layers of values and norms do not only regulate social interaction in families, communities and society at large, they also define who people are and how they define themselves. Promoters of universal human rights therefore have to be mindful of the importance of community and cultural identity.

The question of reconciling these diverse value systems is particularly contentious in the context of promoting women's sexual and reproductive rights, which are often considered a direct threat to the morality and wellbeing of the community. Religious, traditional and community leaders – most of them male – tend to use "culture" and "tradition" to safeguard the status quo and undermine efforts to empower

women through policy, legal and socio-cultural interventions.

Yet some practices that are meant to uphold traditional ways of life can directly harm and undermine the bodily integrity and dignity of women. Polygamy, virginity-testing, circumcision and risky traditional medicine practices, for example, have adverse effects on women's health and increase their susceptibility to diseases. Nonetheless, women's reproductive and sexual health concerns often remain a taboo topic.

Traditional and religious provisions around marriage and childbearing that are founded on outdated models of family and motherhood promote society's "ownership" over women's bodies and their reproductive capabilities. They also perpetuate patriarchy and women's subordination. Where even state provision of sexual and reproductive healthcare services is premised on such concepts, the systemic disconnection between these services and the reality of people's sexual and reproductive behaviour is entrenched even further.

With this edition of *Perspectives*, the Heinrich Böll Foundation seeks to unpack some of these specific tensions and complexities. Cultural and traditional practices in Africa, like everywhere else, are evolving. As they do, and as some of the articles featured here argue, we hope that they will become powerful instruments for the promotion of women's sexual and reproductive rights.

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The Politics of Control and Ownership over Women's Bodies

Discourses that Shape Reproductive and Sexual Rights in Zimbabwe

Kezia Batisai

Zimbabwe is a predominantly conservative and Christian society which, akin to many countries on the continent, supports patriarchal traditional and religious philosophies. These often-restrictive ideologies and practices are deeply entrenched in conventional Christian churches (e.g. Roman Catholic), African Christian churches (e.g. Apostolic and Pentecostal), and African traditional religion, among others. Although diverse in their approaches, these structures heavily influence the ways in which citizens experience their lives.¹ The dominance of patriarchal structures offers researchers an opportunity to interrogate and deconstruct Zimbabwe's 35-year-old flag-democracy for subtly upholding discriminatory practices that shape and violate women's reproductive and sexual rights, irrespective of age, socio-economic status, geographical location and traditional or religious background, and that lead to politics of control and ownership over women's bodies in Zimbabwe.

national" discourse on reproductive and sexual rights.³ However, because African customary law, for example, seldom draws from these international documents, "the national" becomes a site of contestation over rights in Zimbabwe and other African countries. Women's efforts to subvert gendered reproductive and sexual boundaries are often met with a resistance that is deeply entrenched in the need to preserve what the state considers as "the national heritage"⁴ in its bid to eliminate Western influences on cultural identity. The meaning of "being Zimbabwean" for women is therefore framed in terms of the incessant control and ownership of their bodies by the state through conservative policies that police women's sexuality.⁵ These macro-level debates do not only call for a contextual analysis of traditional and religious practices, they are also gateways for exploring the real limitations to women's access to and progress towards universal sexual reproductive rights in Zimbabwe.

The Reproductive and Sexual Rights Landscape in Zimbabwe

In Zimbabwe, traditional and religious practices continue to influence women's access to control and ownership of their bodies. This is evident in the ways women negotiate the restrictive symbolism and frameworks that police notions of virginity, "real" womanhood, marriage, *lobola* (bride price), contraception and termination of pregnancy.

Over the years, religious institutions have had a strong influence on the evolu-

International vs National Rights Discourses

Although the past four decades have witnessed the proliferation and ratification of international instruments² to improve access to reproductive and sexual rights globally, these have been met with tension at the national level. Such tension is largely explained by the fact that countries are expected to ground their national policy frameworks in these international documents that often flow out of the "inter-



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tion of traditional values and moral systems in Zimbabwe. Beyond shaping young women's individual identities, missionaries in the colonial period constructed the meaning of womanhood based on predetermined social and sexual mores.⁶ The sexuality of these young women was governed by religious codes of sexual purity legitimated by biblical teachings, an observation that hints at the subsequent impact of religion on the reading of women's sexuality in contemporary Zimbabwe. The high value set on real womanhood and sexual purity encouraged heavy policing of the sexual body by parents,

society and religious institutions through stringent rules for courtship and other aspects of interaction between genders. In-depth analysis of this surveillance discourse shows how internalising the norms that govern virginity – believing that any deviation is punishable and brings disgrace on the family – can shape young women's sexuality into adult life. Women's bodies become a yardstick of morality in both traditional and religious perspectives.

Zimbabwean women's reproductive and sexual rights are also regulated by the gendered structures of marriage practices,

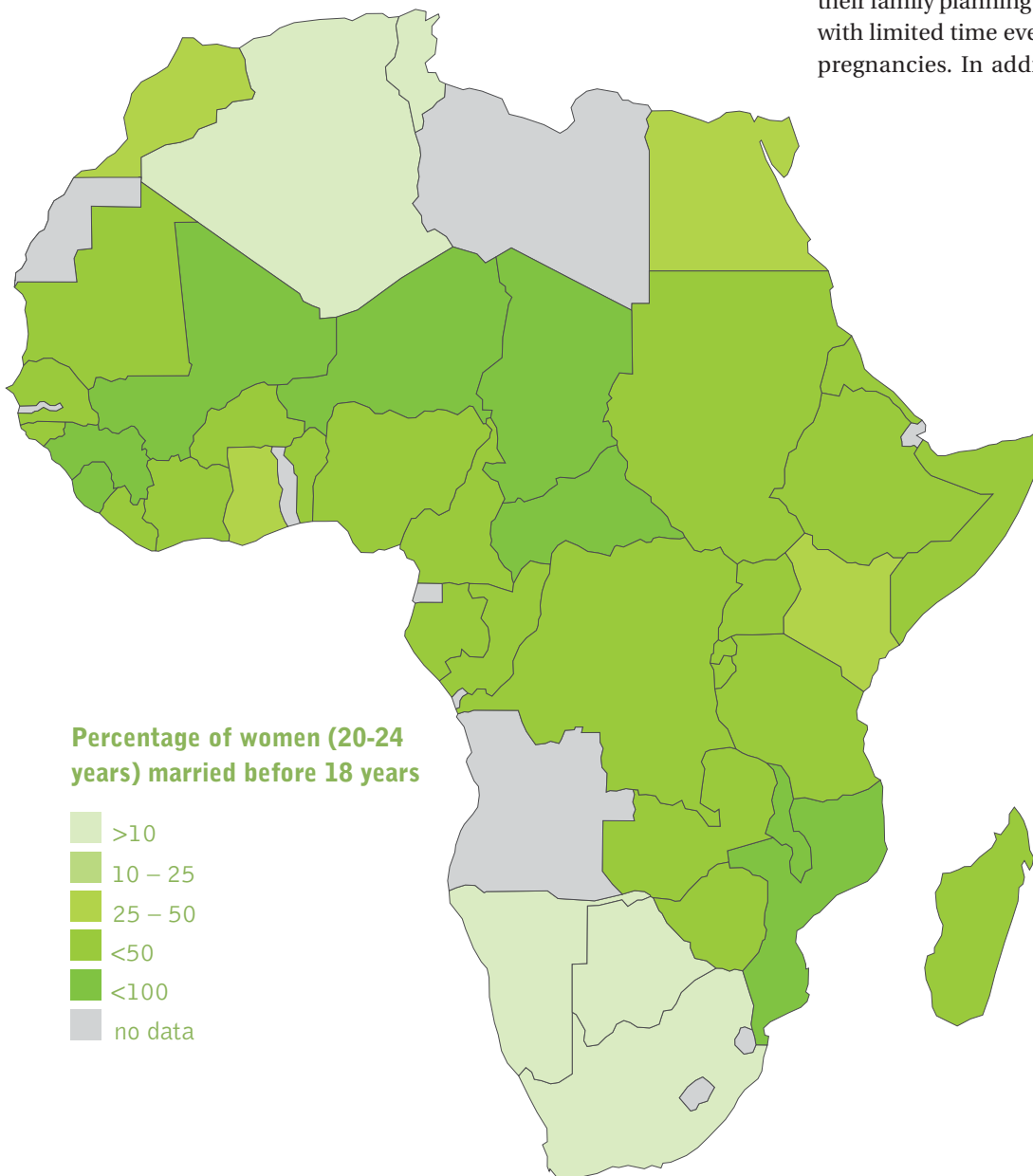
Church goes at the Apostolic Christian Council of Zimbabwe National Mass Convention in Harare. © Gallo Images



especially the traditional practice of *lobola*. Whether married through traditional or religious institutions, women's rights to their reproductive and sexual bodies are negotiated through their relationship to the men (fathers, brothers, husbands, in-laws, patriarchal leaders) who represent these institutions. The payment of *lobola*, through which uxorial rights are transferred to the husband and his family, effectively grants a man the right to demand sex from his wife. The woman is left with very limited (if any) power to resist her husband's demands, and a challenge to his authority is often the basis for gender-based violence within marriages.⁷ Inherent in this practice are silences around women's sexuality and the absence of reproductive and sexual rights in marriage because women feel obliged to fulfil

their wifely responsibilities against all odds. The religious narrative that "we [the married couple] are morally upright" further undermines women's ability to raise suspicions of infidelity or to negotiate safe sex and entrenches their vulnerabilities.

In addition, the values that are central to the establishment of a family – which also regulate ownership over women's bodies and their reproductive capabilities – are deeply embedded and experienced within traditional and religious institutions. In order to simultaneously extend the clan name and fulfil the biblical injunction to "marry and multiply", the family sustains women's procreative function as mothers. Married women who belong to the Apostolic faith sect, for example, fulfil their reproductive obligation by not making use of contraceptives or gynaecological health services. Relying on divine power for all their family planning concerns, they end up with limited time even to breathe between pregnancies. In addition to the effects of



rejecting biomedicine, their reproductive and sexual rights are further compromised by the sect's endorsement of the traditional practice of polygamy. Consequently, a married Apostolic woman makes few decisions concerning her fertility and sexuality as she endeavours to meet all the traditional and religious expectations placed on her body – irrespective of the risk of contracting HIV in polygamous unions or the impact of uncontrolled pregnancy cycles.

Closely linked to the religious discourse of “marry and multiply” is the traditional natural birth-control method of “breast-feeding-weaning”, described by women from an older generation as *mupise dire*, a metaphor that refers to brewing traditional beer over a fire. When the beer is cooked, it is poured into another container to allow fermentation to take place and to make space for the next pot of beer to be brewed. In the same vein, women breastfeed and wean a baby in preparation for next conception.⁸ Framed this way, women's reproductive and sexual roles become a repressive tool that impedes their say over their bodies. From a religious and traditional perspective, family takes on the image of “a brewery for patriarchal practices” where women and men are socialised to accept sexually differentiated roles.⁹ It is within this landscape that battles for reproductive and sexual rights in Zimbabwe are engaged. Women find themselves struggling to subvert longstanding gendered hierarchies that are deeply entrenched in and reinforced by patriarchal traditional and religious structures.

Coerced sex is implicit in these gendered sexual power struggles. Although rape within marriage was legally recognised as a crime in Zimbabwe with the passing of the Sexual Offences Act of 2001, the interplay between law and tradition in Zimbabwe deters women from fully utilising the provisions of this Act. That intersection illuminates how the state institutionalises the control of women's reproductive labour by men.¹⁰ For example, from a cultural perspective, it is problematic for a married woman to report marital rape. To fulfil her procreative function, she cannot terminate the pregnancy, even if she gets pregnant as a result of coerced intercourse – and even though the law recognises marital rape and her right to abort in the Termination of Pregnancy Act No. 29 of 1977.¹¹ Thus, a woman married under the Marriages Act (Chapter 5:11) and the Customary Marriages Act (Chapter 5:07) cannot fully exercise the sex-

ual and reproductive rights subtly enshrined in these Acts. This paradox illuminates the tensions and contradictions between these rights and some cultural and religious beliefs, norms and values, and exposes how a married woman's rights are undermined by the cultural mores and ideological constructions of her societal context¹². These gendered realities indicate that the declaration of the 2013 Constitution of Zimbabwe¹³ to nullify “all laws, customs, traditions and cultural practices that infringe the rights of women” is far from realised.

The UN Children's Fund has estimated the number of illegal abortions performed in

These gendered realities indicate that the declaration of the 2013 Constitution of Zimbabwe to nullify “all laws, customs, traditions and cultural practices that infringe the rights of women” is far from realised.

Zimbabwe at 70 000 per annum.¹⁵ Although this figure is contested by government representatives, it points to a sharp increase from the “5 450 women who sought treatment for incomplete abortions in Harare in 1992 alone.”¹⁶ Despite these alarming figures, a strong pro-life lobby exists in Zimbabwe, constituted predominantly by key political and religious leaders who are influenced by the socio-legal and spiritual dilemmas of abortion. These two quotes demonstrate how contested the discourse is:

Dr Henry Madzorera, then the minister of health and child welfare:

“The Termination of Pregnancy Act of 1977 still stands. By approving post-abortion care to those who could have experienced or practiced unsafe abortions, we are not giving people [women] the right to abort. We are only trying to save lives.¹⁷ The fact that abortion is illegal means it is not a right for women to abort.”¹⁸

A local priest:

“As a Christian, there's no grey area: abortion is murder. The foetus, from conception, has a life, a soul, and we, as human beings, have no right to kill it.”¹⁹

The discourses discussed above are deployed by both institutions to police ways in which women access their reproductive and sexual bodies within and outside of

marriage. In the eyes of religious and traditional authority figures, women who fall pregnant out of wedlock and abort are forever deemed unholy and unfit to hold any respectable positions in society. The label *mapoto women* is often attached to women who are sexually active outside of marriage, especially those who move in with men before they are married customarily. The constructs of tradition and religion emerge as powerful vehicles through which women are perpetually silenced and subordinated in their gendered and sexualised bodies.

Beyond Tensions and Contradictions

The image of women as reproductive and sexual objects is also somewhat contested in contemporary Zimbabwe. Emerging discourses of female sexual pleasure and women's agency to initiate sex deconstruct the generic representation of women as compliant and sexually inferior beings whose primary responsibility is to please men. Empirical research²⁰ shows that Zimbabwean women have always been expected to derive pleasure from the traditional practices of labia elongation and the sexual accessories that a woman received just before marriage. Unlike the "use of herbs/

Emerging discourses of female sexual pleasure and women's agency to initiate sex deconstruct the generic representation of women as compliant and sexually inferior beings whose primary responsibility is to please men.

substances to dry, contract and heat the vagina for enhancement of [men's] sexual pleasure"²¹ – regardless of the increased risk to women of cancer and HIV-infection – women wore bead belts around their waists that had great sexual significance, rubbing against her body during sexual intercourse to enhance her pleasure. However, due to taboos and silences around sexuality in Zimbabwe, such knowledge has only passed through the generations in very private coaching circles. This limits its potential to challenge the mainstream discourse that reserves sexual pleasure for men or to reconstruct women as beings who derive sexual pleasure from a traditional practice.

Furthermore, the predominant Christian religious institutions in Zimbabwe have had an influence on traditional values and moral systems over the years. Traditional practices such as widow inheritance, forced and early marriages, and polygamy have faded away, publicly condemned by the Roman Catholic Church, which celebrates monogamy. In the context of HIV and AIDS, this seemingly positive development has not only given legitimacy to the church and won it support from other progressive religious organisations, it has also advanced the debatable view that "church affiliation alone diminishes pre- and extra-marital sex levels."²² It is, however, imperative to note that conservative anti-contraception and anti-abortion church policies also aggravate the incidence of HIV-infection and AIDS, and negatively impact women's rights. Despite the diversity within these religious institutions, their principles and practices collectively influence the experience of women in Zimbabwe.

Conclusion

Broad engagement with the complex politics of control and ownership over women's bodies in Zimbabwe has revealed that society, through traditional and religious institutions, inherently grants men authority in reproductive and sexual matters. Patriarchal ideologies simultaneously reduce women to objects whose primary function in marriage revolves around their procreative ability. The state's failure to recognise women as central agents in sexual and reproductive decision-making limits women's access to, engagement with, and ownership of their bodies. Its role in addressing gendered inequality will be highly questionable if the government fails to ensure that the provisions of the 2013 Constitution bridge the disconnection between doctrine and practice. For instance, the government should explicitly ensure that these constitutional amendments are directly enshrined in legislation, as mentioned above, that currently sustains patriarchal ideologies that undermine women's reproductive and sexual rights. Targeted legal reform emerges as a key strategy to ensure that Zimbabwean women's control and ownership over their bodies in the face of traditional and religious opposition is improved. ■■■

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Modifying the Female Form: Whose Call is it?

Female Genital Mutilation and Labia Elongation Practices in Africa

Tammary Esho

Women, and increasingly men, practice body modification the world over. These are procedures performed on the body in order to alter physical appearance. When done voluntarily, they can be seen as expressions of personal agency. A woman's autonomy over her own body and her ability to make free choices about her sexual and reproductive functions and her physical appearance are essential to the realisation of her sexual and reproductive health and rights. Feminisms affirm and claim the right for women's bodily autonomy, sexual liberation and personal dignity.

The Noise

In reality, modern and traditional societies' view of women's sexuality and feminine appearance is founded in patriarchy. The feminine form is an object of beauty, sexual attraction, reproduction, sustenance and prestige. Male status is often depicted through the female forms that surround him. The idealisation of masculine genital appearance and sexual power is evident in the aggressive internet advertising for penis enlargement – and of course the notion that this will guarantee his conquest of the most “beautiful” lady! Thus, prevalent definitions of beauty and sexual attractiveness heavily inform bodily modification practices. Take a good look around and you will realise that a great number of us have done some form of body modification: ear and facial piercings, tattoos, tongue splitting, body sculpting, breast augmentation and other subtle or extreme forms of cosmetic surgery. In traditional cultures, particularly in Africa, the Middle East and Asia, genital cutting and

mutilation of girls and women continues to be practised and is the subject of human rights debates.

Body modification is thus practiced in noisy environments that define and construct what is viewed as beautiful and ideal. For instance, in traditional African societies that are yoked to patriarchy – that is, autocratic rule by fathers or men and the subjugation of women and girls – female agency and women's bodily autonomy is difficult. In the same breath, the influence of popular media and modern culture exerts pressure on girls and women to attain a certain standard of beauty and sexual attractiveness. The idealised female body used in advertising suggests that it attracts male power, wealth and status.

Motivations for body modification vary. In some cultures, social status, group affiliation, peer influence and wealth carry significant influence; in others, body modification is associated with sentimental ideals and religious, personal or political meanings. This article will delve into female genital mutilations (FGM) and labia elongation (LE) practices in traditional African societies, and explore the undercurrents that perpetuate these practices.

Illegality

FGM and LE express the social beliefs and cultural norms of the communities that practice them, such as the aesthetics, adornment and beautification of the female genital area and feminine “readiness” for reproduction. Practiced over centuries, it has been a girl's rite of passage into womanhood, but the actual act of genital mutilation is contrary to various human



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rights principles. The practice is considered to be discriminatory, as it propagates violence against women. It is classified as a harmful cultural practice that negates the sexual and reproductive health and rights of women and is against the best interests of the child. It denies girls and women individual autonomy over their own bodies, with negative physical, psychological and sexual consequences. In the wake of the human rights push, there was a realisation that cultural tolerance does not apply to harmful forms of cultural practices. Thus a number of international, regional and national laws and policies exist to prohibit FGM. For example, the International Conference on Population and Development (ICPD)¹ Programme of Action provides principles of the right to reproductive health. At the regional level, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol)² calls on state parties to prohibit FGM. Some countries, such as Kenya, Uganda, Egypt, UK, Ireland, France and Burkina Faso, have national laws enacted for prohibition of FGM.³

Manipulating Genitalia

FGM is practiced in at least 28 African countries. There are different types of FGM, ranging from the least severe, where the prepuce, clitoris and labia minora are damaged or removed, to the most severe, where, in addition to the above, the external genitalia are stitched together to leave a tiny vaginal opening. This process is known as infibulation.

Various reasons are given to justify this practice. Some communities believe that a

The association between virginity and FGM is so strong that a girl who is not infibulated or excised has virtually no chance of marriage, regardless of her virginity.

woman must be a virgin and have undergone FGM to be eligible for marriage. The association between virginity and FGM is so strong that a girl who is not infibulated or excised has virtually no chance of marriage, regardless of her virginity. Due to marital patrilocality – the custom of the wife residing with the husband's family or tribe – a woman's access to resources and thus her very survival are dependent on her having undergone FGM. In some communities, such as the Somalis, the vaginal opening of a young girl is "sewn up" to protect her virginity for marriage and thus her chance for a "secure" future as a wife and mother.

Marriage in these communities is not only a union of two people but also an alliance of two lineages that strengthens clans and inter-clan relationships. FGM is considered vital proof of a bride's virginity, virtue and faithfulness to the husband and also to her family. A woman who has not undergone FGM brings great shame and dishonour to her father's lineage. Likewise, in some communities in Kenya, such as the Kipsigis, Maasai and Kisii, men are convinced that the traditional FGM practice is done for their benefit. A virtuous wife is one who is a virgin at marriage and has been cut to suppress her interest to "stray". Uncut women are viewed as out of control and promiscuous: not of marriage quality.

LE is practiced in some ethnic commu-

nities in central and southern African countries. The process takes several years and begins when the girl is six or seven years old or around menarche, the onset of menstruation. LE is introduced through a sexual socialisation process in which the girl's mother, grandmother, caregivers or sisters impart the knowledge and skill of manually manipulating the genital organs. This involves stretching the inner labia minora and often also the clitoris. Coerced to comply with the ritual by being (mis)informed that it will benefit their reproductive capacities, these girls may not understand the sexual significance and dangers of this procedure. In most communities, herbal substances and oils, which are not scientifically certified, are used to help stretch and retain the labia in position. Girls experience discomfort, irritation, oedema and secondary infections. Often the pain is excruciating!

LE is mandatory for girls and women in these communities; anyone who fails or refuses to comply is stigmatised and ridiculed for being "less of a woman". She is considered to be incapable of satisfying a man sexually and thus unmarriageable, or, if married, she is held responsible for her husband's infidelity. A study in Zimbabwe⁴ found a pervasive belief among men that these practices are done in their favour and that sex with women who have LE is

better than with those who have not. The men said that if they do not get sexual satisfaction from a woman who has not undergone LE, they will look for another woman who has. The same study found that, for Zimbabwean women, the practice of LE is accompanied by the insertion of herbal substances into the vagina to tighten it for the enhancement of male sexual pleasure. This may result in serious medical consequences such as irritation of the vaginal wall, causing painful intercourse and infections. It is also not evident that LE assures marital success, as married women with LE experience the usual sexual and relational problems, often because of their male partners' infidelity. The burden of marital sexual success is purely, and unfairly, placed on the woman.

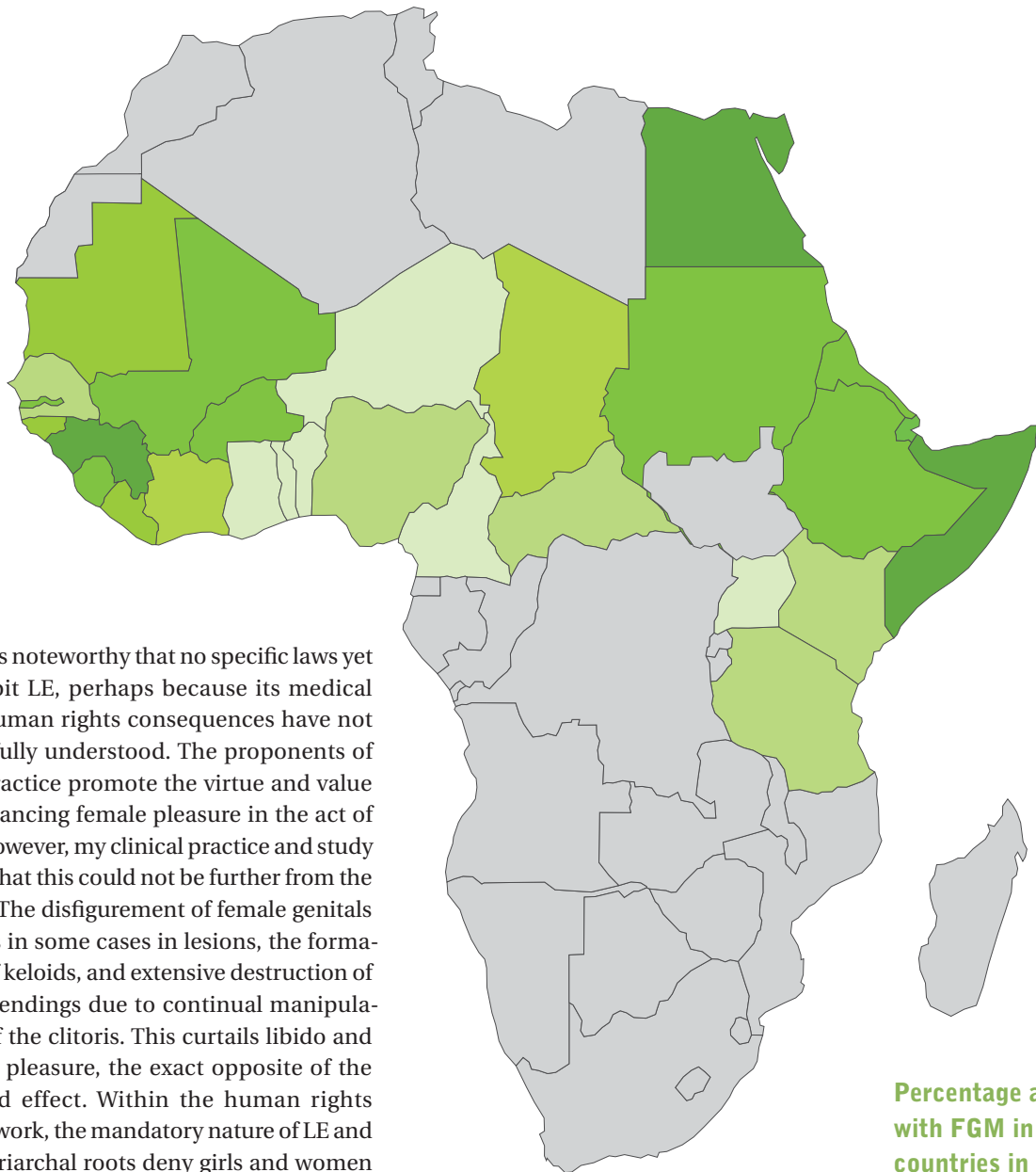
Manipulating Sexuality

The practice of LE among the Baganda people in Uganda is accompanied by another interesting phenomenon called "squirting" or female ejaculation. Aunties known as "senga" teach the art of sexual seduction and pleasure to brides-in-waiting. This means that the girls have a very open way of understanding their sexuality but, like elsewhere, the ultimate goal is to manipulate women's sexuality for male pleasure and the preservation of patriarchal structures.

Kenyan women shows the razor blade she uses to cut girls' genitals.

© Ivan Lieman / Barcroft Media





Percentage aged 15–49 with FGM in the countries in which it is concentrated

- 1–9
- 10–29
- 30–49
- 50–69
- 70–89
- 90–99
- not applicable

Source: UNICEF, 2014.

It is noteworthy that no specific laws yet prohibit LE, perhaps because its medical and human rights consequences have not been fully understood. The proponents of this practice promote the virtue and value of enhancing female pleasure in the act of sex. However, my clinical practice and study show that this could not be further from the truth. The disfigurement of female genitals results in some cases in lesions, the formation of keloids, and extensive destruction of nerve endings due to continual manipulation of the clitoris. This curtails libido and sexual pleasure, the exact opposite of the desired effect. Within the human rights framework, the mandatory nature of LE and its patriarchal roots deny girls and women autonomy over their own bodies and bonds them to early marriage and premature parenthood.

Victims or Influencers?

Although women in patriarchal communities may appear to outsiders as hapless victims, the women themselves do not consider this to be the case. Indeed, they play a significant role in sustaining the patriarchal structures. That FGM practices are performed by women themselves seems to suggest that the “cutters” express a form of agency as custodians of tradition, influencers of culture and social leaders in their own right. While outsiders perceive the women as perpetuating a cruel and harmful traditional practice, those living in these communities begin the socialisation process very early in life. The recognition that this is an important rite of passage is ingrained

into the psyche of girls and women as well as men and boys. Therefore, careful consideration must be given to the opportunity to harness women’s collective influence and feminist agency in these communities to reconfigure rites of passage outside of the mutilation of their own bodies and to appreciate shifting cultural contexts.

Free Choice

Autonomy and free will are washed away when patriarchal systems dictate feminine identity and belonging, whether in traditional or modern contexts, and reproduction and sexuality are the easiest “tools” for men and women to negotiate and preserve male privilege. A woman’s virtue and sexuality are defined by her culture and her future is “secured” by her compliance with norms

and regulations that legitimise her femininity, identity, marriageability, sexuality and inclusion in a social or family class. Her womb is the vehicle for the growth of the community and her reproductive choices are scrutinised and ordained by men.

While our culture defines our identity and provides us a sense of belonging, culture in turn is ever morphing. It gains new meaning with new interpretations of norms and values. In traditional Africa, religion, legislation and education continue to reshape culture, along with fervent efforts to re-examine, unlearn and relearn traditional rites of passage and belonging. For instance,

Women's agency will be experienced when women reject the notion that their own body modifications are for the benefit of men and begin to see them for their own personal gratification.

unhygienic practices such as shared male circumcision, FGM, teeth cutting/removal and face laceration are slowly fading away because of education and HIV/AIDS awareness efforts. Legal measures have also been used to accelerate the abandonment of FGM. In Kenya, medical practitioners are prohibited from performing FGM for non-medical reasons and are liable for punishment and sanction if they do.

I would like to conclude by exploring what real agency and autonomy could look like in the general context of body modification. True agency will be experienced when a woman is able to articulate her desires regardless of the loud noise of societal expectations and prescriptions of who she ought to be. More so when girls and women refuse to be yoked to such practices and begin to see themselves as independent individuals who can make choices that

benefit their personal health and wellbeing. Feminist agency will be experienced when girls and women stop accepting the status of chattels, when they demand rights to education, empowerment and access to opportunities completely independent of their sexual and reproductive functions and physical appearance, or when they otherwise gain recognition and reward for their care functions. Women's agency will be experienced when women reject the notion that their own body modifications are for the benefit of men and begin to see them for their own personal gratification. Subsequently, this will mean that women who seek genital modification, whether for traditional or cosmetic purposes, would experience complete autonomy if they were motivated by their own innate desires. Women in traditional communities could see themselves as able to determine their own destinies and could champion delayed rites of passage for young girls, to protect them and maximise their chance for holistic development. With space for autonomy and agency, women can reshape discourses and redefine themselves, whether through flipping the rhetoric of body modifications or through political decision-making, with an agenda to push the boundaries of social acceptance in various contexts.

Realising the social meaning of body inscriptions helps us to understand that conventions of gender and sexuality are culturally invented, celebrated and sanctioned. They provide a harsh environment when a woman cannot define who she is or wants to be, particularly when her failure to conform would invite real or perceived stigmatisation, ridicule and low self worth, as well as punishment and lost opportunities. Cosmetic beauty surgery and fashionable bodily modifications are not dissimilar to traditional social constructs of bodily modifications. They also ought to be inspected through feminist eyes. ■■■

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African Cultures and the Promotion of Sexual and Reproductive Rights

Thelmah Maluleke

Introduction

Culture can be defined as a continuous process of change that gives a community a sense of identity, dignity, continuity, security and that binds it together. It includes beliefs, art, morals, law, customs and any other capabilities and habits acquired by its people. Traditional values, on the other hand, are attitudes, beliefs and actions that are standards of behaviours by which society expects its members to abide. They guide human behaviour in interpersonal, group and intergroup communications and relationships. Cultural and traditional values influence spheres of social activity such as family life, health, education, wealth distribution, politics and government.^{1,2} In Africa, as elsewhere, values are dynamic and continuously interact with their internal and external environment.

Debates about African cultures and traditional values date back to the 17th century when colonisation came to Africa, and they continue in the 21st century. Until the first wave of African states secured independence in the 1960s, debates on African cultures and traditions were characterised by the wholesale condescension of the colonial conquerors. The second half of the of the 20th century was, to a large extent, dominated by debates about cultural practices that perpetuate discrimination against women and that violate their sexual and reproductive rights: namely the right to a healthy, safe, consensual and enjoyable sex life; to control their bodies, and to sufficient accurate information to make decisions and seek healthy behaviours; and the right to access to affordable services that keep them healthy at all times.

The general view remains that African cultures and certain traditional practices

have affected and continue to affect the health of women negatively and increased their susceptibility to certain diseases and vulnerability to male subordination. Whilst acknowledging the fact that certain African cultural practices expose women to unnecessary health risks, not all African cultural practices are harmful.

Within most, if not all, African cultures an individual is expected to uphold at all times the essential principles of self-respect, respect to others, honesty, trustworthiness and compassion often referred to as “ubuntu” in the southern African region. In its essence, ubuntu expects all human beings to be “human” and to value the good of the community above self-interest.^{3,4,5} Viewed from this perspective, African cultural and traditional values and human rights should not be in conflict. In reality, some individuals violate the rights of others as part of cultural practices or use culture and tradition as excuses for their own misbehaviour.

A plethora of articles and organisations have identified harmful African cultural and traditional practices, such as male child preferences, polygamy, male and female circumcision, and the subervience and subjection of women and girls to male domination. The perpetrators are mainly men who often claim to be acting within their cultural entitlement. The victims are forced to remain in these situations through threats and violence.^{6,7,8} These harmful practices are not unique to African cultures and traditions, though, but are the consequence of a patriarchal view of society entrenched in the political-social system that insists on male superiority and rule over women through various forms of



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physical, social and psychological intimidation and violence.⁹

However, the continued “othering” and portrayal of Africans as victims of their own cultures and traditions is disempowering and even dangerous as these practices move underground, opening them up for abuse by unscrupulous practitioners who have no knowledge of or distort the culture they claim to represent.

It is therefore imperative to identify and find ways to use elements of African cultures that help to promote human rights, women’s rights, and sexual and reproductive rights.¹⁰ The key question then becomes: what type of interventions are necessary to achieve this? Against this backdrop, this article explores the merits of community participation in the promotion of sexual and reproductive rights in the context of cultural practices in South Africa.

Merits of Community-Oriented Views for the Promotion of Sexual and Reproductive Rights

South Africa faces enormous sexual and reproductive health and rights challenges: gender-based violence is rampant, with about 56 percent of female homicides recorded in 2009 committed by an intimate

Puberty rites are not only an indication of society’s interest in sexuality development amongst young people but also offer potential vehicles for the promotion of sexual and reproductive health and rights.

partner.¹¹ UNAIDS statistics for 2014 indicate that 18.9 percent of the South African population between the ages of 15 and 49 is living with HIV. The maternal mortality rate in 2011 was estimated at 197 deaths per 100 000 live births, way off the Millennium Development Goal target of 38 deaths per 100 000 live births.¹² Every year, scores of young men die or are deformed as a result of botched male circumcisions.

Young people in rural areas continue to face substantial barriers to sexual and reproductive health information and services, such as access to comprehensive treatment, prevention and care for sexually transmitted infections, including HIV, and maternal and child health services.

Puberty rites for girls and male circumcision are integral to a number of South African cultures. They are not only an indication of society’s interest in sexuality development amongst young people but also offer potential vehicles for the promotion of sexual and reproductive health and rights. Interventions to use these rites of passage for improving sexual and reproductive health and rights have met with either success or failure depending on context and approach. Two examples will illustrate this point.

Puberty Rites Among the Vatsonga

Puberty rites have different names and different practices in the various regions of South Africa. *Vukhomba*, as the rite is known among the Vatsonga of Limpopo province, is exclusively conducted for girls who have reached menarche. *Vukhomba* is seen to empower women to claim their position in society and strengthen loyalties between the members of the group of initiates. While women acquire temporary recognition and status in the community during the rites, they go back to the low status prescribed by society once the rites are over. Sexuality education in *vukhomba* is usually limited to personal hygiene and the maintenance of virginity, self-control and social morals. The teachings are given in a non-threatening environment through songs, poems, demonstrations and figurines that are shown to the initiates. They encourage abstinence – an important aspect in the prevention of HIV infection – but do not teach initiates about HIV/AIDS, and there is no evidence of a difference in the prevalence of teenage pregnancy between initiated and uninitiated teenage girls. Although this rite of passage does not address human rights, taboos are used to prevent violence against women. Initiates are not made aware of their reproductive rights, such as the right to make decisions concerning reproduction free from discrimination, coercion and violence. The information given is at times unclear and not easy to understand.¹³

But since *vukhomba* brings initiated women and initiated girls together and accommodates new learning that can empower the initiates and women, it could serve as an appropriate platform for sexual health education for these different age

groups. Furthermore, the initiated girls could be available for peer teaching, not only during the initiation, but also in the community and at school.

Based on these observations, a sexual health education programme was developed by this author, with full participation of the initiated and uninitiated girls and women, and implemented in the participating communities.¹⁴ The draft sexual health programme was presented during the *vukhomba* to elders, initiated women, and initiated girls in the form of a talk to give them a feel for what would be discussed. It was presented in Xitsonga and visual aids were used to clarify some aspects. Table 1 indicates the topics presented and the participants' responses or choices.

The participants approved eight of the 11 topics presented for inclusion in the intervention programme. All the topics that were not approved by the *vukhomba* elders were left out of the final intervention programme. However, it was hoped that some

of them could be explored if questions arose. The sexual health programme benefited both the initiated girls and women and was extended to other young people in the participating villages. The programme was not formally evaluated, but its popularity in the participating communities serves as indication of its acceptance.¹⁶

Male Circumcision among the Amaondo

In the 1820s in the Eastern Cape province, King Faku of the Amaondo banned male circumcision because of ongoing attacks by the Zulu King Shaka during times when initiations were in progress. The re-emergence of male circumcision in the 1990s, when almost all male adults were uncircumcised, plunged this cultural practice into deep trouble due to a lack of direct adult supervision.¹⁷ In Amaondo culture, an uncircumcised male is considered to be a boy

Table 1: Topics presented to the *vukhomba* participants and their responses.¹⁵

Topics	Reponses		
	Vukhomba elders	Initiated women	Initiated girls
Anatomy and physiology of the female reproductive system	Approved	Approved	Approved
Anatomy and physiology of the male reproductive system	Not approved	Not approved	Approved
The developmental stages of a woman	Approved	Approved	Approved
Menstruation	Approved	Approved	Approved
Getting pregnant	Not approved, but received a lot of interest	Not approved, also received a lot of interest	Approved
Contraception	Not approved	Approved	Approved
Personal hygiene	Approved	Approved	Approved
Sexually transmitted diseases (STDs)	Approved	Approved	Approved
HIV/AIDS	Approved	Approved	Approved
Breast cancer & breast examination	Approved	Approved	Approved
Cervical cancer & Pap smear	Approved	Approved	Approved



Young boys attend initiation at a circumcision school.

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and, worse, an *inja* (dog).¹⁸ As most fathers, uncles and grandfathers were not initiated, many boys turned to traditional attendants, often self-appointed, who lacked the requisite competence and knowledge, leading to complications and deaths. While accurate statistics are not available, about 950 circumcision-related deaths have been recorded since 1995 in the Eastern Cape alone.¹⁹

Although the government introduced legislative and health interventions for safe circumcision and wound care, deaths continue to occur. The target communities rejected surgeons and nurses who were trained to ensure safe practice as government impositions. The enforcement of the Health Standards in Traditional Circumcision Act (Act No. 6 of 2001) has seen further rapid increases in illegal circumcision schools and untrained surgeons operating underground, leaving boys to suffer and die alone. Criminals and drug lords have taken over this cultural practice and have deliberately ignored the cultural circumcision protocol in order to gain new “customers”.²⁰

The stakeholders in the affected communities themselves need to get engaged in finding solutions. It is necessary for them to find out what is done differently in communities that do not experience these complications with traditional circumcision and to learn from them. Parents need to challenge traditional leaders to ensure that all circumcision schools in their communities are legal and conducted by trained people. Uninitiated boys need to be educated about the presence of illegal initiations practices in their communities.²¹ Fathers and uncles of initiates should supervise the initiation of their boys and be present at the initiation school at all times. Only then can a cultural practice that is currently a hazard to sexual and reproductive rights become a platform that helps to promote them.

Conclusion

The above examples illustrate not only the paramount importance of community participation in any intervention strategy but also that African cultures and tradi-

tional values are dynamic and adaptable. Approached correctly, they can be used as vehicles for the promotion of sexual and reproductive rights. A lack of community engagement and top-down enforcement of interventions will always be met with resistance and lead to unintended outcomes. Awareness of sexual and reproductive rights among young people will encourage them

to ensure that their cultural practices are safe. Their knowledge about and protection of their sexual rights need not interfere with the protection of cultural values but rather can enhance those cultural values and help them to evolve and accommodate new practices that protect the initiates and the community. ■■■

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Teenage Pregnancy and Challenges to the Realisation of Sexual and Reproductive Rights in Nigeria

Interview

Onyema Afulukwe-Eruchalu

High prevalence of adolescent pregnancies is a great concern, both as a health risk and a challenge to the realisation of girls' sexual and reproductive rights in sub-Saharan countries. By 2030, according to a report by the United Nations Population Fund, there will be 26 million more adolescent girls in the world. The largest absolute national increases in adolescent girls will mostly happen in sub-Saharan African countries, with Nigeria at the top of the list. At least one of every five adolescent girls aged 15 to 19 has given birth, according to the 2014 Nigerian National Demographic Survey.

HBf: What are the current factors contributing to the high prevalence of teenage pregnancy in Nigeria? And what are the risks associated with that trend?

Afulukwe-Eruchalu: A combination of socio-cultural, legislative, political and economic factors are currently contributing to the high prevalence of teenage pregnancy in Nigeria. They include socio-cultural perspectives that result in widespread bias against acknowledging adolescent sexuality by major stakeholders such as families, policymakers, healthcare providers, and educators; the absence of laws, policies and services that are targeted at meeting adolescents' sexual and reproductive healthcare needs; the inadequate provision of comprehensive sexuality education to adolescents, in and out of school; as well as impunity for sexual violence, including in schools. The high incidence of child marriage in parts of the country and endemic poverty, which forces some adolescent girls to engage in transactional sexual activities in exchange for basic necessities, such as food, clothing, and school fees, are also important factors. Lastly, the chronically underfunded health system – which lacks youth-friendly services and has raised financial barriers such as high costs and stock-outs of contraceptive methods that prevent adolescents from accessing the contraceptive or family planning information and services they might need – constitutes another key factor.

The risks associated with these trends are grave. With little to no avenue to access necessary sexual and reproductive health information and services, many adolescents experience early, unplanned or unwanted pregnancies. Afraid of being stigmatised by society, disowned by their families or expelled from school, some seek out clandestine and unsafe abortion services, risking severe injury or death. Those who



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Most pregnant students are likely to be expelled from school.

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continue with the pregnancy are likely to be expelled from school with minimal opportunity for re-entry, or drop out, severely limiting their employment opportunities and economic empowerment for life. They also face increased risks of maternal morbidity and mortality due to their physical immaturity and the heightened challenges adolescents encounter while seeking quality and affordable maternal health care services. To avoid the stigma and discrimination that result from being unmarried and pregnant, or to secure the financial means to undertake child-rearing responsibilities, some families force adolescents into early marriages, often to older men who are more likely to be financially secure. However, the unequal power relations in child marriages intensify girls' risks of domestic violence and sexually transmitted infections, including HIV.

What are some of the rights instruments available to further the sexual and reproductive rights of adolescents in Nigeria?

A number of relevant human rights standards are entrenched in the Constitution and in international and regional human rights instruments. These guarantees include the rights to health, equality and non-discrimination, information, education, life, and freedom from cruel, inhuman and degrading treatment, among others. They contain components that have been interpreted to require states to address teenage pregnancy and its consequences and ensure adolescents receive appropriate sexual and reproductive health information and services.

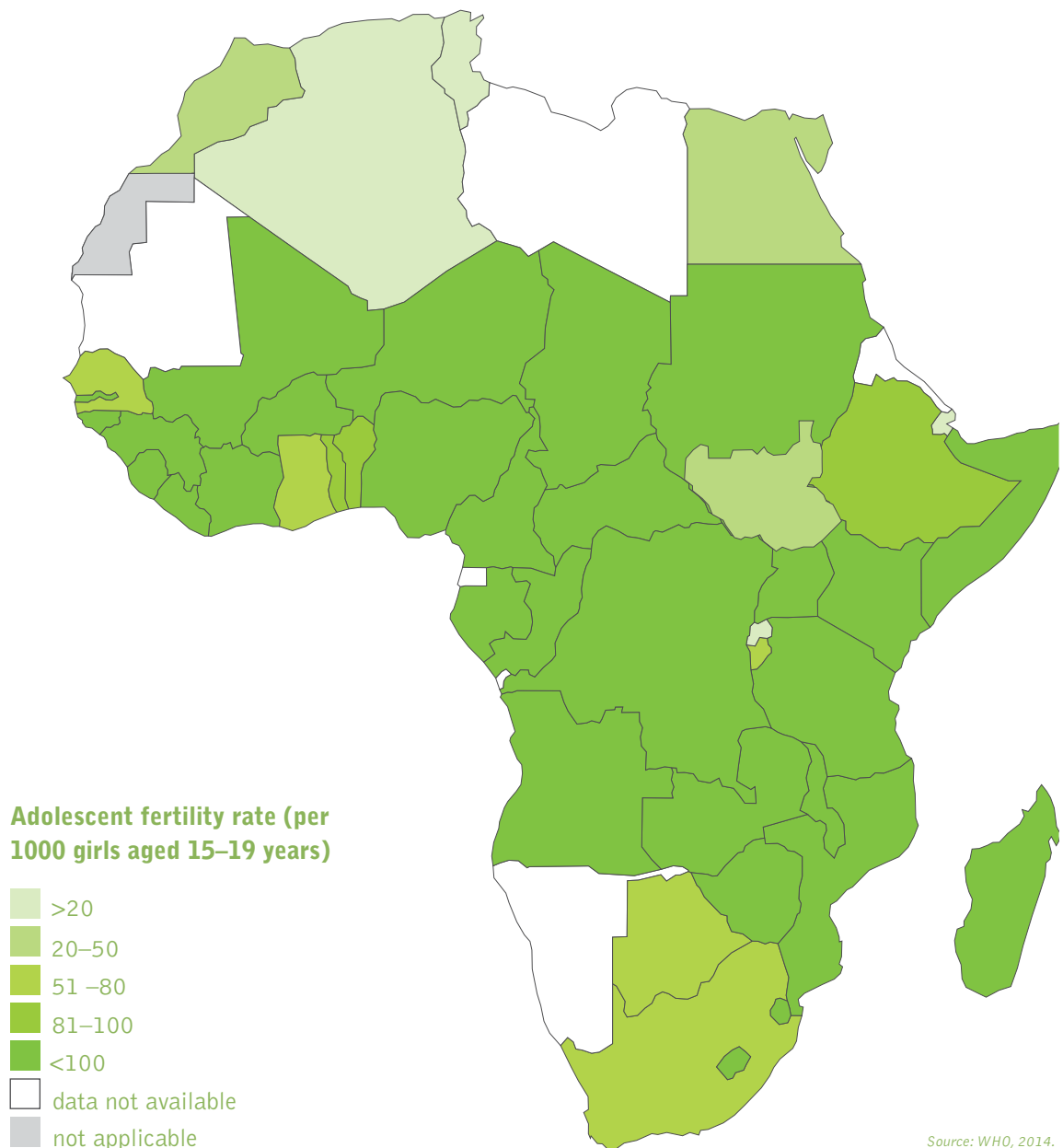
Specifically, the United Nations Covenant on the Rights of the Child, which was developed for children, including adolescents, mandates states to guarantee their right to the highest attainable standard of

health and provide access to family planning and education services, ensure their survival and development, and undertake appropriate measures, including legislative and administrative, to ensure they have the protection and care that is required for their well-being. At the regional level, the African Charter on the Rights of the Child, which Nigeria has ratified, also provides equivalent guarantees.

In which ways do entrenched traditional or religious values and practices hinder the realisation of sexual and reproductive health rights in Nigeria?

Although the rights guaranteed by the United Nations Covenant on the Rights of the Child were domesticated at the national level in the Child Rights Act in 2003, federal states had the authority to modify or refuse to implement the Act to the extent that it contravened local traditions and religions. Many chose not to implement the Act primarily because it prohibited child marriage.

This goes to show how widely-held traditional and religious values and practices in Nigeria play a substantial and multifaceted role in constructing and exacerbating the socio-cultural, legislative, political, and economic factors I mentioned.



In many parts of Nigeria, socio-cultural norms, which are common in most African countries, do not recognise adolescents' evolving capacities and abilities to make decisions about their reproductive health. Religious values – both Christian and Islamic – require that they do not engage in sexual activity outside of marriage. Accordingly, providing adolescents with adequate, if any, sexuality education is viewed with suspicion and there is fear that it would increase their likelihood to engage in sexual activity or promote promiscuity.

This misperception reduces adolescents' opportunities to receive information about sexual and reproductive health issues at home or at health facilities or to access accurate and evidence-based sexuality education in schools. Yet about 14 percent of adolescents in Nigeria have engaged in sexual activity. Those who seek reproductive health information and services, including contraceptive services, from healthcare facilities are frequently subjected to the personal bias of healthcare providers who deny them access based on their age or marital status, or require them to obtain consent from their spouses or parents without any legal basis.

Another unfortunate outcome of these misconceptions is that policymakers have neglected their responsibility to develop or implement relevant policies or faced stiff opposition when they have attempted to do so. The federal government of Nigeria established a national curriculum for sexuality education in schools in 2003. Prior to that, there was much resistance to the process, again stemming from misconceptions about the implications of providing sexuality education to adolescents. It became imperative to link its primary value to the reduction of HIV infections among adolescents, a burning issue at the time, and was ultimately given the title of Family Life and HIV Education Curriculum (FLHE).

All 36 states and the Federal Capital Territory were advised to adopt it. Yet again, a majority of states did not adopt the FLHE for several years, and most of the few states that adopted it early did not adequately ensure its implementation in schools, a reflection of the level of political commitment to implement it. Some states are yet to adopt it, despite reliable evidence that adolescents who received the FLHE exhibited considerably increased knowledge of sexuality and HIV, positive changes in their attitudes towards gender equality, and increased likelihood to want to abstain from sexual activity.

What efforts does Nigerian civil society pursue to promote the sexual and reproductive rights of adolescents?

Efforts include human rights advocacy, research and data collection, awareness-raising and capacity-building to influence decision-makers at the national, regional, and international levels in order to achieve law reform and implementation. A pertinent example is the collaboration between global and Nigerian civil society to do in-depth human rights advocacy before the United Nations Committee on the Rights of the Child during its periodic reviews of Nigeria in 2005 and 2010. This engagement involved submitting shadow reports to the committee with independent and reliable research and data on Nigeria's compliance with its obligations to children under the Covenant. As a result of those efforts, the committee expressed concern at "the high proportion of teenage pregnancies" and issued several recommendations. It urged the government to "formulate adolescent health policies and programmes with a particular focus on the prevention of sexually transmitted infections (STIs), especially through reproductive health education". It also mandated the government to ensure all the states in the country adopt the Child Rights Act as a matter of pri-

ority, despite the government's stance that this would be controversial.

Strategies to secure the full implementation of these and similar recommendations and to mobilise relevant stakeholders continue to date. Indeed, on September 25, 2015, governments worldwide adopted the 2030 Agenda for Sustainable Development Goals (Post-2015 SDGs), which build on their commitments under the Millennium Development Goals. Civil society engagement, from both the global North and global South, including Nigeria, helped ensure that the Post-2015 SDGs include commitments to advance gender equality and sexual and reproductive health and rights. Further, the African Union (AU) has declared 2016 the Year of Human Rights in Africa, and mandated all members states – of which Nigeria is one – to embark on targeted activities to bring this declaration to fruition in their countries. The Nigerian government and other stakeholders must use the concrete opportunity provided by both of these recent regional and international commitments to address the high prevalence of teenage pregnancy. It should develop both immediate and shorter-term strategies to achieve results in 2016, in keeping with the AU's declaration, while also establishing medium- and longer-term measures as part of the commitment under the SDGs to ensure universal access to sexual and reproductive healthcare services, including family-planning information and education.

Is there any role that adolescents could play themselves?

Absolutely. Adolescents are the first and main stakeholders in the process and should be supported to actively engage decision- and policy-makers at the national, regional and international levels, whether as individual advocates or members of youth coalitions, to draw attention to their concerns. Avenues to engage include attending the sessions of the Nigeria national assembly and state houses of assembly, the African Committee on the Rights and Welfare of the Child, and the UN Committee on the Rights of the Child to speak about their experiences and provide input on the development of laws or policies on children. They can identify these opportunities to engage with the support of their schools and civil society groups, and can make their views about teenage pregnancy and its consequences known through social media sites, particularly those that are popular in Nigeria. Adolescents should identify opportunities to hone the necessary research, writing, speaking and other skills to be their own best advocates at these policy- and decision-making fora by undertaking internship or volunteer positions at relevant non-governmental organisations or government offices. ■■■

Too Much Mothering and Not Enough Options

Marion Stevens

Motherhood has always had currency and has been linked to a particular kind of status for women in South Africa. The options involved in becoming a mother are complex and different for each woman. Motherhood was not always linked to marriage, but family arrangements were made to support the woman/mother and children by families involved. Because of the status that motherhood has afforded, there is a legacy of viewing women who do not have children with shame and suspicion. In English, the word “barren” is laden with judgement and describes the isolation and emptiness women are apparently left with. It is interesting that this view is held in all classes and races in South Africa.

It is against this background of celebrated motherhood that this short essay describes some of the challenges in realising sexual and reproductive health and rights for women in South Africa. In doing so, it reflects on the intersecting areas of fertility intentions in relation to contraception, abortion and HIV/AIDS.

Contraception

During apartheid, motherhood was strictly framed by the strictures of racial population control. This certainly left a legacy that informs cultures of motherhood today. While white women were encouraged to procreate, public long-term family planning services were designed to limit black women’s fertility. The 1998 South African Population Policy acknowledges that [p]ast policies, especially with

regard to the demographic processes of fertility, mortality and migration, were flawed in many respects. They were anchored in apartheid ideology and focused on: forced and/or restricted movement and resettlement of the population, especially blacks; reducing the country’s rate of population growth by reducing the fertility of the population primarily through the provision of contraceptive services, often by coercive means; demographic rather than human development targets; restricting the access of blacks to educational and employment opportunities.¹

The widespread introduction of long-term contraception options has also meant that intimate partners tend not to discuss safer sex options. While not having to negotiate contraception or protection from sexually transmitted infection is a relief for some women, the responsibility for contraception was essentially left with them. Thus the planning for motherhood or having children is not well established in relationships. This ties up with experience: globally, some 50 percent of pregnancies are unintended.²

The apartheid legacy of migration and family dislocation, which separated men in urban workplaces from women in rural homelands, persists. Recent South African data suggest that only one-third (33.5 percent) of children live with both parents, while 39.3 percent live with only their mother, 23.9 percent live with neither of their parents, and 3.3 percent live with their father. While 78.8 percent and 67.3 percent of males and females in the age group 18–34



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years were respectively classified as never married in 2010, only 5.3 percent of males and 8 percent of females over the age of 60 years have never been married. The dissolution of families often leads to the formation of female-headed households or the integration of surviving females into extended family units. Both results increase the household's caretaking challenges, and it is not surprising to note that female-headed households are disproportionately affected by poverty.³

HIV and AIDS

The HIV epidemic in South Africa has also changed the context of motherhood and sexual and reproductive health and rights. In 1994, South Africa showed global leadership at the International Conference on Population and Development (ICPD) in Cairo, leading negotiations and language on human rights and sexual and reproductive

The dissolution of families often leads to the formation of female-headed households or the integration of surviving females into extended family units.

health and rights. The conference shifted the programme of population control to one of development and a framework of sexual and reproductive health and rights was mooted for the first time. The South African Population Policy aligned itself with the ICPD, noting that

[t]he Programme of Action also places emphasis on: gender equity, i.e. the equality and empowerment of women both as an important end in itself, and as essential for the achievement of sustainable development; improving education and health conditions; promoting sexual and reproductive health (including family planning) and reproductive rights; supporting the family as the basic unit of society and contributing to its stability; fostering a more balanced distribution of the population and reducing the role of various factors that affect rates of migration; and establishing factual bases for understanding and anticipating the interrelationships of population, socio-economic and

environmental variables, and for improving programme development, implementation, monitoring and evaluation.⁴

HIV/AIDS soon became a pressing challenge in South Africa, which, together with the southern African region, has borne the brunt of the epidemic. Women, and in particular women of reproductive age, are most vulnerable to infection. The US President's Emergency Plan for AIDS Relief (PEPFAR), one of the largest and most influential funding frameworks, is investing over USD 5 billion in South Africa's HIV and TB response, helping to support an unprecedented expansion of prevention, treatment, and care services.⁵ However, it forces partners to declare that they will not engage in any advocacy work on issues such as abortion or sex work. This led to a schism within the sexual and reproductive health rights programmes in South Africa which was highlighted by the Treatment Action Campaign (TAC) and the AIDS Law Project (ALP) asking the Reproductive Rights Alliance⁶ to recuse itself from a 2001 court case against the South African department of health related to the prevention of mother-to-child transmission (PMTCT). The legal arguments of TAC and ALP presented women as mothers wanting to protect their babies. Any other notion – of choice or reproductive rights or reproductive justice – was viewed as not viable for winning the case. The case was based on

a limited notion that only looked to women's choice for motherhood. The primary claims advanced by the legal team (and the parties to the case) merged the interests of women with those of safeguarding children's rights to health and of health professionals' rights to treat their patients. These claims constructed women as bearers of children, and as patients, rather than as active agents in their own right.⁷

It could be argued that a significant part of the HIV and AIDS response in South Africa has been crafted within a maternal health framework. Although the department of health partnered with a technical team in 2010 to develop a sexual and reproductive health rights policy, this was never launched. A maternal, child and women's health policy was implemented instead.⁸ This policy and programming essentially addresses women



as mothers only. Similarly, a number of programmes and partnerships between NGOs and government have been informed by a maternal health framework, e.g. Mothers to Mothers, Mobile Alliance for Maternal Action and Mom Connect.⁹

The Intersection of HIV and Fertility Intentions

PMTCT became a large programme and rallying point. Its indicator of success is revealing: the decrease in the transmission of HIV to babies born. Little attention is paid to the health of the women who are now mothers. As the implementation of programmes progressed, addressing the health needs of pregnant and HIV-positive women was limited to ensuring the continuation of her pregnancy and delivery of an HIV-negative baby.¹⁰ All other their other health and care needs, as well as the option to have an abortion, are certainly not prioritised by healthcare workers. As most women attend antenatal clinics late in their pregnancy, access to early abortion services is not always given, which could force women to look elsewhere for an abortion.

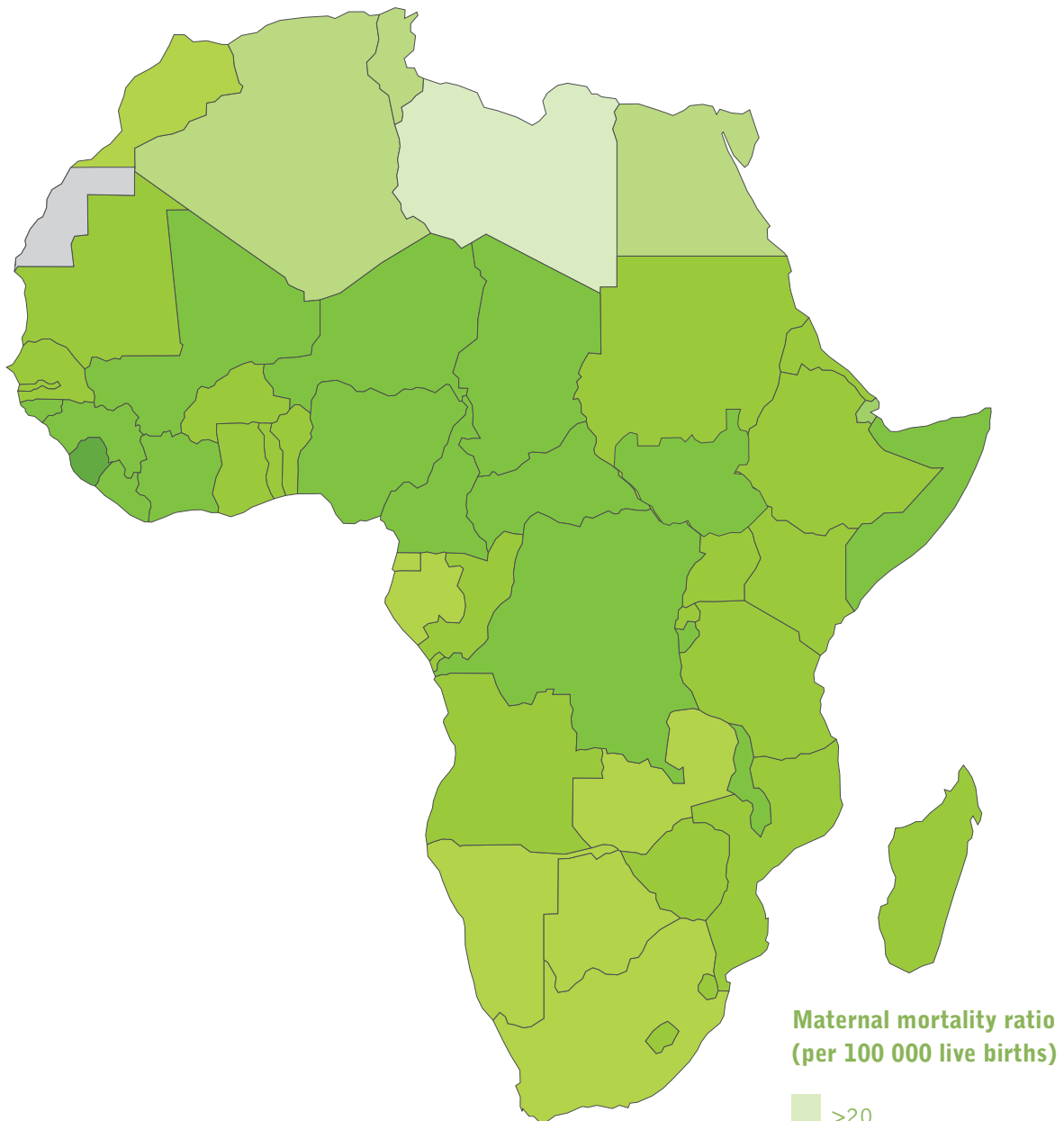
Since 2012, researchers have been debating a possible link between the hormonal contraceptive Depo-Provera

(DMPA)¹¹ and increased risk of acquiring HIV. More than 20 years of research has produced inconclusive results. Within South Africa, the national department of health has noted this debate with concern, given the high use of DMPA and a feminised HIV epidemic. An HSRC survey expressed concern

about the HIV incidence rate among females aged 15 to 24 being more than four times higher than the incidence rate found in males in this group. Among the teenage population, the difference between the HIV prevalence [in] girls and boys is even higher: girls have eight times the infection rate of their male counterparts.¹²

In response to these concerns, the national department of health launched a new contraception and fertility guidelines policy in 2014 that moves away from DMPA as one of the contraception options offered to women.¹³ In the same year, the World Health Organisation published recommendations on the use of hormonal contraceptives by women living with HIV, restating that women at high risk should be warned of the potential association between DMPA and HIV, and urged to use male and female condoms.¹⁴

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The new department of health guidelines are based on principles that include “strong and visible stewardship of sexual and reproductive health and rights”.¹⁵ They explicitly recommend a mixed-methods approach to facilitate contraception within a human rights framework, providing information about the different methods that can be used to prevent pregnancy, HIV and sexually transmitted infections. This includes an expanded range of methods (such as intrauterine contraceptive devices and implants; integration into other health services; trained healthcare providers; an appropriate, regulated institutional framework for service delivery; communications strategies that highlight at least three methods; and effective monitoring and evaluation). This all augurs well for recovering from a context of population control and

a feminised HIV epidemic informed by a maternal health framework.

And yet, change is slow. Despite South Africa’s shift away from DMPA, the mid-term review of the Strategic Plan for Maternal, Newborn, Child and Women’s Health and Nutrition in South Africa reports that injectable contraceptives continued to dominate the contraceptive method mix

in 2013, despite steps to expand method options and provide increased access to other long-acting reversible contraceptives. This is due to challenges in the health-care system, including poor quality of care, lack of informed consent and inadequate health-worker training. It is apparent that the legacy of population control is difficult to shake off. The government seems to be shifting from DMPA provision to the hormonal contraceptive implant Implanon¹⁶. The matchstick-size plastic rod that releases contraceptive hormones is injected underneath the skin and lasts for three years. It is contraindicated for those who are diabetic, epileptic or taking particular anti-retrovirals.

With both high HIV-infection rates for young girls and concern for adolescent pregnancy, the approach of replacing a long-term contraceptive with another longer-term contraceptive is puzzling, given the critique of population-control policy. Indeed, when launching these policies and in the health department's budget vote in 2014, the minister of health emphasised only the long-lasting implant method.¹⁷ In so doing, he left out the fundamental concept that women have the right to freely choose from a range of contraceptive options. This conservatism, combined with a prioritisation of maternal health implementation and the lack of policy specification for a wide range of sexual and reproductive health rights, suggests that contentious aspects – such as abortion, sexual rights and adolescent sexuality – have been, to date, included in policy and sidelined in implementation.

In addition, large numbers of HIV-positive women are being forcibly sterilised, and a national survey revealed that 37 percent of women reported that access to anti-retrovirals was conditional to being on contraception.¹⁸ While some anti-retrovirals are contra-indicated in pregnancy and there may be a biomedical rationale, women's fertility intentions are not being addressed squarely.¹⁹

Much has changed, but so much has stayed the same and needs to transition. Despite our progressive abortion law²⁰, black women still die from unsafe abortions. Pregnancy-related sepsis still accounts for 9.5 percent of maternal deaths.²¹ Only around 50 percent of designated surgi-

cal abortion facilities are operational. The department does little to provide national guidelines on medical abortion, ensure the systematic support and training of providers, and roll out abortion services. Doing so would make a dent in the demand for illegally provided abortion services.

Concluding Thoughts

Of note, however, the department of social development released a national Adolescent Sexual and Reproductive Health and Rights Framework in February 2015, in an attempt to get the human development cluster (health, education and social development) to be clearer on rights and the concept of reproductive justice. The framework includes lesbian, gay, bisexual, transgender and intersex persons, noting the need to address those marginalised groups.²² Also of note, the African National Congress Women's League (ANCWL) announced at their 2015 conference that transgender women would be welcome as members.²³ This is an important political shift as the league's members have often been referred to as "mothers".

South African health policy, led by the department of health, remains "fearful" of women's sexual and reproductive health and rights, leans towards population control and focuses on women as mothers. Politically, the department of social development and the ANCWL are broadening the landscape but it remains an arena of contestation. Women face multi-layered challenges and most do not live in nuclear families. Most families are single-headed households, and the current policy focus on maternal health limits embracing women as more than mothers and caregivers living in dependent and poor contexts. Some women with agency who chose to be sex workers or are lesbian/queer also need the choice to be mothers or to have abortions, even if their complex lives challenge traditional cultural constructs of mother- or parenthood. South Africa is not a barren landscape. Whether biological mothers or not, women are making choices and making sense of their lives. Thus health services ought to meet the needs of all women and provide accessible services. ■■■

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Stagnating Progress: Fragmented Bodies

The Politics of Sexual and Reproductive Health and Rights in Africa

Nebila Abdulmelik

I pray that you will not know of days when
Our bodies
Were fragmented
Compartmentalised along with our identities
When the dignity, integrity and autonomy
Of our bodies which house us
Was up for negotiation

I pray that you will not know of
Violence, abuse and discrimination
At the hands of
Those meant to protect you
Your parents/teachers/partner/police or employers
And perhaps worst of all, by the society at large
Condemning your very birth and gender

I pray that
FGM
Child and forced marriages
Rape, widow inheritance
Breast ironing
Honour killings,
Will be foreign words to you
A taboo to the entire community
That the only culture you know
Puts your safety and well-being
Above all else

– Excerpt from *Letter to my Unborn Child*

“The Declaration passed at this year’s Commission on the Status of Women did not, even once, mention the term sexual and reproductive health and rights as some delegations feel that this is too controversial. Is it really controversy to save the lives of women through providing them with needed services guaranteed by a human rights framework? What is controversial is when we let the lives of women perish from preventable diseases.” – Bathabile Dlamini, Minister of Social Development, South Africa

Perhaps the extent of its contentiousness lies in the fact that, at the heart of it, the movement for the realisation of sexual and reproductive health and rights (SRHR) is an unapologetic political reclaiming of women and girl’s bodies, which for far too long have been viewed as the property of the state, the community or family. Advocacy for the full realisation of SRHR seeks to assert the bodily integrity, dignity and autonomy of all people. What this means, in essence, is that every human being is entitled to personal control over his or her body: when and how



Nebila Abdulmelik is a pan-Africanist and a feminist passionate about social justice. Before moving back to her birth city of Addis, she was based in Nairobi and served as the head of communications for FEMNET, a pan-African organisation working to advance the rights of women and girls since its inception in 1988. Nebila uses the creative arts, including photography and poetry, to speak her peace.

many children to have (if any), the right not to be violated, and the right to make choices over one's body without fear, violence, discrimination or coercion. Furthermore, the movement asserts the right to one's body and choices irrespective of whether or not this will contribute to economic growth and/or improve the political and social standing of the political actors of the day.

Advancing SRHR is both a personal and political process. It begins to dismantle the patriarchal nature and system of the world in which we live: a system that relies on a gendered division of labour and roles, with girls and women seen, for example, as a critical mass of labourers who also reproduce future labourers. The patriarchal world in which we live ensures that the ownership, power and control of and over women's and girl's bodies is kept away from its rightful owners, as evidenced by the discomfort and aggressive pushback and antagonism of those who usurp control when women and girls attempt to reclaim their bodies.

African feminists have long recognised that the struggle for gender justice and women's and girls' rights is not only about access, control and ownership of external resources like land or property. More important perhaps, or at least very critical to their realisation, is access, control and ownership of one's own body. This recognition has made women's bodies a dominant site of struggle.

Advancing SRHR is both a personal and political process. It begins to dismantle the patriarchal nature and system of the world in which we live.

The Politics of Negotiating

A key strategy by African feminists and their allies towards ensuring SRHR has been advocacy for the adoption of national, regional and international law and policy instruments. These aim to bind state parties to reform their legislation, institutions and interventions to protect women's fundamental rights, including their right to personal dignity, and sexual and reproductive autonomy. Unfortunately, it seems that such regional and global negotiations are an affair of "taking one step forward and two steps back".

The issues covered under SRHR vary widely. Key rights (that often elicit contestation) include contraceptive choices, abortion choices, child spacing, comprehensive sexuality education, and inalienable protection from harmful practices such as FGM, child betrothal or marriage. SRHR also includes the quest for justice in instances of denial or contravention of SRHR, including prosecution for marital rape, women's equal claim to matrimonial properties, reforms in evidential procedure in sexual crimes committed in private, and victim protection and reparation.

SRHR, in its totality, presents an uncomfortable position for many African political actors operating in a patriarchal environment who prefer a status quo that subordinates women and girls and guarantees their relegation to reproductive and care roles for the posterity of the nation.

In order to ease this discomfort, policymakers prefer to use the dated concept of "sexual and reproductive health and reproductive rights", as per the International Conference on Population and Development which took place over 20 years ago in 1994. Activists and political actors must not shy away from asserting the necessity for sexual rights, because the future that is envisioned for Africa is not possible when girls are subjected to violence and forced sex or when girls are pulled out of school and into marriage. However, the idea of SRHR is unpalatable and uncomfortable to those who shun the notion of "feminist" political agency – particularly when it goes beyond arguments of "development" to assert the rights of women to make personal choices about their sexuality and reproductive functions.

This is particularly disappointing considering that the African Union's Maputo Plan of Action, adopted by heads of state and governments in 2006, explicitly states that "African leaders have a civic obligation to respond to the Sexual and Reproductive Health needs and Rights of their people. This Action Plan is a clear demonstration of their commitment to advance Sexual and Reproductive Health and Rights in Africa".

Those who contest SRHR at the international level, and in particular at the United Nations, include right-wing conservative lobby groups that push counterfactual and highly emotive arguments with policymakers, contending, for example, that comprehensive sexuality education – a component of SRHR – entails teaching five-year-olds to masturbate. The lobby has been so effec-



tive that we often hear the same arguments espoused by a small but influential group of New York-based African policymakers and lead negotiators themselves in processes such as the annual sessions of the United Nations Commission on the Status of Women, the Commission on Population and Development, and the recent negotiations for the articulation of the Sustainable Development Goals.

Furthermore, these right-wing groups often use “African” culture and tradition to justify resistance to SRHR. They frame it, and women’s human rights in general, as “un-African”, and the civil society organisations advocating for sexual and reproductive justice as pushing a “Western” agenda. These arguments appeal to many African policymakers, as they resonate with their “anti-imperialist” and “anti-neocolonial” agenda. The irony is that these (Western) proponents of preserving “African” culture are essentialising and instrumentalising what they deem as “African culture” to further their own agendas.

Despite national positions and regional

frameworks and declarations meant to guide global negotiations and allow Africa to speak with “one voice”, many factors come into play during negotiations. The disjunction between national and regional positions and the positions advanced at the United Nations is often exacerbated by the personal politics and values of individual policymakers, who act as gatekeepers as they manage the negotiations on behalf of the Africa Group. Their discomfort with addressing women’s liberation and the clear pushback is evidenced in the personal positions that play out in global negotiations.

Additionally, geopolitics often plays a determining role in the outcome of negotiations. This is the case where particularly powerful states and/or coalitions based on political, social or religious affinity dominate the discourse and drive their own agendas, irrespective of the topic of the day. This is also the case when member states align themselves strategically on certain issues to further their own interests in future – or to garner votes on a topic that appears more important to their interests – such as a place

Protestors marching on the eve of 32nd summit of the Southern African Development Community (SADC) in 2012.

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on the Security Council. SRHR, and consequently the bodies and lives of women and girls, is often used as a bargaining chip for enhanced geo-political leverage.

The concept of Africa negotiating as a bloc and “speaking with one voice” seems like a good strategy, and appears to further notions of “pan-Africanism” and “African renaissance”. But with a contentious issue such as SRHR, the position adopted by the majority – or at least by the most influential members – is often a regressive one, based on the lowest common denominator. Critical questions must therefore be asked. In the process of consolidating voices into “one”, whose voices are silenced or sidelined? Often, it is those who are advancing progressive agendas, while only those with the loudest voices or the microphones are heard.

A Collective Responsibility

Commitment coupled with action at all levels is critical to realise sexual and reproductive health and rights for all. We all have a collective responsibility to transform the norms, policies and practices that deny women and girls their rights and that subsequently perpetuate inequalities and curtail development. African leaders and global policy negotiators need to recognise that they cannot play politics with the bodies of women and girls. They must understand that the decisions and bargains they make have profound negative consequences on the lives and future of the majority of their citizens, and women in particular.

At the same time, civil society actors and activists need to recognise that global and regional frameworks are only effective to the extent to which they are implemented at the local and national level. There is a need to refocus priorities and attention. As Amina Mohammed, special advisor to UN Secretary-General Ban Ki-moon on the Post-2015 Development Planning, reminds us, “In the end it will not be about prescriptions from the global level, however well informed they are, but what real activism, leadership and actions can be taken in our countries”. This speaks to the need for concerted and sustained efforts to continuously build strong constituencies around these issues at local and national levels, which can in turn sustain the pressure on government authorities to own and live up to their responsibilities and commitments. Norms emerging from policies and their resulting practices must be institutionalised in order to live beyond political transitions. Strong accountability mechanisms at local and national levels should ideally trickle up to regional and global levels and prevent the apparent disconnection that is currently experienced between these various levels.

As many African countries celebrate 50-plus years of independence and chart their course into the future with the UN’s Post-2015 Development Agenda and the African Union’s Agenda 2063, it is important to recognise that the transformation and sustainable development that Africa has envisioned for itself will not be possible as long as women and girls don’t have full control over their bodies. ■■■

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Wangechi Mutu

Wangechi was born and raised in Kenya and has made art in New York for almost twenty years. Her work has dug deep into investigating gender and racial identity. At the centre of her work, she often places a performing or posed figure and uses this as a means to focus the eye and to unlock the dialogue about perception in both personal and political realms. She's primarily interested in how identity pivots around a kind of social contract that can only be broken through personal and political re-invention and a re-writing of the codes that have been used to represent us.

Wangechi is the recipient of the United States Artist Grant (2014), the Brooklyn Museum's Asher B. Durand Artist of the Year Award (2013), and was honoured as Deutsche Bank's first Artist of the Year (2010). She has exhibited at major institutions including at the Museum of Contemporary Art Australia, Deutsche Guggenheim, Berlin and the Brooklyn Museum of Art.

For more information visit www.wangechimutu.com.



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About the artwork

Title: "Oh, Madonna!"
(detail), 2010

Material: Mixed media ink,
paint, collage on Mylar
Size: 232.4 x 137.2 cm
Courtesy of the artist and
Victoria Miro, London.