Regaining Control:
Realising women's rights to control their own Sexuality, Well-being and Reproductive Health in Africa

Oxfam GB background policy briefing for the Special Session of the conference of African Ministers of Health, 18-22 September 2006, Maputo, Mozambique

Summary

Since 2001, Africa's leaders have committed the African Union and their Governments to promote and protect the right to health in a series of international and continental legal protocols and declarations. These commitments provide a comprehensive package for addressing the challenges of maternal mortality, HIV/AIDS, violence and disease.

However, the urgent action needed to address what African Governments have described as a "continental state of emergency" can only be achieved by ensuring firm policy and programme linkages between Sexual and Reproductive Health, HIV/AIDS and Gender Based Violence.

Specifically, we call on African Health Experts and Ministers of Health meeting in Maputo to ensure that the draft Action Plan contains targets and indicators that enshrine the following;

- Delivery on the Abuja Commitment to allocate 15% of the national budget to health services by setting annual funding targets that will finance comprehensive national public health plans that particularly target men and women living and working in poverty.
- Targeted provision of quality reproductive and health services to women by establishing and strengthen existing antenatal, delivery, post-natal and family planning services for all African women.
- Commitment to remove user fees for primary health care and sexual and reproductive health services.
- A clear commitment to end female genital mutilation in Africa and violence against women by enacting and implementing national laws that enshrine the AU Protocol on the Rights of Women in Africa especially Articles 5 and 14.
- Recruitment, training, and retention of an adequate healthcare workforce that is in line with international standards with special attention to remuneration of female health workers in rural areas.
- The provision of anti-retroviral treatment at no cost.
- Commitment to respond positively to civil society monitoring organisations and to strengthen citizen representation and state oversight mechanisms in monitoring public services.

The Promise of the Continental Policy Triangle: The Abuja Declaration, the Continental Policy Framework on Sexual and Reproductive health and the Protocol on the Rights of Women in Africa.

On 26 and 27 April 2001, African Heads of States and Governments of the Organisation of African Unity declared that they would allocate 15% of their annual national budgets to health services in order to meet "the exceptional challenge of HIV/AIDS, Tuberculosis and Other Related Infectious Diseases". [1] Over the last five years, this commitment was deepened at a series of Presidential Summits (Sirte, July 2005[2], Khartoum, January 2006, Banjul, July 2006) and Health Ministerials (Maputo, July 2003, Gaboronne, October 2004 and Abuja, April 2006). Health issues have been a consistent agenda item on the meetings of African leaders for the last five years.

The adoption of the Continental Sexual and Reproductive Health Policy Framework by 53 African Health Ministers in October 2005 was a landmark moment in the struggle to improve the lives and health of women and girls in Africa.[3] The framework found greater momentum in the adoption of the Call for Accelerated Action on the Implementation of the Abuja Declarations, and the Africa Common Position on Universal Access for the UN General Assembly Special Session (UNGASS) in Abuja and New York in April and June 2006 respectively. These Summits saw African Governments deciding to ensure among other things; "100% access to sexual and reproductive health services including antenatal care".

One month after the Continental Sexual and Reproductive Health Policy framework was adopted, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa came into force on 25th November 2005. [4] The Protocol provides a critical framework to access sexual and reproductive health services such as safe abortion, pregnancy, childbirth and HIV among other issues. Its provisions state that women's sexual and reproductive health is to be both respected and promoted. Women have the right to control their fertility. It places obligations on states to provide adequate, affordable and accessible health services. It demands that governments establish and strengthen existing antenatal delivery, post-natal, and family planning services for all African women. The Protocol also calls for the authorisation of medical abortions in cases of sexual assault/rape, incest or unsafe pregnancies. On HIV and AIDS, the Protocol enforces the right to self-protection and to be informed of one's health status and that of one's partner. It also provides for health services to cope with the effects of HIV and AIDS.[5]

This policy triangle of the Abuja Declaration, Continental Sexual and Reproductive Health Policy framework and the Protocol clearly establishes the obligation on African states to address the healthcare needs of all citizens, but in particular the rights of women and girls.

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[1] The OAU officially became the African Union on 9 July 2002 at the Durban Summit.

[2] The debate on Accelerated Action for Child Survival took place during the 5th Ordinary session of the Assembly of Heads of State and Government in April 2001

[3] The AU Special Summit in Abuja reviewed progress since the 2001 Abuja Declarations on HIV/AIDS, Malaria and Tuberculosis.

[4] See appendix for an extract of the Protocol on the Rights of Women in Africa. Also www.african-union.org

[5] In a few countries like South Africa, the Constitution provides women with more rights than the African Women's Protocol. However, for others like Zamibia, it is an advance on national legislation. Under Zambian law, a panel of 3 doctors have to agree that the mother's health is threatened. The law does not provide for termination even in cases of rape, sexual assault or incest. See Mukasa R. Protocol on the Rights of Women in Africa: Harnessing a Potential Force for Change, Oxfam GB Southern Africa Office, 2005.

The sad reality of sexual and reproductive health rights in Africa

"The reality of sexual abuse and HIV/AIDS must make us rage against women's oppression. I call on African leaders sitting here to protect and promote the human rights of all people and vulnerable groups, particularly women and girls. We ask you not to fail us again."

Ms. Nkhensani Mavasa, Deputy Chairperson, Treatment Action Campaign, UN General Assembly, May 2006

There has been significant improvement in women's health globally. For example, in developing countries, the percentage of women giving birth attended by a trained health workers increased from 41% in 1999 to 57% by 2003. However none of this progress has benefited mothers in sub-Saharan Africa.

Notwithstanding the international and African commitments, inadequate access to quality health services, unsafe abortion and lack of health care for reproductive health care cause the deaths of at least 250,000 women each year in Africa, one of the highest rates in the world. While women in the United Kingdom have a 1 in 5,800 lifetime risk of maternal death, in Ethiopia the equivalent risk is 1:14.

The Cost of Birth in Ethiopia

In rural areas of Ethiopia, just 2 per cent of all deliveries are conducted by a health professional, while more than 60 per cent are attended only by relatives or members of the community. Even if a midwife is available, the costs of consulting her are prohibitive. Families simply don't have the income to send their female relatives to hospital when they go into labour, which would cost 15 birr or just over a US$1.60 Instead they hire a traditional birth attendant, who rubs the woman's abdomen and helps her through the birth. They cost 2 birr –(US 30 cents) but have no formal qualifications. Compared with this, the cost of private care is astronomical: 2,000 birr (US$ 222) for a midwife at a private clinic, but as much as 4,000 (US$444) if a caesarian section operation is needed.

Tadelech Kesale, aged 32, earns around 2-3 birr a week if she is lucky, making and selling *araki,* the local home brew, and *injera,* a type of pancake. She has had six children, but only three are still alive. Although she gave birth to her first child at 18, it is not unusual for girls from poor rural families to marry at the age of 10 and conceive their first child at 12.

When interviewed by Oxfam, she said: *"I don't want to have any more children. It is hard enough with the three I have now. One of* my *children was still-born. I gave birth at home with* a *traditional birth attendant. If I could afford it, I would go into* a *clinic. One of* my *friends, Zenebexh, died in labour - she just started bleeding after breakfast and fell down dead.* A *healer came but couldn't do anything".*

Source: Oxfam GB (Interviews carried out by programme staff)

High maternal death rates have multiple causes, but one major underlying problem is the deep-rooted inequalities between men and women. Women have fewer opportunities for education, they do a disproportionate high share of manual work, have less influence on policy making and are disadvantaged in terms of nutrition and access to health care. Lack of access to health care is a major cause of maternal mortality.

Even where there are positive legislative and policy frameworks, women often battle to exercise these rights within the family and the community. Traditional gender norms and practices, along with the unequal status of women, relegate women to being regarded as primarily responsible for contraception and childcare, with little power to negotiate when, with whom and why to have sex.

Inequalities in health are exacerbated by inequalities in access to other public services. For example, the number of years that a girl spends in primary education on the one hand, has a direct and positive correlation with her chances of avoiding HIV, her

children surviving, and her subsequent income thereafter. Yet on average girls in Africa spend only three years in school.[6]

It is within this broader context that women and girls are more vulnerable to HIV. Women comprise of 57% of all adults infected with the virus in sub Saharan Africa. Of these, younger women account for a disproportionately large number of new infections. According to the African Union, AIDS, malaria and tuberculosis threaten life on a scale unparalleled, erases between 1-2% of Africa's growth rate and reduces life expectancy by 25% for some countries.[7]

Key to the loss of women's control over their own sexuality is the prevalence of female genital mutilation, domestic violence, and rape. More than 90 million women and girls are survivors of female genital mutilation, a practise outlawed in many national laws across Africa and under the Protocol. [8] Violence against women is a recurrent problem in many countries. In Kenya for instance, despite a relatively peaceful history, 49% of women have experienced violence, with one in four having experienced violence in the previous 12 months.[9]

Putting the money where it is needed

A key precondition for accelerating the provision of universal access to sexual and reproductive health services in Africa is adequate funding for an effective healthcare system. However, there is a sharp disparity between the stated intention to act and the resource commitment to enable these laudable commitments to be implemented.

Five years on from the Abuja Summit only Botswana and The Gambia have met the 15% target for national expenditure. 15 countries mostly from West and Central Africa spent less than 5% with only 18 Africa states spending more than 10%. Yet, since 2000, 85% and 77% of African countries have formed national AIDS machineries and approved relevant health policies. [10]

According the World Health Organisation, the minimum expenditure on healthcare per person per year, necessary to provide an essential package of health services is US$ 34. In 29 countries, government expenditure per person per year was less than US$ 10. This includes Angola that has one of the fastest growing economies on the continent.

The burden of this funding gap invariably falls on the poorest and most vulnerable sections of the population. Inadequate investment in primary healthcare infrastructure, acute shortage of human resources, ineffective or non-existent data collection and information management systems and the lack of inexpensive medicines and basic equipment all combine to disproportionately affect the poorest and most vulnerable. In order to close the financing gap many countries have been encouraged to impose user fees on healthcare services.

[6] Oxfam In the Public Interest: Health, Education, and Water and Sanitation for All, 2006.
[7] African Union, Progress Report on the Implementation of the Plans of Action of the Abuja Declaration for Malaria, HIV/AIDS and Tuberculosis, 20th September 2005
[8] Solidarity for African Women's Rights Coalition and the African Union Commission Breathing Life into the African Women's Protocol on Women's Rights in Africa, 2006
[9] UNICEF Violence against Women and Girls in the era of HIV and AIDS in Kenya, 2006
[10] African Union, Progress Report on the Implementation of the Plans of Action of the Abuja Declaration for Malaria, HIV/AIDS and Tuberculosis, 20th September 2005

User fees have proved to be a barrier to many poor men and women who simply cannot afford to access healthcare even with minimum fees. Through the 1990s, Ugandans faced high costs for fragmented health services. When in the run up to the 2001 presidential election, President Museveni ended user fees for all government health clinics, the public response was phenomenal. Most health facilities saw 50 to 100 per cent increases in patients. This access was particularly significant for poor women in rural areas who could not afford to pay for care.

Oxfam research shows that relatively small investments can yield high returns in terms of saving lives. The cost of providing basic services for mothers and infants averages US$3 per capita in Africa. This year, approximately 63,000 women will die from obstetric problems in Ethiopia, Mozambique, Tanzania and Uganda. An investment of US$411 million would prevent 80 percent of these deaths:– roughly US$700 for every maternal and child life saved.

African governments could reverse the situation by dropping user fees, improving the effectiveness of the health care system and raising their health expenditure to 15%. External development assistance is necessary to expand the financing available preferably within a predictable and long-term cycle that targets front line services, in particular primary and reproductive health care. It is estimated that an initial immediate investment of $90 billion per annum is required for healthcare personnel, hospitals and other infrastructure, medicines and so forth in Africa, as against the $25 billion promised for Africa by 2010.[11]

Back to the Basics: Engendered Health Services and access to Essential Medicines

"Respect for the rights of women and the girl child is also critical in the struggle against HIV/AIDS. An educated woman or girl child would be empowered to negotiate her way around social and cultural practices that might threaten her health. . . . Any comprehensive strategy [to prevent HIV/AIDS] should include respect for reproductive health rights and provision of sexual and reproductive health services"

H.E. Ambassador Crispin Grey-Johnson, Permanent Representative of the Gambia, June, 2005

2005 saw an important return to the concept of a development state in Africa. This state would enshrine the right to essential services, the fight against poverty and economic growth as core obligations.[12] Recent Oxfam research into Essential Services re-affirm the primary of Governments in the provision of effective, universally accessible and regulated health and services.

There is a crisis of health workers in Africa. At least 10 countries (Liberia, Uganda, the Central African Republic, Mali, Chad, Eritrea, Ethiopia, Rwanda, Somalia and The Gambia) have only enough trained health workers to cover 10% of the population. The African Union must maintain its position that additional financing must be found not only for medical facilities and medicines, but also for the recruitment and remuneration of doctors, nurses and other health cadres.

[11] Oxfam The Cost of Childbirth: How women are paying for broken promises on aid, 2004

[12] Apart from African Union positions and declarations, other influential development literature such as the Commission for Africa report, 2005, the UN Human Development Report took up this theme squarely in 2005.

African Governments, Parliaments and civil society organisations must guard against public resource diversion away from social services through lack of prioritisation, corruption, misuse of national resources and military expenditure. A number of African countries including Sudan, Angola and Ethiopia are currently experiencing rapid economic growth, yet continue to spend a paltry 2-5% on health expenditure. They and other countries can follow the examples of Botswana, Uganda and Seychelles by providing free universal primary education and health services or attempting new models of service provision such as in Kenya (National Health Insurance Services) and Burkina Faso.

Several African organisations and parliamentarians have cited the IMF/World Bank Medium Term Expenditure Frameworks/Ceilings (3 year planning tools) as too restrictive on public expenditure on health and education. African Governments should consider carefully all policy advice that undermines their capacity to promote and realise the right to health.[13] The comments of Kenyan Assistant Minister Hon Enock Kibunguchy are relevant for many African countries.

Ignore the World Bank on health, says minister
By Elizabeth Mwai, The Standard, Tuesday March 7, 2006

Kenya should ignore donor restrictions and employ health workers needed urgently countrywide, an assistant minister has said. **The country needs 10,000 health workers to offer improved services, Health assistant minister Enock Kibunguchy said. "We have to put our foot down and employ. We can tell the International Monetary Fund and the World Bank to go to hell," Kibunguchy said.**

Speaking at an Aids workshop in Nairobi on Monday, Kibunguchy said the Government should ignore the freeze imposed by the World Bank and IMF. He said 7,000 nurses, 600 doctors and 2,000 clinicians and laboratory experts were urgently needed in various health centres. Kibunguchy said over 1,000 nurses leave the country every year yet the Government cannot hire more. He said about 130,000 infants born yearly to HIV-positive mothers were not being cared for effectively for lack of medical staff. He said the scaling up of the prevention of mother-to-child transmission of HIV could only be achieved if there was adequate personnel and infrastructure.

African governments must demand that IMF assistance be modelled on long-term growth rather than short-term sustainability, in order to fulfil internationally agreed commitments to achieve the Millennium Development Goals, rather than the narrow goal of sustaining debt repayments from low-income countries. The Global Call to Action Against Poverty as well as specialist African debt networks such as the Jubilee movement in Africa and AFRODAD have joined the African Union call in 2005 for full debt cancellation to be extended to many more countries. To do otherwise, would be to render sustainable financing for Universal Access in Africa unachievable.

[13] Statement from 75 representatives of Civil Society Groups and SADC Parliamentarians to African Heads of States, Health Ministers meeting at African Union/UN meeting on Universal Access to Act Immediately to save Africa from worsening HIV//AIDS Epidemic, Johannesburg, 3rd March 2006

Recommendations for the Draft Action Plan

The urgent action needed to address what African Governments have described as a "continental state of emergency" will only be achieved through firm policy commitments and programme linkages between Sexual and Reproductive Health, HIV/AIDS and Gender Based Violence.

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