

## Chapter 7

# Reproductive rights and sexual and reproductive health

### 7.1 ISSUE ANALYSIS

Art. 14 of the Maputo Protocol guarantees the respect and promotion of women's right to health, including **sexual and reproductive health** (SRH). Control over fertility, and over whether and when to have children, are central to women's health. This is in turn closely related to women and girls' right to choose any method of contraception and their right to family planning education (Arts 14(1)(a)(b)(c) and (f)). Art. 14 of the Maputo Protocol also addresses women's right to self-protection and to be protected from HIV, and to be informed of their health status and that of their partner. Chapter 7 focuses on these latter two rights, which are specifically related to HIV. The current chapter looks at reproductive health, family planning and safe abortion.

Control over fertility, and over decisions on whether and when to have children, is closely linked to access to contraceptive methods and comprehensive SRH education. Health services, in particular antenatal, delivery and postnatal services as well as safe abortion services, are critical to women and girls' SRH. The interrelationship between these rights and services means the violation of one of them will have a direct effect on the others. For example, if a girl does not have information or education regarding contraception or sexual protection, the chances of unwanted pregnancy, STI transmission and even abortions and maternal mortality are high.<sup>i</sup> Both women and men have sexual and reproductive rights but violations of these affect women disproportionately, such as through adolescent pregnancy, unsafe abortions, maternal mortality and morbidity, fistula and cervical cancer.

#### 7.1.1 Fertility and contraception

The total **fertility rate** for the African continent is the highest in the world, at an estimated 4.6 children per women.<sup>ii</sup> With a few exceptions, the total fertility rate is generally high for countries in Sub-Saharan Africa, with 32 countries at between 4 and 5.5 and 9 countries above 5.5. Niger (7.3) Somalia (6.4), Chad (6.4), Democratic Republic of Congo (DRC) (6.3) and Angola (6.2) are examples of African countries with a high fertility rate.

The proportion of women using a method of **contraception** is much lower for Africa than for other parts of the world, at 33%.<sup>1</sup> Sub-Saharan Africa (28%), Middle Africa<sup>2</sup> (23%) and West Africa (17%) have the lowest proportions.<sup>iii</sup> These fairly low levels of contraceptive use are accompanied by an **unmet need**<sup>3</sup> for modern contraceptives (see Figure 7.1). Overall, Africa has the highest proportion of women without access to contraceptive methods (24%).<sup>iv</sup> Actual unmet need is likely to be higher, as these figures do not include unmarried women or sexual minorities.

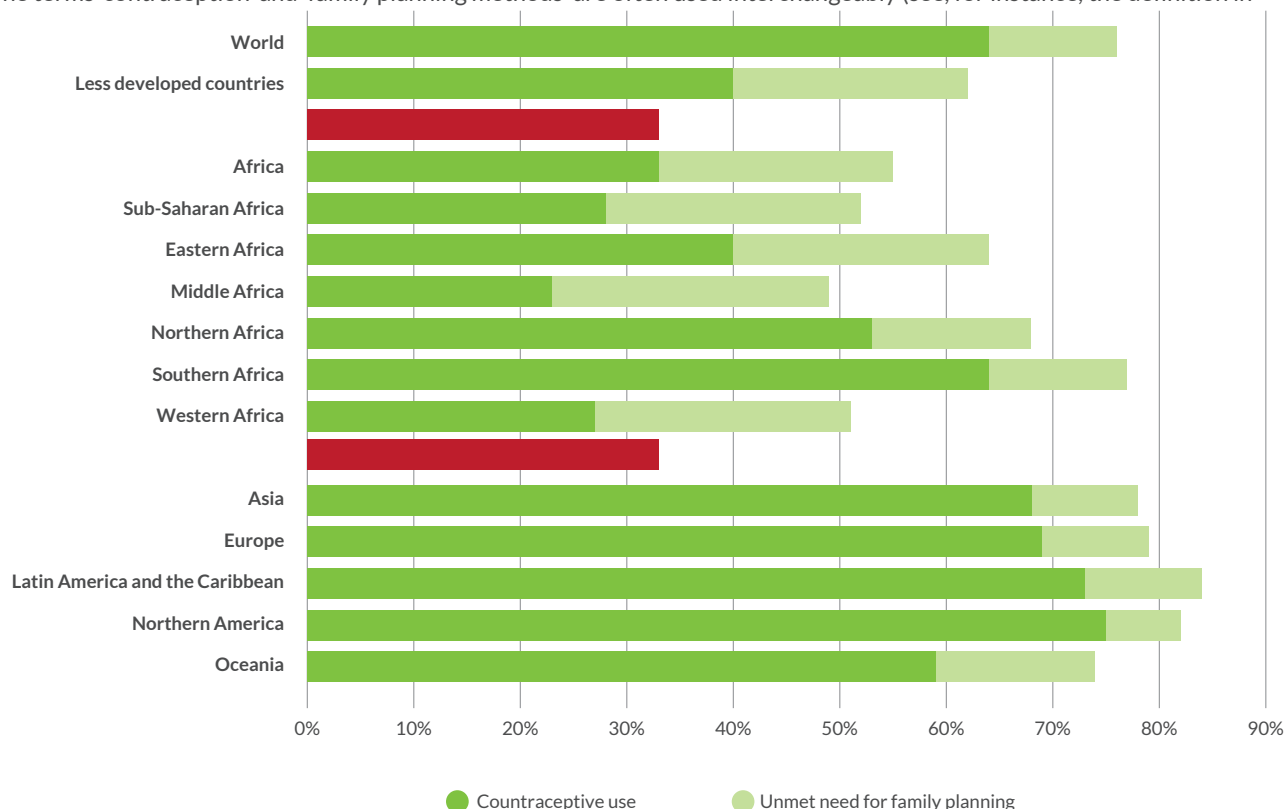
<sup>1</sup> This refers to women using any method of contraception, so includes both modern and traditional or natural methods.

<sup>2</sup> The Middle Africa region defined by the United Nations Department for Economic and Social Affairs Population Division comprises Angola, Cameroon, CAR, Chad, Congo Republic, DRC, Equatorial Guinea, Gabon and São Tomé and Príncipe.

<sup>3</sup> Unmet need for family planning can be defined as the proportion of women who do not want to become pregnant but are not using contraception.

**Figure 7.1. Contraceptive prevalence and unmet need for family planning among married or in-union women aged 15–49 years, 2015<sup>v</sup>**

The terms ‘contraception’ and ‘family planning methods’ are often used interchangeably (see, for instance, the definition in



General Comment No. 2 below). In this report, we prefer the use of **contraception**, rather than family planning. The latter is problematic for its implicit assumption that birth control methods are to be made available to only women in ‘family’ settings, that is married women. This excludes use of contraceptive methods by non-married women.

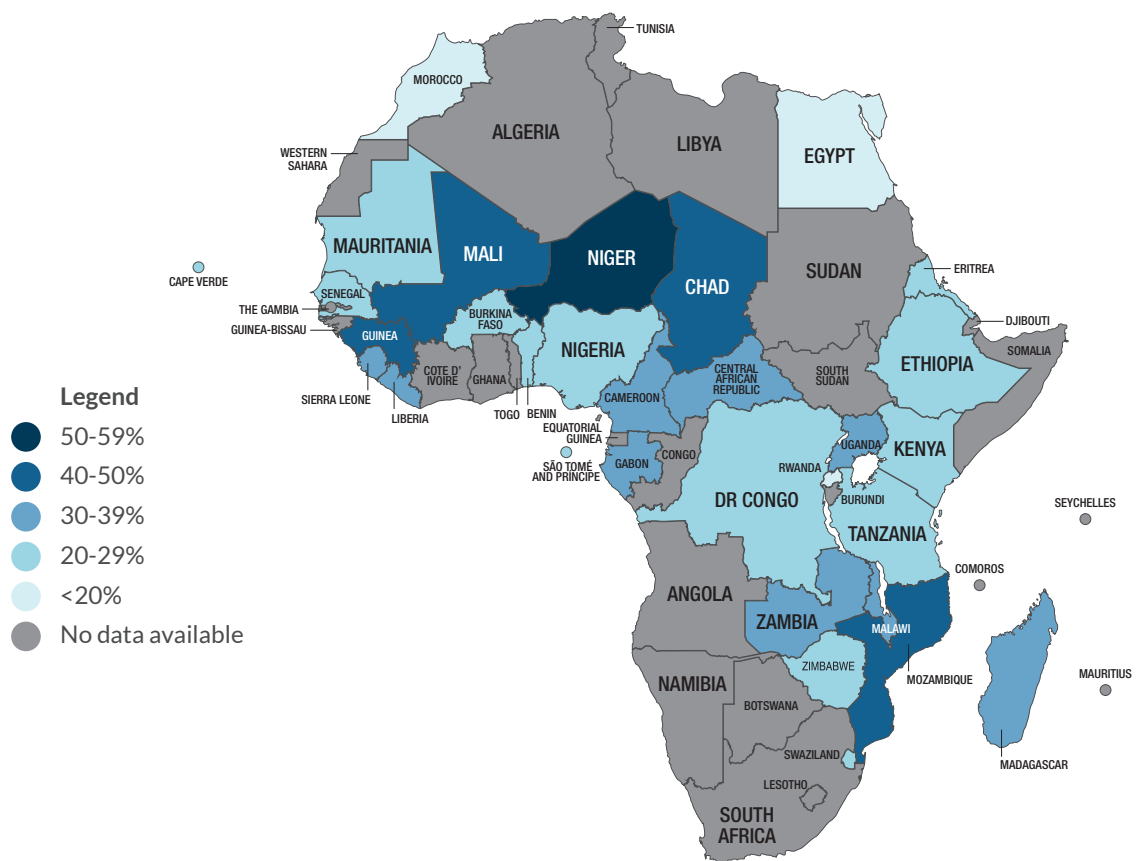
This clarification on terminology proves relevant when considering fertility, contraception and unmet need among adolescents.

**Adolescent pregnancy** rates are highest in Sub-Saharan Africa.<sup>vi</sup>

In West and Central Africa, more than one in four girls become pregnant before age eighteen and about one in twenty before the age fifteen.<sup>vii</sup> Incidence of adolescent pregnancy is strongly related to child marriages. Countries such as Niger (51%), Chad (48%), Mali (46%), Guinea (44%) and Mozambique (42%) report the highest numbers of pregnancies before the age of 18 in the region in 2013 (see Figure 7.2).

#### Contraception (General Comment No. 2)

**Contraception/family planning** comprises ‘the measures taken for an individual to control their fertility, including the use of contraception, if they choose not to have children neither immediately nor in the future’. General Comment No. 2 refers to ‘family planning/contraception’. This report uses the term ‘contraception’.

Figure 7.2. Proportion of women aged 20–24 reporting birth before age 18<sup>viii</sup>

The unmet need for contraception is higher among adolescent girls than among older women in Sub-Saharan Africa.<sup>ix</sup> Among married women aged 15–19 contraceptive use is generally lower than among the total sample of married women (aged 15–49).<sup>x</sup> Country-level data can be found in Table 7.1. Levels of contraceptive use among women aged 15–19 can vary considerably by country, as well as by marital status. The lowest rates of contraceptive use (less than 4%) among *married* women aged 15–19 are reported in Chad, Eritrea, The Gambia, Guinea, Nigeria and Sudan. In Gabon, Kenya, South Africa, Swaziland and Zimbabwe, more than 40% of the women in this group use contraception. When looking at all women aged 15–19 years, about half of women in Comoros, Ghana, Liberia and São Tomé and Príncipe have an unmet need for contraception. In a total of 14 countries, more than 30% of the women aged 15–19 have an unmet need for contraception.<sup>xi</sup>

**Table 7.1. Current contraceptive use and unmet need for family planning across the total sample of women and girls aged 15–19**

	% of married women currently using any method of contraception	% of married women aged 15–19 currently using any method of contraception	% of total sample of women with unmet need for family planning	% of women aged 15–19 years with unmet need for family planning
Angola	13.7	8.0	38.0	43.0
Benin	16.9	8.2	27.3	34.6
Botswana	33.0	17.2	-	-
Burkina Faso	16.2	6.6	24.5	21.7
Burundi	11.9	10.1	32.4	18.8
Cameroon	23.4	16.1	23.5	25.7
CAR	14.8	12.5	19.1	18.4
Chad	5.7	2.9	22.9	22.5
Comoros	19.4	19.7	32.3	50.0
Congo	44.7	36.2	18.4	34.8
Côte d'Ivoire	18.2	11.0	27.1	26.5
DRC	20.4	12.5	27.7	30.8
Egypt	58.5	20.5	12.6	9.0
Eritrea	8.0	2.4	28.5	43.6
Ethiopia	35.9	31.9	22.3	20.5
Gabon	31.1	40.1	26.5	41.4
The Gambia	9.0	3.3	24.9	16.9
Ghana	26.7	18.6	29.9	50.7
Guinea	5.6	2.8	23.7	23.4
Kenya	58.0	40.2	17.5	23.0
Lesotho	60.2	35.3	18.4	28.9
Liberia	20.2	13.2	31.1	46.6
Madagascar	39.9	24.6	19.0	26.8
Malawi	52.9	38.1	18.7	22.2
Mali	10.3	6.7	26.0	23.3
Mauritania	8.0	5.3	32.1	35.5
Morocco	63.0	38.4	11.9	10.3
Mozambique	27.1	15.4	23.1	26.2
Namibia	56.1	37.2	17.5	31.7
Niger	13.9	7.0	16.0	13.1
Nigeria	15.1	2.1	16.1	13.1
Rwanda	53.2	35.3	18.9	3.6
São Tomé and Príncipe	38.4	22.2	37.6	48.3
Senegal	25.1	6.7	23.6	26.4
Sierra Leone	16.6	7.8	25.0	30.8
South Africa	56.3	49.4	16.5	26.8
Sudan	8.7	3.8	-	-
Swaziland	50.6	42.8	24.7	24.6
Tanzania	38.4	14.7	22.1	23.0
Togo	19.9	8.4	33.6	41.6
Tunisia	49.8	11.1	-	-
Uganda	39.0	21.9	28.4	30.4
Zambia	49.0	37.5	21.1	25.1
Zimbabwe	66.8	45.8	10.4	12.6

Based on data from most recent national DHS, ranging from 1990 to 2016. No data available for Algeria, Cape Verde, Guinea-Bissau, Sahrawi Democratic Republic, Seychelles and South Sudan.

## 7.1.2 Maternal mortality and morbidity

Neglect of women's SRHR undermines maternal health and contributes to high rates of maternal mortality, both in Africa and around the world. **Maternal mortality** refers to 'the death of a woman while pregnant or within 42 days of termination of pregnancy irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes'.<sup>xii</sup> Ironically, most maternal deaths are preventable: the major direct causes of 75% of all maternal deaths include severe bleeding, infections, high blood pressure, complications from delivery and unsafe abortion. Indirect causes such as HIV, STIs, cervical cancer and fistula also contribute.<sup>xiii</sup> The health care solutions to prevent and manage these complications are well known. Ante and postnatal care, as well as skilled birth attendance, is critical to women's maternal health and keeping mothers and babies alive.<sup>xiv</sup>

Measuring maternal mortality is not easy, as underreporting and misclassification may occur, especially in places where rates are high. It is estimated, however, that approximately 830 women die every day from preventable causes related to pregnancy and childbirth. Of these, 99% occur in developing countries, and more than half in Sub-Saharan Africa.<sup>xv</sup> Globally, the maternal mortality ratio (MMR), or maternal deaths per 100,000 live births, has fallen nearly 44% over the past 25 years, to an estimated 216 in 2015 from 385 in 1990. The annual number of maternal deaths fell to an estimated 303,000 in 2015—down 43% against approximately 532,000 in 1990. The approximate global lifetime risk of maternal death fell considerably, from 1 in 73 to 1 in 180, during this period.<sup>xvi</sup>

MMRs vary strongly across countries and regions, and some countries have seen strong progress over the past years. By 2015, the MMR in Northern Africa was estimated at 70 per 100,000 live births, against 546 in Sub-Saharan Africa. Numbers of maternal deaths were 3,100 and 201,000, respectively. Sierra Leone is the country with the highest MMR, at 1,360 deaths per 100,000 live births in 2015. Another 18 countries, all in Sub-Saharan Africa, are estimated to have a very high MMR in 2015, ranging from 999 down to 500 (see Table 7.2).<sup>xvii</sup> Maternal mortality is higher among women living in rural areas and in poorer communities.<sup>xviii</sup> An additional factor that affects maternal mortality in Sub-Saharan Africa is **conflict and insecurity**: the highest MMRs have been recorded in countries in conflict or with a large refugee population.<sup>xix</sup>

**Table 7.2. Maternal mortality ratio estimates of 2015<sup>xx</sup>**

Country	MMR
Sierra Leone	1,360
CAR	882
Chad	856
Nigeria	814
South Sudan	789
Somalia	732
Liberia	725
Burundi	712
The Gambia	706
DRC	693
Guinea	679
Côte d'Ivoire	645
Malawi	634
Mauritania	602
Cameroon	596
Mali	587
Niger	553
Guinea-Bissau	549
Kenya	510

According to WHO, 'the risk of maternal mortality is the highest for **adolescent girls** under 15 years old and complications in pregnancy and childbirth is a leading cause of death among adolescent girls in developing countries'.<sup>xxi</sup> Stillbirths and deaths are 50% higher in babies born to mothers younger than 20 years than among those born to mothers aged 20–29.<sup>xxii</sup> Adolescent girls in Africa, where the rate of harmful practices and particularly early marriages is the highest in the world,<sup>xxiii</sup> are exposed to multiple violations of their sexual and reproductive rights.<sup>xxiv</sup> They are also more vulnerable to complications and maternal death than other women. The immaturity of most adolescent girls' bodies means they are exposed to many risks during pregnancy, delivery and even post-partum, such as obstetric fistula, which is also a major source of morbidity in Africa.<sup>xxv</sup>

In addition to maternal mortality, a major concern is **obstetric fistula**—a serious childbirth injury caused by prolonged obstructed labour, without access to timely, high-quality medical treatment. This leads to an abnormal opening between a woman's genital tract and her urinary tract or rectum, and leaves women leaking urine, faeces or both. The urinary or faecal incontinence can also lead to damage to the vulva and thighs. Women with fistula are often socially isolated and ostracised, and are often abandoned by their husbands and families. They are likely to experience depression, and can experience loss of fertility and amenorrhea and have low levels of sexual intercourse.<sup>xxxvi</sup> Women living with fistula are also at higher risk of physical and sexual violence.<sup>xxxvii</sup> It is estimated that 2–3 million women live with and are affected by obstetric fistula, most of them in Sub-Saharan Africa and South Asia. Obstetric fistula is estimated to develop in between 50,000 and 100,000 women worldwide each year, mostly in geographically remote areas.<sup>4</sup> Obstetric fistula is a medical situation that can be completely prevented with access to adequate antenatal care and timely access to obstetric care, including caesarean sections. Delaying of the age of first pregnancy and ending of harmful practices, in particular FGM, is also key to preventing obstetric fistula.<sup>xxxviii</sup> Adverse obstetric outcomes are more likely with women who have undergone FGM, and the risks are greater with more extensive forms of FGM.<sup>xxix</sup> Post-partum complications can also be treated if access to post-natal services is received.<sup>xxx</sup>

### 7.1.3 Unsafe abortion

Abortion is the termination of pregnancy, which can be spontaneous, also known as miscarriage, or intentional (or induced).<sup>xxxi</sup> An **unsafe abortion** is 'a procedure for terminating unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking minimal medical standards or both'.<sup>xxxii</sup> Safe abortion includes both medical and surgical abortion (see definitions in Box 7.1). In countries where abortion is illegal or there is a lack of information or proper services, the chances of women undergoing unsafe induced abortion is higher.<sup>xxxiii</sup> This in turn increases the risks of delivery complications and death.<sup>xxxiv</sup> Complications from unsafe abortions include incomplete abortions, heavy bleeding, infection, uterine perforation and damage to the genital tract and internal organs. As with other key issues in this report, the reliability of data on (un)safe abortions is affected by the sensitivity of the issue and the criminalisation of abortion in many countries. Reliable data on induced abortion is not available for all countries, and is even harder to obtain in case of illegal or unsafe abortions.

#### Box 7.1. Defining safe and unsafe abortion

**Safe abortion** refers to 'services provided through specific medicines or methods, with all the necessary information and the informed consent of concerned individuals, by primary, secondary and tertiary level health professionals, trained in safe abortion, in line with the WHO standards. These services also include surgical techniques and treatments' (General Comment No. 2 on the Maputo Protocol, para. 10).

**Medical abortion** refers to 'medical methods of abortion'. These are defined as 'the use of pharmacological drugs to terminate pregnancy' and are sometimes also called 'non-surgical abortion' or 'medication abortion' (WHO. 2012. *Safe Abortion: Technical and Policy Guidance for Health Systems*. Geneva: WHO, p. iv).

**Surgical abortion** refers to 'surgical methods of abortion'. These are defined as 'the use of transcervical procedures for terminating pregnancy, including vacuum aspiration and dilatation and evacuation' (WHO. 2012. *Safe Abortion: Technical and Policy Guidance for Health Systems*. Geneva: WHO, p. iv).

An **unsafe abortion** is 'a procedure for terminating unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking minimal medical standards or both' (WHO. 2012. *Safe Abortion: Technical and Policy Guidance for Health Systems*. Geneva: WHO, p. 18).

During 2010–14, an estimated 8.2 million induced abortions occurred each year in Africa.<sup>xxxv</sup> In absolute terms, this is almost twice as high as the number of abortions 20 years earlier (see Table 7.3). The estimated abortion rate—that is, the number of abortions per 1,000 women aged 15–44—remained almost constant for Africa as a whole between 1990–94 and 2010–14.<sup>5</sup> It did show a rise in Middle, Western and Southern Africa and a decline in Northern Africa. The abortion rate varies only slightly between sub-regions, with Eastern, Middle and Southern Africa having an abortion rate of 34 or 35 per 1,000 women. The rate is slightly higher in Northern Africa, at 38, and slightly lower in Western Africa, at 31. Each sub-region (except for Southern African), however, has seen a significant increase in the number of induced abortions since 1990–94. There are also striking variations between the regions in terms of the percentage of pregnancies ending in abortion. For the African continent as a whole, the proportion is 15%, and Eastern, Middle and Western Africa are close to this, with 14%, 13% and 12%, respectively. One in four pregnancies ends in abortion in both Northern and Southern Africa.

<sup>4</sup> A coordinated response to obstetric fistula has been hampered by a lack of reliable data on prevalence and incidence.

<sup>5</sup> The estimated number of abortions and abortion rates in *The Lancet* article by Sedgh et al. (2016) ('Abortion Incidence between 1990 and 2014: Global, Regional, and Subregional Levels and Trends') refers to induced abortions. They are the sum of abortions in married and unmarried women with different levels of contraceptive use and unmet need for contraceptives. The estimates on induced abortion do not distinguish between safe and unsafe abortion.

Globally, and in most regions in the world, abortion rates for women aged 15–44 years are lower among unmarried women than among married women. Africa's abortion rates show a different trend, however: it is one of the few world regions where abortion rates in this age group are higher among unmarried women. The abortion rate in Africa is 26 procedures per 1,000 for married women aged 15–44 years and 36 induced abortions per 1,000 for unmarried women in that age group.<sup>xxxvi</sup>

**Table 7.3. Regional and sub-regional estimates of induced abortion, Africa, 1990–94 and 2010–14<sup>xxxvii</sup>**

Region and sub-region	No. of abortions (millions)		Abortion rate**		% of pregnancies ending in abortion
	1990–94	2010–14	1990–94	2010–14	2010–14
<b>World</b>	50.4	56.3	40	35	25
<b>Developing countries</b>	38.6	49.6	39	37	24
<b>Africa</b>	4.6	8.2*	33	34	15
<i>Eastern</i>	1.4	2.7*	33	34	14
<i>Middle</i>	0.5	1.0*	32	35	13
<i>Northern</i>	1.3	1.9*	41	38	23
<i>Southern</i>	0.3	0.5	32	34	24
<i>Western</i>	1.1	2.1*	28	31	12

\* Difference between 2010–14 and 1990–94 is statistically significant.

\*\* Abortions per 1,000 women aged 15–44.

Three out of four induced abortions in Africa are unsafe;<sup>xxxviii</sup> this is much higher than for all developing countries and for the world as a whole. Table 7.4 provides an overview of safe, less-safe, least-safe and unsafe abortions in Africa and its sub-regions, as well as worldwide and in all developing countries. Southern Africa stands out not only because it has lower numbers of abortions but also because many of these are safe. Trends in Eastern and Northern Africa resemble the continental picture of three out of four abortions being unsafe. In Western and Middle Africa the share of unsafe abortions is even higher, at almost nine out of ten induced abortions.

Any woman with an unwanted pregnancy but without access to safe abortion is at risk of unsafe abortion. Unsafe abortion can lead to death and disability, and almost all of this is preventable through education and information, effective contraceptive methods, safe abortion care and timely care for complications from unsafe abortions.<sup>xxxix</sup> It is estimated that 36,000 women and girls die each year in Sub-Saharan Africa from unsafe abortion.<sup>xl</sup> This translates into 520 deaths per 100,000 unsafe abortions in Sub-Saharan Africa.<sup>xli</sup> Women in Africa are disproportionately affected by mortality from unsafe abortion: the continent accounts for 29% of all unsafe abortion but for 62% of deaths related to unsafe abortion.<sup>xlii</sup> Unsafe abortions also come with high social and economic costs, to women, their families and communities, as well as to health systems. Health systems costs include resources required for treatment of the consequences and complications of unsafe abortion.

**Table 7.4. Number of safe, less-safe, least-safe and unsafe abortions over 2010–14<sup>xliii</sup>**

Regions	Total abortions per year (millions)	Total of safe abortions (millions) (%)	% of less-safe abortions	% of least-safe abortions	Total of unsafe abortions (millions) (%)
<b>Worldwide</b>	55.9	30.6 (54.9%)	30.7%	14.4%	25.1 (45.1%)
<b>Developing countries</b>	49.3	24.8 (50.5%)	12.4%	16.3%	24.3 (49.5%)
<b>Africa</b>	8.2	2.0 (24.4%)	27.6%	48.0%	6.2 (75.6%)
<i>Eastern</i>	2.7	0.6 (23.9%)	29.2%	46.9%	2.0 (76.1%)
<i>Middle</i>	1.0	0.1 (11.8%)	19.2%	69.0%	0.9 (88.2%)
<i>Northern</i>	1.9	0.6 (29.0%)	26.6%	44.4%	1.4 (71.0%)
<i>Western</i>	2.1	0.3 (15.3%)	32.6%	52.1%	1 820 000 (84.7%)
<i>Southern</i>	0.5	0.4 (73.5%)	19.4%	7.1%	135 000 (26.5%)

Note: African regions based on UNDESA Population Division regions.

Safe abortion—provided by health care workers and with methods recommended by WHO. Less-safe abortion—conducted by trained providers using non-recommended methods or using a safe method (e.g. misoprostol) but without adequate information or support from a trained individual. Least-safe abortion—carried out by untrained people using dangerous, invasive methods.

Adolescent girls, both married and unmarried, are more exposed to unsafe abortions, for multiple reasons. These include low levels of education and limited information on SRHR as well as contraceptive methods. Early and unwanted pregnancies without physical maturity are also a factor. Other factors in adolescent girls seeking unsafe abortions are social and family pressure, the fear of being stigmatised or ostracised, lack of economic resources and fear of having to drop out of school.<sup>xliv</sup>

Estimates for developing countries indicate that 3.2 million unsafe abortions take place every year among girls aged 15–19 years. In Africa, this number is 1.4 million (see Table 7.5). The unsafe abortion rate for the African continent is 26 unsafe abortions per 1,000 girls aged 15–19 years. Sub-Saharan Africa accounts for 44% of all unsafe abortions in the developing world among adolescents between the ages of 15 and 19 (excluding East Asia).<sup>xlv</sup>

**Table 7.5. Estimates of unsafe abortions and unsafe abortion rates among those aged 15–19, 2008**<sup>xlvi</sup>

	Annual number of unsafe abortions	Unsafe abortion rate (per 1,000)
Developing countries	3,200,000	16
Africa	1,400,000	26
Asia excluding East Asia	1,100,000	9
Latin America and Caribbean	670,000	25

#### 7.1.4 Access to quality SRH services and information: rural women and adolescents

The high levels of unmet need for contraception, of maternal mortality and morbidity and of unsafe abortion point to limited access among women and girls to SRH services. It is beyond the scope of this section to discuss this in depth, but a few specific concerns are highlighted here. First, **poor women living in rural areas** generally face more limitations in accessing SRH services and realising their sexual and reproductive rights. They are more vulnerable to maternal mortality, unwanted pregnancies and unsafe abortions, as well as STIs and HIV, as family planning services and SRHR information may also be out of their reach. Accessing services such as antenatal care or skilled birth attendance can be a ‘luxury’ for many women in rural areas, where health and medical services are scarce, often located far away and not always affordable.<sup>xlvii</sup> Even when health services are free of charge, accessing them implies some costs that many women cannot really cover, such as for transportation.<sup>xlviii</sup> Moreover, for many, the distance from their home to the health facility is a major constraint to, for instance, delivering at health centres or hospitals. Patriarchal norms and attitudes also constrain women and girls’ access to and use of contraceptives, especially in contexts where high fertility is strongly valued. Moreover, unequal gender relations and male domination also limit women and girls’ negotiating power and agency, and result in them not using contraception because their male partners and husbands do not agree or resist it.

**Unmarried** poor women may also face more barriers to accessing SRH services as well as information, especially when living in conservative religious communities and patriarchal societies where unmarried pregnant women are more susceptible to stigmatisation and discrimination. Lack of education can also be a critical factor affecting **adolescent girls and young women**, and is associated with early pregnancy, abortion and maternal mortality. Evidence suggests that interventions that encourage school attendance are effective in reducing adolescent pregnancy.<sup>xlix</sup> At the same time, education becomes a right that many girls and young women lose over the violation of their sexual and reproductive rights. Adolescent pregnancy, unsafe abortion and pregnancy complications often lead to girls not being able to continue their studies. According to Plan International, ‘A young girl in South Sudan is three times more likely to die in pregnancy or childbirth than to complete primary education’.<sup>i</sup> In fact, fear of not being able to continue their education is an important reason why many girls decide to terminate their pregnancy and seek abortion in unsafe services.<sup>ii</sup>

Furthermore, studies have shown how adolescents (both male and female) **lack information about SRH**, SRHR and overall sexual and reproductive rights.<sup>iii</sup> Data shows that girls do recognise the importance of accessing to such information and services (see Table 7.6). The table indicates the proportion of female and male adolescents that agrees with the attitudes towards sexuality education.



Table 7.6. Attitudes of adolescents aged 12–14 regarding sexuality education for young people<sup>iii</sup>

	It is important that sex education be taught in school	12–14 year olds should be taught about using condoms to avoid AIDS	Providing sexuality education to young people does not encourage them to have sex
<b>Females</b>			
Burkina Faso	78	73	63
Ghana	91	49	68
Malawi	67	76	68
Uganda	82	76	49
<b>Males</b>			
Burkina Faso	81	78	59
Ghana	89	63	62
Malawi	73	73	68
Uganda	78	76	52

Access of adolescents and youth to SRH services and education is affected by a number of commonly reported challenges and constraints.<sup>iv</sup> Low availability of SRH and contraceptive services (including emergency contraception and safe abortion services) is a factor. High costs of SRH services can constrain access, especially for adolescents. Geographical barriers can be that services are located either too far or too close to the home. There are also restrictive laws and policies that allow for provision of SRH services and/or contraception only to married women. Adolescent girls also report a lack of privacy and confidentiality, as well as negative and judgemental attitudes from service providers. Combined with shame and stigma around pre-marital sexuality, a lack of knowledge and skills about adolescent SRH among health workers hinders adolescents' access to SRH services.

## 7.2 CONTINENTAL AND REGIONAL POLICY FRAMEWORKS

Women's right to health, including SRH, is at the heart of **Art. 14** of the Maputo Protocol, on 'health and reproductive rights'. The article defines women's reproductive freedoms, right to choose contraceptive methods and right to access education on measures to control their fertility. It mandates state parties to provide health services, including information and education as well as ante and postnatal and delivery services. It also mandates state parties to authorise medical abortion on specified grounds.

In May 2014, the ACHPR adopted **General Comment No. 2**. This provides interpretative guidance on the normative content and obligations of state parties for the effective domestication and implementation of Art. 14 of the Maputo Protocol. It specifically concerns Arts 14.1 (a), (b), (c) and (f), as well as Arts 14.2 (a) and (c). Arts 14.1 (d) and (e) are the focus of General Comment No. 1, and these are discussed in Chapter 7.

### Health and reproductive rights (Maputo Protocol, Art. 14)

- 1. States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes:**
  - a) the right to control their fertility;
  - b) the right to decide whether to have children, the number of children and the spacing of children;
  - c) the right to choose any method of contraception;
  - [...]
  - f) the right to have family planning education.
- 2. States Parties shall take all appropriate measures to:**
  - a) provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas;
  - b) establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding;
  - c) protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.

This section discusses the continental commitments on reproductive rights issues, as laid down in Art. 14 and the General Comment No. 2. These are organised into four key aspects of these rights: (1) the right to the highest attainable standard of health, (2) the right to control fertility, choose contraception and access family planning education, (3) the right to non-discriminatory access to SRH services and to full, free and informed consent and (4) the right to safe abortion.

### 7.2.1 The right to the highest attainable standard of health

General Comment No. 2 is grounded in a reaffirmation of the Maputo Protocol of women's right to health, and their entitlement to enjoy the highest attainable standard of health. It also reaffirms that 'the right to health entails both freedoms and rights' (see also Chapter 1).<sup>6</sup> Sexual and reproductive freedom is integral to the right for human beings to control their own health and their own body. Freedom also concerns the fundamental right not to be subjected to torture and not to be subjected, without consent, to medical treatment or experiment. Rights include the right to access a system of health protection that guarantees equally to everyone the chance to enjoy the best health condition possible.

Art. 14 of the Maputo Protocol specifies that women and girls' right to health includes a number of specific rights: the right to control one's fertility and the right to decide on one's maternity and the number and spacing of children. General Comment No. 2 underlines that these rights are inextricably linked, interdependent and indivisible. They are strongly linked to women's right to life and to dignity. The General Comment refers to the right to **dignity** when pointing to women and girls' freedom to make personal decisions without interference from the state or non-state actors (para. 24). This right entails women and girls 'taking into account or not the beliefs, traditions, values and cultural or religious practices' and their right to question or to ignore them. 'Administrative laws, policies, procedures and practices, as well as socio-cultural attitudes and standards that impede access to contraception/family planning violate the woman's right to life, non-discrimination and health', in that they deprive her of her decision-making power. They also 'force her to undergo early pregnancy, unsafe or unwanted pregnancy, with as consequence, the temptation to seek unsafe abortion at the risk of her health and life' (para. 27).

<sup>6</sup> By referring to General Comment No. 14 of the United Nations Committee on the ICESCR.

General Comment No. 2 emphasises that women's sexual and reproductive rights, and the provisions in Arts 14.1(a), (b), (c) and (f) and 14.2(a) and (c) in particular, must be read and interpreted in light of other provisions on women's human rights in the Protocol. These are in particular, in addition to the already highlighted right to dignity (Art. 3), the right not to be discriminated against (Art. 2), the right to integrity and security (Art. 4), the right to access to justice (Art. 8) and the right to education (Art. 12) (General Comment No. 2, para. 11). General Comment No. 2 explicitly recognises that multiple forms of discrimination prevent women and girls from exercising and enjoying their sexual and reproductive rights. These include, and are not limited to, 'ethnicity, race, sex, gender, age, marital status, HIV status, sexual orientation, socioeconomic status, disability, geographic residence, legal residence and/or traditional, religious and cultural beliefs' (General Comment No. 2, para. 12).

General Comment No. 2 underlines the pivotal importance of a rights-based approach to health and to the implementation of policies and programmes that seek to reduce maternal morbidity and mortality. A rights-based approach to health, and women's SRHR in particular, is reflected in the obligations of state parties that are articulated in the General Comment. The General Comment specifies both general and specific state obligations regarding Arts 14.1 (a)(b)(c) and (f) and Arts 14.2(a) and (c). The specific state obligations are discussed in the last part of this Section 7.2. The *general* state obligations concern four sets of obligations on state parties—namely, to respect, protect, promote and fulfil.

#### General state obligations articulated in General Comment No. 2

To **respect**—requires states to refrain from hindering, directly or indirectly, women's rights and to ensure women are duly informed on family planning/contraception and safe abortion services.

To **protect**—requires states to take the necessary measures to prevent third parties from interfering with the enjoyment of women's sexual and reproductive rights.

To **promote**—requires states to create the legal, economic and social conditions that enable women to exercise their sexual and reproductive rights with regard to family planning/contraception and safe abortion, as well as to enjoy them.

To **fulfil**—requires states to adopt relevant laws, policies and programmes that ensure the fulfilment *de jure* and *de facto* of women's sexual and reproductive rights. This includes the allocation of sufficient and available resources for the full realisation of these rights.

These obligations entail removing impediments that limit women and girls effectively claiming their reproductive freedoms and rights and having control and choice over their fertility and sexuality. Impediments may come from the state itself, from third parties or from society at large. The obligation to protect and to promote women's enjoyment of sexual and reproductive rights requires states to both remove obstacles and create an enabling environment. Eliminating stigmatisation and discrimination related to reproductive health is essential for the promotion of women and girls' rights to contraception and safe abortion services. This entails supporting women's empowerment; sensitising and educating communities, religious leaders, traditional chiefs and political leaders on women's sexual and reproductive rights; and training health care workers (para. 44).

This is reaffirmed under the specific obligations of states to remove obstacles to the right to contraception and safe abortion services (paras 60, 61). This specific obligation requires state parties to take 'all appropriate measures, through policies, sensitization and civic education programs, to **remove all obstacles** to the enjoyment by women of their rights to sexual and reproductive health'. This is in accordance with Arts 2 and 5 of the Protocol, and it specifically concerns efforts to address gender disparities, patriarchal attitudes, harmful traditional practices, prejudices of health care providers and discriminatory laws and policies. This requires states to work in cooperation with 'health care providers, traditional and religious leaders, civil society organizations, non-governmental organizations, including women's organizations, international organizations and technical and financial partners' (para. 60).

### 7.2.2 The right to family planning education

Art. 14.1(f) provides for women and girls' right to family planning **education**. This implies that states must 'provide complete and accurate information which is necessary for the respect, protection, promotion and enjoyment of health, including the choice of contraceptive methods' (General Comment No. 2, para. 28). In the obligations articulated in General Comment No. 2, the importance of access to information and education on contraception and safe abortion for women, and especially adolescent girls and young people, is emphasised. State parties must ensure that sexual and reproductive rights issues are included in the curricula of educational institutions, at primary, secondary and tertiary level. State parties must take necessary measures to reach girls in private schools, those in faith-based schools and those out of school (para. 52). They must also enable health facilities, institutions and teaching programmes, health care providers and competent CSOs to provide information and education on contraception and safe abortion services.

General Comment No. 2 further specifies that this information and education should be comprehensive, age-appropriate, rights-based and without judgement. State parties must 'ensure **comprehensive** information and education on human sexuality, reproduction and sexual and reproductive rights'. This should be 'based on clinical findings, **rights-based, without judgement** and take into account the **level of maturity** of adolescent girls and the youth' (para. 51). This is in accordance with the MPoA, and Arts 2 and 5 of the Maputo Protocol, on the elimination of discrimination against women and of harmful practices, respectively.<sup>7</sup> This information and education should be '**complete**' information, including on contraceptive methods, causes of failure of practised contraceptive methods and available options in case of unwanted pregnancy (para. 28).

The ACRWC and the AYC confirm the right to the highest attainable standard of health of, respectively, children (Art. 14 ACRWC) and youth (Art. 16 AYC). They also confirm the right to education of children (Art. 11) and youth (Art. 13) and stipulate that this must foster respect for human rights and fundamental freedoms, in particular provisions in African human rights instruments as well as international conventions and declaration. The AYC highlights the importance of education that is directed towards the development of life skills, including in relation to reproductive health and HIV and AIDS, and calls for culturally appropriate, age-specific sexuality and responsible parenthood education (Arts 13.3f and 13.4n). Both charters explicitly provide that girls or young women who become pregnant before completing their schooling shall have an opportunity to continue their education (ACRWC Art. 11.6; AYC Art. 13.4c). This is also strongly articulated in the Joint General Comment of the ACHPR and ACEWRC regarding Ending Child Marriage (adopted 2017, see also Chapter 5); this states that 'It is compulsory for States Parties to facilitate the retention and re-entry of pregnant or married girls in schools' (para. 31).

The same Joint General Comment of the ACHPR and ACEWRC presents comprehensive sexuality education and information programmes as a key obligation of states. Under institutional obligations regarding access to and uptake of health services, the Joint General Comment avers that states should develop and implement **comprehensive sexuality education and information** programmes with age-appropriate information (para. 36). These should include age-appropriate information about 'sex, sexuality, sexual and reproductive health rights and sexually transmitted infections, including HIV and AIDS' and about 'what constitutes consent to sex, as distinct from consent to marriage, and information about gender, sexuality and social norms and stereotypes that perpetuate gender inequality and its manifestations, including child marriage' (pars. 36.). Comprehensive sexuality education (CSE) should be part of the school curriculum and also be disseminated to non-school settings and in media that reach rural and remote settings.

A commonly agreed on and used definition of CSE is provided in the *International Technical Guidance on Sexuality Education* (see Box 7.2). This definition is also referred to in, for instance, the so-called 'ESA Commitment' of 20 countries in Eastern and Southern Africa: the *Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for adolescents and young people in Eastern and Southern Africa* (see also Case study 21 on the ESA Commitment in Section 7.4).

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<sup>7</sup> Maputo Protocol Art. 2 (Elimination of Discrimination of Women) provides that 'States parties shall commit themselves to modify the social and cultural patterns of conduct of women and men through public education, information, education and communication strategies, with a view to achieving the elimination of harmful cultural and traditional practices and all other practices which are based on the idea of the inferiority or superiority of either of the sexes, or on stereotyped roles for women and men' (Art. 2.2). Art. 5 (Elimination of Harmful Practices) provides that state parties take all necessary measures, including 'creation of public awareness in all sectors of society regarding harmful practices through information, formal and informal education and outreach programmes' (Art. 5a).

### Box 7.2. Defining comprehensive sexuality education and sexuality

The International Technical Guidance on Sexuality Education proposes an inclusive definition of **comprehensive sexuality education** as ‘a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to: realize their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and, understand and ensure the protection of their rights throughout their lives.’<sup>8</sup>

**Sexuality** is a core aspect of CSE, as it ‘seeks to equip young people with the knowledge, skills, attitudes and values they need to determine and enjoy their sexuality – physically and emotionally, individually and in relationships’.<sup>iv</sup> The WHO working definition of sexuality sees it as ‘a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors.’<sup>vi</sup>

The core features of CSE are that it is:

- *Scientifically accurate*—fact- and evidence-based content in relation to SRH, sexuality and behaviours
- *Incremental*—a continuous educational process starting at an early age
- *Age- and developmentally appropriate*—responsive to changing needs and capabilities of the child and young person
- *Curriculum-based*—including written curriculum guiding educators and supporting students’ learning
- *Comprehensive*—providing opportunities for children and young persons to acquire comprehensive, accurate, evidence-informed and age-appropriate information on sexuality
- *Based on a human rights approach*—promoting understanding of universal human rights and right to non-discrimination, health, education and information equality for all persons
- *Based on gender equality*—addressing the different ways gender norms impact inequality and how this can affect the health and well-being of children and young people
- *Culturally relevant and context-appropriate*—fostering responsibility and respect within relationships
- *Transformative*—empowering individuals and communities, promoting critical thinking and strengthening young people’s citizenship
- *Able to develop life skills needed to support healthy choices*—promoting the ability to make informed decisions, reflect, communicate and negotiate effectively

The most recent version of the *Technical Guidance* was published in 2018, updated from the first version stemming from 2009. The *Technical Guidance* has been developed with the purpose of assisting education, health and other relevant institutions in the development and implementation of CSE programmes both in school and in the community. It is published by UNESCO together with UNAIDS, UNFPA, UNICEF and WHO.

<sup>8</sup> This definition is from UNESCO, UNAIDS, UNFPA, UNICEF and WHO. (2018). International Technical Guidance on Sexuality Education. An Evidence-Informed Approach. [http://www.unaids.org/sites/default/files/media\\_asset/ITGSE\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/ITGSE_en.pdf). Different guidelines with definitions on CSE definitions have been developed since 2009, by IPPF and UNFPA among others: UNFPA. (2014). UNFPA Operational Guidance for Comprehensive Sexuality Education: A Focus on Human Rights and Gender. <https://www.unfpa.org/publications/unfpa-operational-guidance-comprehensive-sexuality-education>; IPPF (2010). *IPPF Framework for Comprehensive Sexuality Education (CSE)*. [https://www.ippf.org/sites/default/files/ippf\\_framework\\_for\\_comprehensive\\_sexuality\\_education.pdf](https://www.ippf.org/sites/default/files/ippf_framework_for_comprehensive_sexuality_education.pdf)

### 7.2.3 The right to non-discriminatory access to health services and to informed and voluntary consent

The rights to control fertility, decide on maternity and children and choose a contraception method are closely linked to women's right to health care without discrimination. Art. 14.2(a) provides that state parties shall take all appropriate measures to 'provide adequate, affordable and accessible health services, including information, education and communication programmes to women, especially those in rural areas'. General Comment No. 2 provides further interpretative guidance on what is entailed with this article.

This first means that states must provide a legal and social environment conducive to women and girls exercising their sexual and reproductive rights. This includes their **access** to contraception and safe abortion services. These reproductive health care services should be *available, accessible, acceptable and good quality*. Moreover, they have to be *comprehensive, integrated and rights-based*. They also need to be *inclusive and sensitive* to the diverse realities of women, and *adapted* to women living with disabilities and the youth (paras 46 and 53). Provision of these services also entails the availability, accessibility and acceptability of procedures, technologies and comprehensive and quality services for SRH (para. 55). A critical element in this is that 'Family planning and contraception services should include a **variety** of contraceptive methods, including short-term, long-term and permanent methods.' These can be provided through both family planning/contraception programmes and under post-abortion care (para. 56), and preferably in comprehensive SRH service centres.

The right to adequate and affordable health services obliges state parties to develop 'a **national public health plan with comprehensive sexual and reproductive health services**, protocols, guidelines and standards that are consistent with current evidence-based standards provided by WHO' and the committees ensuring state compliance with ICCPR, ICESCR and CEDAW (para. 30). The legal and policy framework should include accountability mechanisms, implementation guidelines and standards, monitoring and evaluation frameworks and redress mechanisms.

The right to access to SRH services entails that these services are ensured '**without any discrimination** relating to age, health condition, disability, marital status or place of residence' (para. 29). Access to services must be guaranteed to all women, especially rural women (para. 55). State parties are required to remove obstacles that women and girls face in accessing contraception and safe abortion services. This especially concerns young women, adolescent girls, women living with disabilities, women in situations of conflicts, displaced or refugee women and rural women (para. 61). In particular, **HIV testing** should not be 'used as a condition for accessing family planning/contraception and safe abortion services' (para. 59).

Women and girls' own **consent** is key to their use of contraception and safe abortion services. The legal and policy framework should ensure informed and voluntary consent of women and girls themselves. This implies that **no woman is forced** to use contraception, or undergo sterilisation or abortion 'because of her HIV status, disability, ethnicity or any other situation' (para. 47). Indeed, access to SRH services has to be free from any coercion, discrimination or violence (para. 53).

The General Comment explicitly refers to women and girls' right to health care without discrimination, and explains that this 'requires State parties to remove impediments to health services reserved for women, including ideology or belief-based barriers' (para. 25). State parties shall 'ensure that health services and health providers **do not deny women access** to contraception/family planning or safe abortion information and services because of, for example, requirements of third parties or reasons of conscientious objection' (para. 48). This refers to the obligation of the state to *respect* rights, and hence refrain from hindering women and girls' rights. It means that 'Administrative discriminatory laws, policies, procedures, practices must be removed so that women can effectively claim their reproductive freedom and the rights thereof, and enjoy the same' (para. 25). When necessary, this entails the revisiting of restrictive laws, policies and administrative procedures (para. 46). The legal framework also needs to be accompanied by administrative **appeal and complaints** mechanisms, to allow women to fully exercise their rights, and to understand and challenge reasons and decisions that deny them family planning/contraception services.

Ensuring access without discrimination and ensuring no woman is denied access also bring into play the obligation of the state to *protect* women and girls' sexual and reproductive rights. This obligation to protect requires states 'to prevent of third parties from interfering with the enjoyment of women's sexual and reproductive rights' (para. 43). This calls for particular attention to the rights of vulnerable groups such as adolescent girls, women living with disabilities, women living with HIV and women in situations of conflict. This means that **third party consent** and the involvement of, for instance, parents, guardians, spouses and partners, 'is *not* required when adult women and adolescent girls want to access family planning/contraception and safe abortion services in the cases provided in the Protocol' (para. 43). The Joint General Comment of the ACHPR and ACEWRC (2017) also explicitly provides that access to comprehensive SRH should be ensured, and that 'Third party permission for accessing these services should not be required' (para. 35).



Impediments to women and girls' access to contraception and safe abortion services can include administrative provisions in the law, policies and procedures that restrict such access on the basis of religious beliefs. The General Comment specifies that the right to freedom from being subjected to discrimination prohibits any deprivation concerning access to contraception services by health care providers based on **conscientious objection** (para. 26). State parties 'must ensure that the necessary infrastructure is set up to enable women to be knowledgeable and referred to other health care providers on time'. It is emphasised that health personnel directly involved in the provision of contraception/family planning services enjoy the right to conscientious objection, but that 'this is not so for the institutions'. Also, the right to conscientious objection 'cannot be invoked in the case of a woman whose health is in serious risk, and whose condition requires emergency care or treatment'.

#### 7.2.4 The right to safe abortion

General Comment No. 2 reaffirms that the Maputo Protocol places on state parties the obligation to protect women's reproductive rights by authorising safe abortion on specific grounds. Being well informed of and having access to products, procedures and health services, including contraception and safe abortion services, are critical to the non-discriminatory enjoyment by women and girls of their rights. This includes their right to benefit from scientific progress and its applications.<sup>9</sup> <sup>lvii</sup> 'This right is denied when women are denied the means to interrupt an unwanted pregnancy safely, and using effective methods' (General Comment No. 2, para. 33). Women and girls' fundamental rights also include their right to be free from cruel, inhuman and degrading treatment when they seek reproductive health services, as part of their right to life, integrity and security of her person (Art. 4 of the Maputo Protocol and Art. 5 of the African Charter).

Art. 14.2(c) of the Maputo Protocol specifies the cases in which safe abortion should be authorised. Section 7.1 of this chapter defined safe abortion. Box 7.3 presents the four grounds for safe abortion provided in the Maputo Protocol.

##### Box 7.3. Grounds for safe abortion in the Maputo Protocol (Art. 14.2(c), General Comment No. 2)

The grounds for abortion and for women to terminate a pregnancy are stated in the Maputo Protocol and in General Comment No. 2 as:

- In case of pregnancies contracted *following sexual assault, rape and incest*
- When the pregnancy poses *a threat to the health of the pregnant mother*, including her physical and mental health<sup>10</sup>
- When the *woman's life is threatened*<sup>11</sup>
- When the pregnancy poses *risks to the life of the foetus*—that is, when the foetus suffers from deformities that are incompatible with survival<sup>12</sup>

Provision of **safe abortion services** is part of states' obligation to ensure the availability, accessibility, acceptability and good quality of reproductive health care. In terms of procedures, technologies and techniques, safe abortion services should include the methods recommended by WHO, which are updated and based on clinical findings (General Comment No. 2, para. 57).<sup>13</sup> Access to and provision of safe abortion care should be facilitated by the establishment of national standards and guidelines.<sup>lviii, 14</sup>

<sup>9</sup> Articulated in Art. 27 of the UDHR and Art. 15 of the ICESCR.

<sup>10</sup> The General Comment explicitly states that 'the reasons put forward by the woman seeking an abortion must be taken into account, and States are required to ensure that the legal frameworks in place facilitate access to medical abortion when the pregnancy poses a threat to the health of the pregnant mother. This implies notably that the evidence of prior psychiatric examination is not necessary to establish the risk to mental health' (para. 38).

<sup>11</sup> The General Comment explicitly states that 'women's lives are in danger when they have no access to legal security procedures which obliges them to resort to unsafe, illegal abortions' (para. 39).

<sup>12</sup> This can also occur in women who need special medical treatment for heart diseases, cancer or other diseases that may endanger the survival of the foetus (General Comment No. 2, para. 40).

<sup>13</sup> These methods include 'procedures such as evacuation, dilation and intrauterine manual or electric suction, as well as the use of other efficient methods or medicines that might become available in the future. The equipment and medicines recommended by WHO should be included in the lists of national essential products and medicines. Techniques such as dilation and curettage should be replaced with safer methods' (General Comment No. 2, para. 57).

<sup>14</sup> 'Standards and guidelines should cover: types of abortion service, where and by whom they can be provided; essential equipment, instruments, medications, supplies and facility capabilities; referral mechanisms; respect for women's informed decision-making, autonomy, confidentiality and privacy, with attention to the special needs of adolescents; special provisions for women who have suffered rape; and conscientious objection by health-care providers.' In addition to standards and guidelines, other principles for planning and managing safe abortion care are ensuring health care provider skills and performance, financing and a systemic approach to policy and programme development (WHO. 2012. 'Unsafe Abortion Incidence and Mortality', pp. 63–85).

In accessing safe abortion care, women and girls' rights to be **free from discrimination** and to **privacy and confidentiality** are of particular importance. This has implications for both health care providers and the legal framework and practice. General Comment No. 2 provides that state parties 'should avoid all unnecessary or irrelevant restrictions on the profile of the service providers authorized to practice safe abortion and the requirements of multiple signatures or approval of committees, in the cases provided for in the Protocol' (para. 58). It also articulates the obligation to train health workers, including both physicians and mid-level providers (such as midwives and other health workers) on the provision of safe abortion. This training should include 'non-discrimination, confidentiality, respect for autonomy, and free and informed consent of women and girls' (para. 58).

For the legal framework and practice, the rights to non-discrimination and to privacy and confidentiality require the **decriminalisation of abortion and post-abortion care**. This means that women are not subjected to criminal proceedings, or incur legal sanctions when seeking and benefiting from health services, including abortion and post-abortion care. These rights are violated when women are subjected to interrogation on the reasons why they are interrupting a pregnancy that meet the specified grounds, or when they are charged or detained on suspicion of illegal abortion when seeking post-abortion care.<sup>15</sup> Within this, health service providers should not fear prosecution, disciplinary reprisal or other for providing such services, as provided in the Maputo Protocol. In order to realise this, states should ensure training and sensitisation of law practitioners, judges and magistrates and judicial police officers (General Comment No. 2, para. 49).

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<sup>15</sup> The General Comment states that 'WHO recommends to the Member States to end the practice of extortion of confessions from women seeking emergency medical care as a result of an illegal abortion and to remove the obligation imposed by law to physicians and other health care providers to denounce cases of women who have undergone abortions. States are required to ensure, immediately and unconditionally, the treatment required for anyone seeking emergency medical care. UN human rights bodies have also condemned such practices which constitute a human rights violation' (para. 35).



## 7.2.5 Obligations of states

Art. 14.2 specifies the **measures** state parties should take to realise these rights. The General Comment provides further interpretative guidance on what Art. 14.2(a), on the right to adequate and affordable health services and information, education and communication, entails, and on Art. 14.2(c), on the right to safe abortion in specified cases. The obligations are presented together as a comprehensive set of measures, integrating contraception and safe abortion services. Table 7.7 summarises the specific obligations of states; many of these were discussed in the text above.

**Table 7.7. Interpretative guidance on the obligations of states on contraception and safe abortion services**

Specific State obligations	
General Comment No. 2 provides interpretative guidance on states' obligations on contraception and safe abortion services, as reflected in Arts 14.1 (a), (b), (c) and (f) and 14.2(a) and (c)	
<b>Enabling legal and political framework</b>	<p>Provide a legal and social environment that is <i>conducive</i> to the exercise by women of their sexual and reproductive rights, including, if necessary, <i>revisiting restrictive laws, policies and administrative procedures</i></p> <p>Ensure <i>informed and voluntary consent</i>: ensure legislative measures, administrative policies and procedures stipulate that <i>no woman is forced</i> to use contraceptives methods or undergo sterilisation or abortion</p> <p>Ensure <i>access</i> to contraception and safe abortion services, as provided in the Maputo Protocol; ensure health services and health providers <i>do not deny</i> women this access, either because of requirements for <i>third party consent</i> or on the basis of <i>conscientious objection</i></p> <p>Ensure women are <i>not arrested, charged or prosecuted</i> when seeking safe abortion services or post-abortion care, by ensuring law practitioners, judges, magistrates and judicial police officers receive adequate training</p> <p>Establish accountability mechanisms, implementation standards and guidelines, a monitoring and evaluation framework and redress mechanisms</p>
<b>Access to information and education on contraception and safe abortion</b>	<p>Ensure provision of <i>comprehensive information and education on human sexuality, reproduction and sexual and reproductive rights</i> to women and especially <i>adolescent girls and young women</i></p> <p>Ensure educational institutions at <i>primary, secondary and tertiary</i> levels include sexual and reproductive rights issues in their programmes, and ensure these reach women in <i>private</i> schools, including faith-based schools, as well as those <i>out of school</i></p>
<b>Access to contraception and safe abortion services</b>	<p>Ensure <i>availability, accessibility, acceptability and quality</i> of reproductive health care, including contraception and safe abortion services</p> <p>Integrate and/or link contraception and safe abortion services to other services relating to reproductive health, primary health care and HIV and other STIs</p>
<b>Procedures, technologies and services for SRH</b>	<p>Ensure availability, accessibility and acceptability of <b>procedures, technologies</b> and comprehensive and good quality <b>services</b>, using technologies based on clinical findings; ensure access of services to all women, especially rural women, by ensuring availability of supplies and properly functioning procurement systems</p> <p>Include a <i>variety of contraceptive methods</i>, including short-term,<sup>16</sup> long-term<sup>17</sup> and permanent<sup>18</sup> methods, to be provided through both family planning/contraception programmes and after post-abortion care</p> <p>Safe abortion services should include the <i>methods recommended by WHO</i>, updated and based on clinical findings. The required equipment and medicines recommended by WHO should be included in the lists of national essential products and medicines</p> <p><i>Avoid all unnecessary or irrelevant restrictions</i> on the categories of service providers authorised to practise safe abortion and the requirement of multiple signatures or approval by committee, in cases provided for in the Maputo Protocol</p> <p><i>Training of health workers</i> to provide safe abortion care should include non-discrimination, confidentiality and respect for the autonomy and free and informed consent of women and girls</p> <p>Ensure <i>HIV testing is not used as a condition</i> for accessing contraception and safe abortion services</p>
<b>Obstacles to the right to contraception and safe abortion services</b>	<p>Take all appropriate measures (through policies, sensitisation and civic education programmes) to <i>remove all obstacles</i> to the enjoyment by women of their rights to SRH</p> <p>Work with health care providers, traditional and religious leaders, CSOs and NGOs, including women's organisations, international organisations and technical and financial partners</p> <p>Take all appropriate measures to remove obstacles arising from <i>marital status and age disability, as well as economic and geographical barriers</i> facing women who want to access contraception and safe abortion services, especially young women, adolescent girls, women living with disabilities, women in situations of conflict, displaced or refugee women and rural women</p>
<b>Allocation of financial resources</b>	<p>Allocate <i>adequate financial resources</i> to strengthening public health services so comprehensive care in contraception and safe abortion services can be provided, pursuant to Art. 26.2 of the Maputo Protocol, para. 26 of the Abuja Declaration and para. 7 of the MPoA</p>
<b>Compliance with submission of periodic reports</b>	<p>Submit in a timely manner periodic reports on the legislative and other measures taken towards the full realisation of the rights recognised in the Maputo Protocol, taking into account General Comment No. 2 and in compliance with the ACHPR guidelines for reporting</p>

<sup>16</sup> Hormonal contraceptives, male and female condoms and emergency contraception.

<sup>17</sup> Implants, IUDs (intrauterine contraceptive devices) and vaginal rings.

<sup>18</sup> Voluntary sterilisation.

## 7.3 NATIONAL LEGAL AND POLICY FRAMEWORKS

Against the backdrop of the prevalence of unmet need, maternal mortality and unsafe abortion, discussed (in Section 7.1), and the commitments in Art. 14 of the Maputo Protocol and General Comment No. 2 of 2014 (in Section 7.2), this current section tracks the extent to which these commitments are being implemented at the national level. Are women's rights to health guaranteed in national-level legal and policy frameworks? Can they decide on their own informed and full consent? How is their right to safe abortion ensured?

It has proven difficult to identify and formulate proper and useable legal and policy indicators regarding the reproductive rights that are central to this chapter. A first observation is therefore that it is much harder here to assess the extent to which the rights provided for in Art. 14 of the Protocol and General Comment No. 2 are domesticated in national law and policies. The right to choose family planning or contraception is very rarely articulated in national-level legislation. It may be reflected in national policy frameworks, but from a methodological point of view these could not be assessed in a systematic way within the scope of the desk research conducted for this review. Because of these difficulties, the narrative analysis that accompanies the indicator tables uncovers critical issues that cannot (yet) be captured in proper legal and policy indicators. The case studies in Section 7.4 also bring added value, as they illustrate and provide insights into important legal and policy changes contributing to women and girls' reproductive rights.

One legal indicator is formulated with respect to the *right to health* as articulated in the national constitution. Two policy indicators are used regarding *government health budgets*, and are derived from the AU Scorecard on Domestic Financing for Health published by Africa AIDS Watch.<sup>18</sup> A fourth indicator relates to CARMMA implementation. With respect to *safe abortion*, a fifth indicator is scored based on the grounds provided for in the Maputo Protocol. Box 7.4 presents and explains the five legal and policy indicators on reproductive rights.

In addition to these four/five indicators, which are discussed in a systematic manner for all regions, our review draws on the secondary data of two existing reviews that look specifically at *adolescent access to SRHR* in certain countries. The findings of these are included in the narrative analysis for the appropriate regions. These two sources of secondary data are the UNESCO 2016 progress review of the ESA Commitment and the IPPF 2017 review of sexual rights, young people and the law.<sup>19</sup> Finally, we refer to the next chapter, which discusses legislation on sexual orientation or gender identity or expression; this can also be taken into account in this chapter, as legislation on same-sex activities and relations affects access to SRH services.

This section then discusses trends, gaps and contestations on these indicators, first for the continent as a whole and then by region. The final section of the chapter then proceeds to present case studies that complement the tables and narrative analysis on the national legal and policy frameworks.

<sup>19</sup> The full references are IPPF. (2017). *Sexual Rights, Young People and the Law*. London: IPPF (Africa only; countries covered: Chad, Ethiopia, Kenya, Mali, Mauritania, Niger and Zambia); and UNESCO. (2016). *Fulfilling Our Promise to Young People Today 2013-2015. Progress Review of the Eastern and Southern African Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People*.

## Box 7.4. Reproductive rights: legal and policy indicators

Name/description of indicator	Codes	Explanation of the indicator codes	
Indicator 1 – Constitutional provision on the right to health	Yes	There is a constitutional provision on the right to health	
	Yes*	The constitutional provision specifically speaks of right to <i>reproductive</i> health	
	No	There is no constitutional provision on the right to health	
Indicator 2 – Joined CARMMA campaign	Yes	Country has joined and launched a CARMMA campaign	
	No	Country has not joined the CARMMA campaign.	
Indicator 3 – Government funding for health at least 5% of GDP <sup>20</sup>	Yes	Government funding for health is at least 5% of GDP	
	No	Government funding for health is less than 5% of GDP	
Indicator 4 – Government funding for health at least 15% of annual budget <sup>21</sup>	Yes	Government funding for health is at least 15% of annual budget	
	No*	Target of 15% government funding for health of annual budget is not achieved but country is making progress; percentage is between 10% and 15%	
	No	Target of 15% government funding for health of the annual budget is not achieved; percentage is below 10%	
Indicator 5 – Legal guarantees to access safe abortion	When life mother is endangered	Yes	Abortion is allowed when the life of the mother is in danger
		No	Abortion is <i>not</i> allowed when the life of the mother is in danger
	When mental and or physical health of mother is threatened	PH	Abortion is allowed when the <i>physical</i> health of the mother is threatened
		MH	Abortion is allowed when the <i>mental</i> health of the mother is threatened
		PH+MH	Abortion is allowed when the health of the mother is threatened ( <i>physical</i> and <i>mental</i> health both mentioned explicitly)
		H	Abortion is allowed when the <i>health</i> of the mother is threatened (no further specification given)
		No	The mother's health is not provided as a grounds for accessing safe abortion
	In case of sexual assault, rape or incest	Yes	Abortion is allowed in case of sexual assault, rape or incest
		No	Abortion is <i>not</i> allowed in case of sexual assault, rape or incest
	In case of foetal impairment	Yes	Abortion is allowed in case of foetal impairment (when survival of foetus is threatened, when foetus suffers from serious deformities incompatible with survival or in case of impairments after birth).
		No	Abortion is <i>not</i> allowed in case of foetal impairment (when survival of foetus is threatened, when foetus suffers from serious deformities incompatible with survival or in case of impairments after birth)
	On other grounds	Yes	Abortion is allowed on other grounds than the ones listed above <sup>22</sup> (footnote is provided with explanation on grounds for abortion provided for)
No		Abortion is <i>not</i> allowed on other grounds than the ones listed above	

Tables 7.8 and 7.9 present an overview of legal and policy frameworks regarding reproductive rights and SRH. (For an explanation of the regional units used here, see Section 1.6.3 in Chapter 1.) Please note that the total for the continent has been recalculated, as some countries are included in more than one region.<sup>23</sup> The main trends are that eight out of ten countries have constitutional provisions that articulate women and girls' right to health. These include provisions regarding the right to health as well as to health care and health services. Kenya is the only country that has a constitutional provision that specifically refers to the right to reproductive health. Forty-five countries have launched a CARMMA campaign. Table 7.8 further shows that a minority of the countries have made good on the commitments expressed in the Abuja Declaration (2001) on health financing. In nine of the fifty-five countries, health expenditures are higher than 5% of GDP (indicator 3). When looking at health as an arm of government expenditure (Indicator 4), only four countries have reached the target of at least 15%. Twenty countries, many of them in Southern or Eastern Africa, are making progress towards this target.

<sup>20</sup> This indicator relates government funding for health to the country's GDP. GDP is the value of all goods and services provided in a country by residents and non-residents without regard to their allocation among domestic and foreign claims. This corresponds to the total sum of expenditure (consumption and investment) of private and government agents.

<sup>21</sup> This indicator relates government funding of health to total government expenditure (i.e. gender expenditure).

<sup>22</sup> This fifth score can include legislation that for instance provides for (a) age of the mother and her capacity to care for the child as grounds for considering allowing abortion or (b) socio-economic reasons to allow safe abortion, or (c) poses no restriction as reason to access safe abortion.

<sup>23</sup> A few countries are part of more than one of the regions used as analytical units here. For the continent 'total', these countries should be counted only once. (Angola and DRC are in both the Central and the Southern regional units, Rwanda and Burundi are in both Eastern and Central Africa and Tanzania is in both Eastern and Southern Africa).

Table 7.9 provides an overview of the grounds on which access to safe abortion is guaranteed in national legislation. In 48 countries, access to safe abortion is guaranteed when the life of the mother is in danger, and in 36 countries when the health of the woman (physical, mental, unspecified or both) is threatened. Thirty countries provide access to safe abortion in cases of rape, sexual assault or incest. Twenty-four allow for access to safe abortion in case of foetal impairment. When looking at the four grounds specified in the Maputo Protocol, 22 countries have legal guarantees to access safe abortion on all four grounds specified there. Three countries provide access to safe abortion on three of the four grounds (when the life or the health of the mother is in danger and in cases of rape, sexual assault or incest). Fifteen countries have highly restrictive abortion laws, and either prohibit abortion under any conditions (which means it can occur only on the grounds of necessity) or allow it only to save the life of the mother (see also Chapter 2, map 5, for a visual representation of these findings).

With respect to adolescents' access to SRH and CSE, covered in the narrative analyses by region, the trends are that progress is being observed with respect to countries having policies or strategies in place for CSE but that challenges continue to exist in terms of their implementation. In the Eastern and Southern regions, where 20 countries have agreed to work collaboratively on the ESA Commitment (see also Section 7.2.3 above, and case study 21 in section 7.4), 15 countries report providing CSE and life skills in at least 40% of primary schools, and 12 countries in at least 40% of secondary schools. There is a need to further scale up these efforts, and to strengthen the quality of the CSE curricula. Fifteen of these countries have also developed a strategy or national policy on sexuality education for out-of-school youth. All ESA countries have in-service training programmes for teachers on CSE and life skills, and half of them offer such training in pre-service teacher programmes. In relation to training programmes for social and health workers, 17 of the ESA countries have in-service training on the delivery of adolescent- and youth-friendly SRH services, and 10 address this in pre-service training. It is noted that more efforts and work are needed to build the capacity of and train teachers and health workers, and to align training materials with WHO standards.<sup>24,ix</sup>

**Table 7.8. Continental and regional overview of legal and policy indicators, reproductive rights and SRH**

Reproductive rights	INDICATORS												
	Constitutional provision on right to health			Country has joined/launched CARMMA campaign			Government funding for health >5% of GDP			Government funding for health >15% of general government expenditure			
	Y	Y*	N	Y	N	M	Y	N	M	Y	N*	N	M
Western (15)	13	0	2	14	1	0	2	13	0	1	4	10	0
Central (11)	9	0	2	10	1	0	2	9	0	0	4	7	0
Eastern (11)	8	1	2	9	2	0	1	8	2	1	6	2	2
Southern (16)	12	0	4	15	1	0	4	12	0	2	7	7	0
Northern (7)	6	0	1	2	3	2	1	4	2	0	1	4	2
Total (55) <sup>25</sup>	44	1	10	45	8	2	9	42	4	4	19	28	4

**Table 7.9. Continental and regional overview of legal and policy indicators, access to safe abortion**

Reproductive rights	INDICATORS																	
	Legal guarantee to access safe abortion under specified circumstances																	
	Allowed when life of mother is threatened			Allowed when mental or physical health of mother is threatened/in danger						Allowed in cases of foetal impairment			Allowed in cases of sexual assault, rape or incest			Allowed under other circumstances		
	Y	N	M	PH	MH	PH+MH	H	N	M	Y	N	M	Y	N	M	Y	N	M
Western (15)	13	2	0	1	0	7	0	7	0	5	10	0	8	7	0	2	13	0
Central (11)	9	2	0	0	0	3	5	3	0	5	6	0	5	6	0	1	9	1
Eastern (11)	11	0	0	0	0	1	7	3	0	4	7	0	6	5	0	3	0	8
Southern (16)	15	1	0	2	1	7	3	3	0	10	5	1	9	7	0	4	10	2
Northern (7)	4	2	1	1	0	2	0	3	1	2	4	1	2	4	1	1	5	1
Total (55) <sup>26</sup>	48	6	1	4	1	19	12	18	1	24	29	2	29	25	1	10	35	10

<sup>24</sup> A UNESCO global review (UNESCO. 2015. 'Emerging Evidence, Lessons and Practice in Comprehensive Sexuality Education: A Global Review') also found that many countries were making progress by having policies and strategies for CSE in place but faced challenging in full implementation on the ground. This global review included 48 countries worldwide. The African countries included were Botswana, Burundi, Cameroon, CAR, Chad, Côte d'Ivoire, DRC, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, South Sudan, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.

<sup>25</sup> Excluding regional duplicates.

<sup>26</sup> Excluding regional duplicates.

### 7.3.1 Western region

#### Trends, gaps and contestations

In the Western African region, most countries score positively on one or two of the reproductive rights indicators regarding constitutional provisions on the right to health, on the CARMMA campaign or on government spending on health. They vary as to which of these they score positively on. Most countries have joined the CARMMA campaign. The Gambia stands out with a positive score on all four, and Sierra Leone with three positive scores, both marking orange on the Abuja target of 15% health funding.

With respect to legal grounds for safe abortion, the countries vary considerably and are grouped at both ends of the continuum. Burkina Faso, Liberia and Togo provide legal guarantees to access safe abortion on all four grounds articulated in the Maputo Protocol; so do Cape Verde and Ghana, which in addition have other circumstances in which abortion is permitted. On the other end of the spectrum, Guinea-Bissau and Senegal have the most restrictive abortion laws. Slightly less restrictive are Côte d'Ivoire, Niger and Nigeria, which allow abortion on only one grounds (when the life of the mother is in danger). Five countries are in the middle of the spectrum: Benin, The Gambia, Mali and Sierra Leone (with two positive scores) and Guinea (with three positive scores).

**Table 7.10. Key legal and policy indicators in Western Africa, reproductive rights and SRH**

Country	INDICATORS								
	Constitutional provision on health	Joined/launched CARMMA campaign	Government funding for health >5% of GDP	Government funding for health > 15% of general government expenditure	Legal guarantees to access safe abortion				
					When the life of the mother is threatened	When pregnancy poses threat to mental or physical health of mother	In cases of foetal impairment	In case of sexual assault, rape or incest	Allowed under other circumstances
Benin	Yes <sup>27</sup>	Yes	No	No	Yes	No	No	Yes	No
Burkina Faso	Yes <sup>28</sup>	Yes	No	No*	Yes	PH + MH	Yes	Yes	No
Cape Verde	Yes <sup>29</sup>	No <sup>30</sup>	No	No*	Yes	PH + MH	Yes	Yes	Yes <sup>31</sup>
Côte d'Ivoire	Yes <sup>32</sup>	Yes	No	No	Yes	No	No	No	No
The Gambia	Yes <sup>33</sup>	Yes	Yes	Yes	Yes	PH + MH	No	No	No
Ghana	No <sup>34</sup>	Yes	No	No	Yes	PH + MH	Yes	Yes	Yes <sup>35</sup>
Guinea	Yes <sup>36</sup>	Yes	No	No	Yes	PH + MH	No	Yes	No
Guinea Bissau	No	Yes	No	No	No <sup>37,38</sup>	No	No	No	No
Liberia	Yes <sup>39</sup>	Yes	No	No*	Yes	PH + MH	Yes	Yes	No
Mali	Yes <sup>40</sup>	Yes	No	No	Yes	No	No	Yes	No
Nigeria	Yes <sup>41</sup>	Yes	No	No	Yes	No <sup>42</sup>	No	No	No
Niger	Yes <sup>43</sup>	Yes	No	No	Yes	No	No	No	No
Senegal	Yes <sup>44</sup>	Yes	No	No	No <sup>45,46</sup>	No	No	No	No
Sierra Leone	Yes <sup>47</sup>	Yes	Yes <sup>48</sup>	No*	Yes	PH+MH	No	No <sup>49</sup>	No
Togo	Yes <sup>50</sup>	Yes	No	No	Yes	PH	Yes	Yes	No

<sup>27</sup> Under Art. 8 of the 1990 Constitution, the state 'shall assure to its citizens equal access to health'.

<sup>28</sup> Art. 26 of the 1991 Constitution provides for the right to health.

<sup>29</sup> Art. 68 of the 1992 Constitution, amended in 2010: 'Everyone shall have the right to health and the duty to defend and promote it, irrespective of his economic condition.'

<sup>30</sup> carmma.org lists Cape Verde as 'other'. There is no information on whether it is in the process of launching CARMMA.

<sup>31</sup> In Cape Verde, legislation places no restriction as to reason (Guttmacher Institute. 2016. 'Abortion in Africa'. Fact Sheet).

<sup>32</sup> Art. 9 of the 2016 Constitution provides for the right to access to health care services.

<sup>33</sup> Under Art. 216.4, the state shall endeavour to facilitate equal access to clean and safe water, adequate health and medical services, habitable shelter, sufficient food and security to all persons. In other sections of the Constitution, health is discussed in the context of a specific group such as children and disabled persons.

<sup>34</sup> The Ghanaian Constitution does protect the right to health for specific groups but not for all citizens (for example in the context of employment and the right to work under healthy conditions).

*Trends in legal, policy and institutional reform*

**Constitutional provisions:** Ten out of fifteen countries in the Western African region have constitutional provisions on health: Benin, Burkina Faso, Cape Verde, Guinea, Mali, Niger, Nigeria, Senegal, Sierra Leone and Togo. The constitutions of Côte d'Ivoire, The Gambia and Liberia have provisions that speak to the right to health care and medical services. The Constitution of Ghana protects the right to health in the context of employment and the right to work in healthy conditions but does not have a provision that refers to all citizens. None of the countries' constitutions includes language that enshrines the right to SRH. Similarly, no provisions were found specifically addressing family planning. Although not addressing family planning services specifically, the constitutions of Nigeria and Sierra Leone, respectively, include provisions whereby the state shall commit its policy towards ensuring there are adequate medical and health facilities.

**Statutory law on reproductive health:** Benin, Burkina Faso, Guinea, Mali, Senegal and Togo have all enacted legislation on reproductive health. Côte d'Ivoire is in the process of adopting such a law.

**Legal guarantees to safe abortion:** All countries in the region, except for Guinea-Bissau and Senegal, allow abortion when the life of the mother is in danger. Senegal has one of the most restrictive abortion laws in Western Africa, despite ratifying the Maputo Protocol. In fact, the country's abortion law is also unclear: the Criminal Code prohibits pregnancy termination but the Code of Medical Ethics allows an abortion if three doctors testify that the procedure is necessary to save a pregnant woman's life.<sup>35, 36</sup> Côte d'Ivoire also has restrictive abortion laws: the Penal Code states abortion is not illegal if it is required to save a woman's life. Nigeria and Niger also only provide one grounds for accessing safe abortion—when the health of the mother is threatened. Although abortion is not allowed in Guinea-Bissau, the law does not seem to be enforced and the practice is quite liberal. Nigeria has two abortion laws, one for the northern states and one for the southern states. One key difference between the two is that in the southern states abortion is allowed if a pregnancy poses a threat to the mental or physical health of the mother; in the northern states abortion is only allowed to save the life of a woman.

Eight countries in total allow safe abortion under this circumstance of endangered mother's health; and all except Togo refer to both physical and mental health in this respect. Five countries allow for abortion in the case of foetal impairment. Another eight provide sexual assault, rape or incest as grounds for accessing safe abortion. Legal guarantees to accessing safe abortion as articulated in the Maputo Protocol and General Comment No. 2 are in place in Burkina Faso, Cape Verde, Ghana, Liberia and Togo. Those in Ghana and Cape Verde are more liberal than those in the Maputo Protocol. In Ghana, abortion is also allowed when the age of the woman or incapacity to care for the child is an issue. Cape Verde has no restrictions as to reason for accessing safe abortion.

**Policy and institutional reforms on reproductive rights:** The right to control family planning and access to contraceptives is primarily addressed through government policies and programmes. Burkina Faso, Cape Verde, Côte d'Ivoire, Ghana, Liberia, Mali, Niger and Togo have adopted policies and programmes specially focusing on family planning and reproductive health. All countries with the exception of Cape Verde have launched a CARMMA campaign.

35 In addition to the cases above, abortion is permitted when the woman's age is an issue and in incapacity to care for the child.

36 Art. 15 of the 2010 Constitution: 'Each one has the right to health and to the physical well-being. The State has the duty to promote them, to fight against the epidemics and the social calamities.'

37 The Portuguese law forbidding abortion has not been repealed; however, it is not enforced and abortion is largely tolerated.

38 Indication for abortion to save women's life by interpreting 'general principles of necessity'

39 Art. 8: 'The Republic shall direct its policy towards ensuring for all citizens, without discrimination, opportunities for employment and livelihood under just and humane conditions, and towards promoting safety, health and welfare facilities in employment.'

40 Art. 16 of the 1992 Constitution: 'Education, instruction, formation, work, housing, leisure, health, and social protection shall constitute recognized rights.'

41 Section 17 of the 1999 Constitution: '(3) The State shall direct its policy towards ensuring that- c) the health, safety and welfare of all persons in employment are safeguarded and not endangered or abused; (d) there are adequate medical and health facilities for all persons.'

42 According to Abortion Policies: A Global Review, published by the UN, Nigeria has two abortion laws: one for the northern states and one for the southern states. Both specifically allow abortions to be performed to save the life of the woman. In addition, in the southern states, the holding of *Rex v. Bourne* is applied, which allows abortions to be performed for physical and mental health reasons.

43 Art. 13 of the Constitution: 'Every person has the right to enjoy the best state of physical and moral health.'

44 Art. 8: 'The Republic of Senegal guarantees to all citizens their individual fundamental freedoms such as the right to health.'

45 The country's Criminal Code completely prohibits pregnancy termination; the Code of Medical Ethics allows an abortion if three doctors testify that the procedure is necessary to save a pregnant woman's life.

46 Indication for abortion to save women's life by interpreting 'general principles of necessity'

47 While the Constitution does not mention the right to health, it does under Art. 8 (3) stipulate that 'The state shall direct its policy towards ensuring there are adequate medical and health facilities.'

48 The 2015 Safe Abortion Act was passed in December 2015 by Parliament; however, it has been blocked since then at the State House. The law would give new hope for women and girls by changing the 150-year old colonial 1861 Abortion Law to allow the termination of a pregnancy under any circumstances up to 12 weeks. Furthermore, it would allow abortion in cases of incest, rape and foetal impairment up to 24 weeks.

49 Art. 2 of the Safe Abortion Act 2015 stipulates that abortion services may be also provided on felonious intercourse. This law has been passed by Parliament, but has not been signed by the President.

50 According to Art. 34 of the Constitution, the state recognises citizens' right to health and works to promote it.



Many initiatives have been taken by various governments across the region to improve access to SRH services. In Côte d'Ivoire, the government states in its Implementation Plan for Family Planning, 2015–20 a goal to increase the contraceptive prevalence rate, budgeting 400 million FCFA for the purchase of contraceptives for 2018 to allow people access to these in health centres. The plan also seeks to address demand for family planning services. Niger has adopted a Family Planning Action Plan 2012–20 and Liberia intends to scale up family planning services across the country. In Côte d'Ivoire, four out of the sixteen mobile clinics in place are intended for family planning. Niger also has established mobile clinics throughout the country, thus expanding access to such services.

The Nigerian government has made a commitment of a minimum **budgetary** allocation of 15% to health care with the aim of implementing free health services for vulnerable groups of the population, especially women during pregnancy. The two countries in the region where government funding for health is greater than 5% of the country's GDP are The Gambia and Sierra Leone. The Gambia is the only country that has reached the 15% of the government budget target; another four countries are making progress towards this (Burkina Faso, Cape Verde, Liberia and Sierra Leone).

Ghana, Niger, Nigeria and Sierra Leone have adopted policies and plans that specifically address the health of **adolescents**. Nigeria has adopted the National Strategic Framework on the Health and Development of Adolescents and Young People 2007–11. Sierra Leone has established the National Secretariat for the Reduction of Teenage Pregnancy. Both Ghana and Niger have adopted plans that specifically address adolescent reproductive health. Ghana has integrated CSE into mainstream mandatory subjects in its primary and secondary education curricula, and the quality of this CSE meets standardised benchmarks.<sup>lxiii</sup> In addition, it has been reported that Côte d'Ivoire provides CSE in primary and secondary education, meeting standardised benchmarks, although it is not known whether this is mandatory and in an integrated or stand-alone way.<sup>lxiv</sup>

Niger adopted the National Plan for Adolescent Sexual and Reproductive Health in 2011. This stands out in many ways. It focuses on four areas: improving access to information; access to and use of health services; promoting an environment supportive of adolescent and youth health; and improving management of operations targeting adolescents.<sup>lxv</sup> It is also worth noting that Niger has an emphasis on integrating family planning in the school health curriculum and sexuality and family planning in the secondary curriculum. In Niger, the age of sexual consent for different-sex sexual acts is set at 13.<sup>51, lxvi</sup>

## Key gaps and contestations

A first gap is that none of the countries in the Western region has either constitutional or statutory provisions on women's right to reproductive health or rights. With respect to the right to decide and control the size of the family, in none of the countries surveyed was this right enshrined in the Constitution. Family planning and access to contraceptives is primarily conducted through programmes and policies, but the rights perspective of these is hard to establish.

In 10 of the 15 countries in the region, the **legal guarantees for accessing safe abortion** are not in line with the grounds provided for in the Maputo Protocol and General Comment No. 2. Most countries have provisions on abortion in their **penal or criminal code**, and this frames access to abortion in the context of criminality, rather than under a human rights perspective. In cases of sexual assault, rape or incest, most countries do not allow for abortion.

While in some countries abortion laws are being reviewed, the process of adopting these sometimes gets stuck. In Sierra Leone, the president has refused to sign the 2015 Safe Abortion Act into law. The law was unanimously passed by Parliament in 2015, with no opposition votes. This would have allowed women to terminate a pregnancy in any circumstances up to 12 weeks and in cases of incest, rape and foetal impairment up to 24 weeks.<sup>lxvii</sup> The president refused to sign the bill in 2016, and again in 2017.

From the desk review, it is unclear to what extent the policies and plans include **safe abortion care and post-abortion care**, or, if they do, to what extent these meet the needs of women and girls in all areas of the countries under review. Safe abortion care and post-abortion care should play an important role in addressing access to and use of family planning and reproductive health services.

Although there are institutional mechanisms and bodies addressing women and children, all countries would gain from investing in mechanisms that address **adolescent girls and youth** with respect to SRHR. Moreover, countries need to develop policies and action plans that specifically address the right and access to contraceptives. These need to take into account particularly vulnerable areas and women and girls. Only a few countries have taken steps to include family planning in school curricula, which means youth and adolescents often have limited access to information that could potentially reduce the incidence of adolescent pregnancies.

<sup>51</sup> This study could not obtain consistent information on the age of sexual consent for the other countries in Western Africa, except for Mali, where it is reported to be 15 (see IPPF. 2017. 'Sexual Rights, Young People and the Law').

## 7.3.2 Eastern region

### Trends, gaps and challenges

The legal and policy frameworks on reproductive rights in the Eastern region show fairly similar profiles across the countries, with some notable exceptions. Regarding constitutional provisions on health, joining the CARMMA campaign and government health spending, eight countries have two positive scores, mostly on the first two indicators. South Sudan, Sudan and Tanzania score positively on only one of the four indicators. Ethiopia is the only country that scores positively on three indicators.

The legal framework provisions on legal guarantees to access safe abortion are relatively strong. Kenya and Uganda have legal guarantees in line with the Maputo Protocol. So do Ethiopia and Rwanda, which have the strongest provisions, including all grounds provided in the Maputo Protocol, as well as additional circumstances. The most restrictive provisions are found in Somalia and South Sudan, where safe abortion is only allowed if the life of the mother is threatened. There are no countries in the Eastern African region where abortion is completely prohibited.

**Table 7.11. Key legal and policy indicators in Eastern Africa, reproductive rights and SRH**

Country	INDICATORS					Legal access to safe abortion in specified circumstances				
	Constitutional provision on health	Joined/ launched CARMMA campaign	Government funding for health >5% of GDP	Government funding for health >15% of general government expenditure		When the life of the mother is threatened	When pregnancy poses threat to mental or physical health of mother	In cases of foetal impairment	In cases of sexual assault, rape or incest	Allowed under other circumstances
Burundi	Yes	Yes	No	No*	Yes	H	No	No	No	-
Djibouti	No	Yes	Yes	No*	Yes	H	No	No	No	-
Ethiopia	Yes <sup>52</sup>	Yes	No	Yes	Yes	H	Yes	Yes	Yes	Yes <sup>53</sup>
Eritrea	Yes <sup>54</sup>	Yes	No	No	Yes	PH + MH	No	Yes	Yes	Yes <sup>55</sup>
Kenya	Yes*	Yes	No	No*	Yes	H	Yes	Yes	Yes	-
Rwanda	Yes	Yes	No	No	Yes	H	Yes	Yes	Yes	Yes <sup>56</sup>
Somalia	Yes <sup>57</sup>	Yes	-	-	Yes	No	No	No	No	-
Sudan	Yes <sup>58</sup>	No	No	No*	Yes	No	No	No	Yes	-
South Sudan	Yes <sup>59</sup>	No	-	-	Yes	No	No	No	No	-
Tanzania	No	Yes	No	No*	Yes	H	No	No	No	-
Uganda	Yes <sup>60</sup>	Yes	No	No*	Yes	H	Yes	Yes	Yes	-

<sup>52</sup> Women have the right to maternity leave with full pay and the right to access family planning education, information and capacity. In addition, the state has an obligation to allocate increasing resources to public health.

<sup>53</sup> Abortion also permitted on other grounds such as woman's age and capacity to care for a child.

<sup>54</sup> Art. 21(1): 'Every citizen shall have the right of equal access to publicly funded social services. The State shall endeavor, within the limit of its resources, to make available to all citizens health, education, cultural and other social services.'

<sup>55</sup> Abortion also permitted on other grounds such as woman's age and capacity to care for a child.

<sup>56</sup> Abortion also permitted on other grounds such as woman's age and capacity to care for a child.

<sup>57</sup> Art. 27(2): 'Every person has the right to healthcare, and no one may be denied emergency healthcare for any reason, including lack of economic capability.'

<sup>58</sup> Art. 19: 'The State shall promote public health and guarantee equal access and free primary health care to all citizens' and Art. 46: 'The State shall promote public health, establish, rehabilitate, develop basic medical and diagnostic institutions, provide free primary health care and emergency services for all citizens.'

<sup>59</sup> Art. 31: 'All levels of government shall promote public health, establish, rehabilitate and develop basic medical and diagnostic institutions and provide free primary health care and emergency services for all citizens.'

<sup>60</sup> Art XX: 'The State shall take all practical measures to ensure the provision of basic medical services to the population.'



**Trends in legal, policy and institutional reform**

**Constitutional provisions:** Nine of the twelve countries in the Eastern region have constitutional provision on the right to health. Djibouti and Tanzania lack such a provision. Ethiopia's Constitution does not stipulate a general right to health but articulates specific related rights: women have the right to maternity leave with full pay and to access family planning education, information and capacity. In addition, the state has an obligation to allocate increasing resources to public health. Kenya is the only country that has a constitutional provision that specifically articulates the right to reproductive health.

The constitutions of Eritrea, Ethiopia, Rwanda, Somalia, South Sudan, Sudan and Uganda outline the right to access publicly funded social and health services. All states have constitutional provisions that may be referred to in making the case for the right to contraceptives. These provisions concern the need to respect the rights and liberties of all persons, through equality and non-discrimination on the basis of sex or any other status before the law. Kenya and Somalia have provisions in their constitutions regarding access to safe abortion care (see below).

**Statutory law on reproductive health:** Most states do not have laws that specifically elucidate on the right to contraceptives. Kenya has a Health Act that covers the right to reproductive health care, which includes the right to safe, effective, affordable and acceptable family planning services.

**Legal guarantees to safe abortion:** The constitutions of Kenya and Somalia explicitly outline the right to safe abortion care. Art. 26(4) in Kenya's Constitution outlines broad legal indications with regard to safe and post-abortion care where this is necessary in the opinion of a trained health professional, in emergency situations and where the life or health of the mother is in danger, or if permitted in any other written law. The constitutional provision in Somalia is more restrictive. Art. 15(4) states that abortion is contrary to Shari'ah and is prohibited unless necessary, to save the mother's life. All other countries in the region have constitutional provisions that can be utilised to make the case for access to safe abortion care (Burundi, Djibouti, Eritrea, Ethiopia, Kenya, Rwanda, Somalia, South Sudan, Sudan, Tanzania and Uganda).<sup>61</sup>

All countries have statutory laws that outline the legal indications for the provision of and access to safe abortion and post-abortion care services. These are either within the penal code (all states) or in laws specifically dedicated to health-related services (Djibouti, Kenya). They cover when a woman can access services, who can provide such services and penalties for non-compliance with the law. Access to safe abortion is allowed in all countries in the Eastern region when the life of the mother is endangered. In Somalia and South Sudan this is the only grounds for abortion. The other 10 countries allow abortion on one of the other legal guarantees. In nine countries, abortion can be accessed when the pregnancy poses a risk to the health of the mother. Eritrea explicitly mentions both physical and mental health in this respect. Sudan, together with Somalia and South Sudan, does not allow abortion when the health of the mother is threatened. Four countries allow abortion in cases of foetal impairment. Sexual assault, rape or incest is provided as a grounds for abortion in six countries: Eritrea, Ethiopia, Kenya, Rwanda, Sudan and Uganda. In three countries, the woman's age and capacity to care for a child is a reason for permitting abortion (Eritrea, Ethiopia and Kenya).

States that make mention of addressing unsafe abortion in national health policies include Eritrea (Health Sector Strategic Development Plan 2010–14) and Kenya (National Adolescent Sexual and Reproductive Health Rights Policy 2015; National Guidelines for Quality Obstetrics and Perinatal Care and National Guidelines on Management of Sexual Offences 2014). States that have specific policies and procedures that relate to post-abortion care include Ethiopia, Kenya, Tanzania and Uganda.

Ethiopia is the only state reviewed that has guidelines specifically dedicated to comprehensive safe abortion care services. Kenya adopted specific standards and guidelines in 2013 but senior government officials un-procedurally withdrew these in early 2014. Uganda developed National Standards and Guidelines for Reducing Maternal Morbidity and Mortality from Unsafe Abortion in Uganda in 2015; these suffered the same fate as the Kenyan guidelines.

**Policy and institutional reforms on reproductive rights:** Ten countries have policy instruments that touch on family planning, specifically meeting unmet need: Burundi, Eritrea, Ethiopia, Kenya, Rwanda, Somalia, South Sudan, Sudan, Tanzania and Uganda. The desk-based research did not reveal any policy instrument in Djibouti that is specific to family planning.

<sup>61</sup> These constitutional provisions touch on, *inter alia*, the need to respect the rights and liberties of all persons, through equality and non-discrimination on the basis of sex or any other status before the law, the right to health, including access to emergency treatment, and the right to be free from inhuman, cruel and/or degrading treatment.

Policy frameworks specifically targeting *adolescents* with respect to family planning are present in Djibouti (Health Sector Strategic Plan 2010–14); Ethiopia (National Adolescent and Youth Health Strategy 2007–15); Kenya (National Adolescent Sexual and Reproductive Health Rights Policy 2015); South Sudan (Health Sector Development Plan 2011–15); and Tanzania (National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child and Adolescent Health 2016–20). For young people to access SRH services and information, these services need to be youth-friendly. Guidelines and/or standards for adolescent- and youth-friendly health services are present in Burundi, Ethiopia, Kenya, Rwanda, Tanzania and Uganda, and these countries all offer a standard minimum package of SRH services that should be provided to youth and adolescents. It is reported that Eritrea has draft guidelines, but it is not known whether these have been adopted yet.<sup>lxviii</sup>

Access of adolescents to SRH services and information can further be affected by the legal age of sexual consent. Many countries in Eastern Africa set the minimum age of consent to different-sex sexual activity at 18 for both girls and boys (Burundi, Eritrea, Ethiopia, Kenya, Rwanda, South Sudan, Uganda). In some countries, this minimum age is lower for girls than for boys. For example, in Tanzania, girls can consent to sexual activity at 15, whereas boys can consent at 18.<sup>lxix</sup> Provisions on the age of sexual consent are often articulated with reference to sexual defilement or rape; although such provisions protect young people from non-consensual sex, exploitation and abuse, they may restrict their expression of their sexuality and their ability to access SRH services.<sup>lxx</sup> Information regarding such laws in Djibouti, Somalia and Sudan was not found.

Of the seven Eastern African region countries that are part of the ESA Commitment, Burundi, Tanzania, Kenya and Uganda report that CSE is provided in at least 40% of primary and secondary schools. All seven, so also including Ethiopia, Rwanda and South Sudan, report having CSE training programmes for teachers.<sup>62, lxxi</sup> A national CSE policy has been reported to be in place in Burundi, Ethiopia, Kenya, Tanzania and Uganda.<sup>lxxii</sup> CSE is provided in an integrated way in mandatory subjects in primary and secondary curricula and according to benchmarked standards in Ethiopia, Tanzania and Uganda. Its provision is in progress in Burundi, Kenya and Rwanda.<sup>lxxiii</sup> Burundi, Kenya, Rwanda, South Sudan, Tanzania and Uganda have developed national policies and/or strategies related to CSE for out-of-school youth.<sup>lxxiv</sup>

With respect to contraception, innovation and progress in policy and institutional reforms has been observed in different countries. The Ministry of Health in Tanzania has established a Reproductive and Child Health Section, which is tasked with implementing reproductive health commitments. In Burundi, the Ministry of Health formulated a Technology Reference Manual in 2013 to increase the quality of access to contraceptives.

Nine countries (not South Sudan and Sudan) have joined and launched a CARMMA campaign. Somalia made commitments at the July 2017 Global Family Planning 2020 Commitment Conference to formulate laws, policies and frameworks linked to reproductive health including family planning by 2020. Somalia also committed to addressing barriers that relate to reproductive health in line with CARMMA. These are significant steps for a state in which a history of conflict has had a debilitating effect on socioeconomic progress.

Djibouti is the only country where government *spending* on health is higher than 5% of GDP. Ethiopia is the only country that reaches the target of health expenditure at 15% of the government budget; Burundi, Djibouti, Kenya, Sudan, Tanzania and Uganda are reported to be making progress in this regard. In terms of costing implementation plans, Kenya is set to launch a costed family planning policy in line with the Global Family Planning 2020 Commitment. South Sudan intends to have a dedicated budget line of 1% in the Ministry of Health budget in 2017/18.

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<sup>62</sup> Djibouti, Eritrea, Somalia and Sudan are not part of the ESA Commitment.

## Key gaps and contestations

With respect to legal guarantees for access to safe abortion, a first concern is that abortion laws are mostly **outlined in countries' penal or criminal codes**. This indicates that the right is not framed using a human rights perspective. Rather, the allowed grounds, such as to save a mother's life or health, are premised within the strictures of criminality; this contributes to increasing stigma on access to and provision of safe abortion care, on the basis that, from the onset, the service is viewed as illegal. This framing also risks driving access underground, potentially leading to unsafe practices.

Another gap is the **absence of safe abortion care standards and guidelines**. With the exception of Ethiopia, no state has specific standards and guidelines exclusively dedicated to safe abortion care provision. The withdrawal or stalling of SAC/PAC guidelines in, for instance, Kenya and Uganda obstructs implementation of existing law and can restrict women and girls' access to safe abortion even when the law permits it. No specific measures with regard to policy and institutional reform were identified with respect to Sudan.

A key contestation with regard to domestication and implementation of the Maputo Protocol provisions on safe abortion are the **constraints that some religious actors put on legal, policy and institutional reforms**. This is what has happened in Kenya: inclusion of provisions on abortion in the 2010 Constitution was a contentious issue, which meant Art. 26 was drafted in such a way as to appeal to both pro-life and pro-choice advocates. This has led to a lack of clarity among state and non-state actors on the legality of abortion in Kenya. Religious influence is also evident in the wording of Art. 15(4) of Somalia's Constitution, which clearly states that abortion is outlawed in line with Shari'ah except where necessary to save a woman's life.

A final contestation in abortion law and practice is the variance between what the law provides for and its actual **implementation**. In Sudan, the consent of a third party is not necessary to perform a safe abortion care service, but in practice doctors tend to seek the consent of a male guardian or spouse, thus infringing on women and girls' right to bodily autonomy.

### 7.3.3 Central region

#### Trends, gaps and challenges

National legal and policy frameworks on reproductive rights in Central region show quite some variation. Regarding the four indicators on constitutional provisions on health, joining the CARMMA campaign and government health expenditure, none of the countries score red on all three indicators. Angola and Congo Republic stand out with three positive scores. Burundi, CAR, DRC, Gabon, Equatorial Guinea and Rwanda score positively on constitutional provisions and the CARMMA campaign.

There are large variations between the countries in terms of legal guarantees to access safe abortion provided in national legal and policy frameworks. Rwanda provides for access to safe abortion under all five conditions specified. CAR, Chad and São Tomé and Príncipe allow access to safe abortion under all grounds articulated in the Maputo Protocol and General Comment No. 2. At the other end of the spectrum, Congo Republic and DRC have highly restrictive legal frameworks and do not allow for access to safe abortion. Gabon also has restricted legal guarantees, and provides access to safe abortion only when the life of the mother is endangered.

**Table 7.12. Key legal and policy indicators in Central Africa, reproductive rights and SRH**

Country	INDICATORS								
	Constitutional provision on health	Joined/ launched CARMMA campaign	Government funding for health >5% of GDP	Government funding for health >15% of general government expenditure	Legal access to safe abortion in specified circumstances				
					When the life of the mother is threatened	When pregnancy poses threat to mental or physical health of mother	In cases of foetal impairment	In cases of sexual assault, rape or incest	Allowed under other circumstances
Angola	Yes <sup>63</sup>	Yes	Yes	No	Yes	PH + MH <sup>64</sup>	Yes <sup>65</sup>	No <sup>66</sup>	No
Burundi	Yes	Yes	No	No*	Yes	H	No	No	-
Cameroon	No	Yes	No	No	Yes	H <sup>67</sup>	No	Yes	No
CAR	Yes <sup>68</sup>	Yes	No	No*	Yes	H <sup>69</sup>	Yes	Yes	No
Chad	No	Yes	No	No	Yes	PH + MH	Yes	Yes	No
Congo Republic	Yes <sup>70</sup>	Yes	Yes	No	No <sup>71</sup>	No	No	No	No
DRC	Yes <sup>72</sup>	Yes	No	No*	No <sup>73</sup>	No	No	No	No
Gabon	Yes	Yes	No	No	Yes <sup>74</sup>	No	No	No	No
Guinea Equatorial	Yes <sup>75</sup>	Yes	No	No	Yes	H <sup>76</sup>	No	No	No
Rwanda	Yes	Yes	No	No	Yes	H	Yes	Yes	Yes <sup>77</sup>
São Tomé and Príncipe	Yes <sup>78</sup>	No <sup>79</sup>	No	No*	Yes	PH + MH	Yes	Yes	No

<sup>63</sup> Art. 21(f) provides 'To promote policies that will make primary health care universal and free'; Art. 77: 'The state shall promote and guarantee the measures needed to ensure the universal right to medical and health care, as well as the right to child care and maternity care, care in illness, disability, old age and in situations in which they are unable to work, in accordance with the law.'

<sup>64</sup> <http://srhr.org/abortion-policies/country/angola/>

<sup>65</sup> <http://srhr.org/abortion-policies/country/angola/>

<sup>66</sup> However, the Penal Code permits abortion in case of pregnancy as a result of crimes against freedom and sexual self-determination: <http://srhr.org/abortion-policies/country/angola/>

<sup>67</sup> Art. 339 of the Code Penal (2016) stipulates that, when the mother can be saved from a 'serious health risk', abortion is allowed.

<sup>68</sup> Art. 7 of the Constitution refers to 'physical and moral health of the family' and Art. 8 to the state obligation to provide the right to access health facilities and adequate medical treatment provided by trained professionals who have the necessary equipment.

<sup>69</sup> 'When a young pregnant girl is in serious distress' (Art. 79, Penal Code).

<sup>70</sup> Art. 36 of the Constitution: 'The State is the guarantor of public health. The State guarantees the right to establish private socio-sanitary facilities in conditions regulated by law.'

<sup>71</sup> Indication for abortion to save women's life by interpreting 'general principles of necessity'.

<sup>72</sup> Art. 53 provides that the state ensures the protection of the health of the population and Art. 42 protects youth against attacks on their health.

<sup>73</sup> Indication for abortion to save women's life by interpreting 'general principles of necessity'.

<sup>74</sup> The Penal Code (1963) prohibits this altogether with no explicit legal exception to save the life of a woman (Guttmacher Institute. 2016. 'Abortion in Africa'. Fact Sheet). But criminal law stipulates that it is permitted when the life of a woman is in danger ([www.un.org/esa/population/publications/abortion/doc/gabon.doc](http://www.un.org/esa/population/publications/abortion/doc/gabon.doc)).

<sup>75</sup> Art. 23 of the Constitution refers to the responsibility of the state to promote primary health care.

### *Trends in legal, policy and institutional reform*

**Constitutional provisions:** Nine of the eleven countries in the Central region have constitutional provisions on health. Reproductive health is not mentioned explicitly in any of the constitutions but the constitutions of CAR and Congo Republic provide, respectively, for the protection of the health of the family and of mothers and children's rights. The Constitution of Chad has a broad provision on the state's responsibility to protect women's rights in the public and private sphere, which could include health rights.

The constitutions of CAR and Equatorial Guinea explicitly refer to the state obligation to promote or provide health care, which could include reproductive health care. All states have constitutional provisions that may be referred to in making the case for the right to contraceptives and reproductive health information and services. These provisions concern the right to health protection (e.g. São Tomé and Príncipe), promote and respect the (personal, social) rights and liberties of (all) persons (e.g. São Tomé and Príncipe), equality between men and women (e.g. Chad) and non-discrimination on the basis of sex or any other status before the law (e.g. Chad, DRC).

**Statutory law on reproductive health:** Five countries have adopted *reproductive health acts*: Cameroon in 1980, Chad in 2002 (not yet endorsed), CAR in 2006, Equatorial Guinea in 2007 and Rwanda in 2016. In Cameroon and Chad, these have replaced the 1920 French law prohibiting incitement to abortion and contraceptive propaganda. Both CAR and Chad have integrated rights as defined in the Maputo Protocol, including the right to decide whether to have children, the number of children and the spacing of children, the right to choose a method of family planning and the right to access affordable, acceptable and efficient health services. The Rwandan Reproductive Health Act has general provisions on the right to decide on reproductive matters and family planning but does not address family planning methods, contraceptives, sexuality education or safe abortion. All five acts also provide for the protection of the right to equal treatment and non-discrimination regarding reproductive health. CAR includes an article that obliges the state to propose and make available all legal contraceptive methods. A reproductive health and family planning act is in proposal stage in DRC, as part of the recent (2012) turning point in the government's support for family planning.<sup>76,77</sup>

Regarding *access to information and education on reproductive health and access to contraceptives*, some countries prohibit the publication and distribution of information on contraceptives or on abortion (Cameroon, Congo Republic) or restrict the sale of prescription medications and contraceptive products (Cameroon, DRC). A 1969 ordinance in Gabon stipulates that contraceptives can be obtained only through prescription when the women's health is in danger by a further pregnancy or when the well-being of the family requires it. The decision to prescribe contraceptives may be made only by a commission of three physicians.

**Legal guarantees to safe abortion:** In Congo Republic and DRC, safe abortion is prohibited altogether and can be accessed only on the grounds of necessity. All the other countries in the Central region allow abortion to save the life of a woman. For Gabon, this is the only circumstance where access to safe abortion is permitted. Burundi, Cameroon and Equatorial Guinea also allow for safe abortion when the health of the mother is threatened. So do Angola, CAR, Chad, Rwanda and São Tomé and Príncipe, which in addition provide for it in case of foetal impairment. Angola, Chad and São Tomé and Príncipe explicitly refer to both physical and mental health of the mother. Whereas Cameroon does not articulate the life of the mother as grounds for accessing safe abortion, it does allow abortion when the health of the mother is in danger, and in cases of sexual assault, rape or incest. Five countries in the Central region provide for access to safe abortion in cases of sexual assault, rape or incest: Cameroon, CAR, Chad, Rwanda and São Tomé and Príncipe. Most countries in their penal codes (e.g. CAR, Chad, Equatorial Guinea, São Tomé and Príncipe) explicitly require (authorised) doctors or specialised health professionals to provide abortion services.

<sup>76</sup> Guttmacher Institute. (2016). 'Abortion in Africa'. Fact Sheet.

<sup>77</sup> Abortion is also permitted on other grounds such as woman's age and capacity to care for a child. Another grounds mentioned in the Penal Code (2012) is forced marriage (Art. 165).

<sup>78</sup> Formulated in Art. 50 of the Constitution: 'All have the right to health protection and the duty to defend it.'

<sup>79</sup> São Tomé and Príncipe is listed as 'other' on the CARMMA scorecard.

An interesting trend is that countries that have recently revised their penal code (Cameroon, CAR, Chad, São Tomé and Príncipe) have included rape, incest and sexual aggression as reasons to allow abortion. Countries with older legislation, such as Equatorial Guinea and Gabon, do not have this provision. CAR permits abortion for minors. São Tomé and Príncipe have reduced penalties for abortion when it is practised to avoid social ostracism.

**Policy frameworks and institutional mechanisms on reproductive rights:** Most strategic development plans, such as poverty reduction strategies, mention reproductive health or population control in relation to the SDGs and the demographic dividend. For example, Vision Burundi 2025 prioritises strategies to control population growth in the context of pressure on food security and land. This is translated in a National Accelerated Family Planning Action Plan 2015–20. The right to control family planning and access to contraceptives is primarily addressed through ministerial reproductive health policies or sub-sector policies and programmes such as on family planning (e.g. Burundi, Cameroon, DRC), strategies to secure the availability of contraceptives (e.g. Chad), condom policies (e.g. Rwanda), maternal, neonatal and infant health (all countries), strategies to address obstetric fistula (e.g. Cameroon, Chad, Gabon, Guinea Equatorial) and cervical cancer (Angola). CSE programmes and curricula are mostly integrated in primary and secondary education policies. In Cameroon, this is a mandatory and examinable subject. Chad has developed multiple operational plans, including family planning service norms and reproductive health communication plans.

This review has established that policy frameworks exist targeting *adolescents* and SRH in DRC and Gabon. Moreover, Rwanda is known for its efforts to achieve universal health coverage and Chad rolled out a health insurance system in 2015. DRC has guidelines/standards for adolescent- and youth-friendly health services in place.<sup>lxvii</sup> Age of sexual consent laws are set at 14 and 18 for girls and boys, respectively, in DRC.<sup>lxviii</sup> Age of sexual consent could not be established for most other countries in the region, except for Chad, where the legal age of sexual consent is 13 for different-sex sexual activity, and, by contrast, 21 for same-sex sexual activity.<sup>lxviii</sup> This difference of eight years in the minimum age of consent, which may be present in other countries as well, contributes to stigmatisation of same-sex sexual relations between young people and undermines their access to SRH information and services.

Angola and Congo Republic are the two countries in the Central region where government *funding* for health is more than 5% of GDP. No states in the region spend over 15% of general government expenditure on health. Burundi, CAR, DRC and São Tomé and Príncipe are, however, making progress in terms of reaching this target: 10–15% of general government expenditure is allocated to health in these countries.

## Key gaps and contestations

A first gap is that, in most countries, women and girls' reproductive rights, as articulated in the Maputo Protocol and General Comment No. 2, are **not explicitly reflected** in either constitutional provisions or statutory law. It is hard to assess to what extent they are reflected in national policy frameworks. CAR and Chad have explicit legal frameworks speaking to women and girls' reproductive rights. In addition to absence or weak domestication of women and girls' reproductive rights as provided in Maputo Protocol Art. 14, a second gap is that some countries actually have legal **restrictions on access to information on contraceptive methods** or on access to these products and services. A third gap is that adopted laws on reproductive health and rights are **not endorsed**, as is the case in Chad, whose Reproductive Health Act has not been endorsed since it was created in 2002.

A fourth gap is that few countries, except for CAR and Chad, explicitly prohibit **discrimination** in the area of sexual and reproductive health and reproductive rights. Chad, in its yet to be endorsed Reproductive Health Act, stipulates that 'All individuals have equal rights and dignity in the field of reproductive health without discrimination on the basis of age, gender, fortune, religion, ethnic origin, marital status or any other situation.' The latter may include grounds such as refugee status, disability or sexual orientation. None of the countries has legal provisions on non-discrimination of these groups. In its Reproductive Health Act, CAR includes an article stipulating the right to a satisfying and secure sex life for everyone. A contested issue in many countries is adolescent pregnancy and discrimination of girls in schools. Recently, Equatorial Guinea introduced the rule that adolescent girls must take a pregnancy test before enrolling in school; a positive result means no access to education.

A critical gap and contestation is the **prohibition or criminalisation of sexual orientation and same-sex relations**. These are found in some penal codes, often under a chapter on homosexuality or 'moral order'. For example, Cameroon (2016) and Chad (2017) criminalise same-sex intercourse in their new penal codes. Prior to the adoption of these laws, there were no legal restrictions on same-sex relations. CAR and Gabon prohibit sexual acts between people of the same sex. The penal codes of Congo Republic, Equatorial Guinea and São Tomé and Príncipe do not prohibit same-sex relations. Homosexuality is not illegal in Rwanda, and the government rejected moves to make it illegal in the revised Penal Code.<sup>lxxix</sup>

Multiple types of **restrictions regarding access to safe abortion** could provide barriers to the realisation of the right to safe abortion; this represents a sixth gap/contestation. These barriers include the need for third party authorisation, from one or more health care professionals (CAR, Chad, Equatorial Guinea, Gabon, Rwanda, São Tomé and Príncipe), an expert provided by the court (Gabon), the court (CAR, Chad, Rwanda)<sup>80</sup> the ministry (Chad) or the police (in the case of rape in São Tomé and Príncipe). There are also requirements for authorisation or consent from a woman's spouse or partner (Equatorial Guinea), or her guardian or parent if the woman is under age 16 (São Tomé and Príncipe), and prohibitive time limits within which abortion can be performed, for example eight weeks in CAR and twelve weeks in São Tomé and Príncipe.

A final gap relates to **contradictions and lack of harmonisation** between provisions on legal grounds for safe abortion in different laws within one country. For example, the 2006 Reproductive Health Act of CAR provides for other circumstances under which abortion is allowed than those in the Penal Code of 2010.<sup>81</sup> Similarly, Chad has a Medical Code of Conduct that provides different conditions for third party authorisation (a physician requires written approval of two other doctors, one of whom must be an expert on the list of the Civil Court) under which an abortion can be performed than those in the Penal Code (authorisation by the ministry) and the Reproductive Health Act (authorisation by an advisory group of doctors after advice from the court). Hence, even though Chad is one of the countries in the region with the most liberal abortion legislation, actual implementation may be severely hampered because of several legal restrictions and inconsistencies.

<sup>80</sup> In December 2017, the Rwandan Parliament passed a draft amendment to the Penal Code that takes out the requirement to have the court's approval. It would allow a woman and her doctor to decide among themselves whether or not to terminate a pregnancy. The amendment is waiting approval from the President. (Rwihira, R. 2018. 'Rwanda's Proposed Abortion Amendment Takes Procedure Out of the Courts')

<sup>81</sup> The provisions overlap but, in addition, the Reproductive Health Act allows abortion when the health of the woman is in danger. The Penal Code does not mention the health of the woman but permits abortion for young girls in serious distress.



### 7.3.4 Southern region

#### Trends, gaps and challenges

With respect to health and reproductive rights indicators, the Southern African countries show a mixed picture. Angola, Malawi, Lesotho and Swaziland score positively on constitutional provisions on the right to health, on launching a CARMMA campaign and on one or both of the health financing indicators. Mauritius scores negatively on all these three indicators. Three countries score positively only on CARMMA and not on the other three indicators (Botswana, Namibia, Tanzania). Eight countries have two positive scores, in all cases on the constitutional provision to right to health and CARMMA (Comoros, DRC, Madagascar, Mozambique, Seychelles, South Africa, Zambia and Zimbabwe).

Regarding legal guarantees to access safe abortion, there are large variations between the countries in the region. The most restrictive laws on abortion are in DRC (fully prohibited), and then Madagascar and Malawi, where abortion is permitted only to save the mother's life. At the other end of the spectrum, in total eight countries have provisions for safe abortion in line with the grounds articulated in the Maputo Protocol and General Comment No. 2. Of these eight, Mozambique, Seychelles and South Africa actually have broader provisions.

**Table 7.13. Key legal and policy indicators in Southern Africa, reproductive rights and SRH**

Country	INDICATORS								
	Constitutional provision on health	Joined/ launched CARMMA campaign	Government funding for health >5% of GDP	Government funding for health >15% of general government expenditure	Legal access to safe abortion under specified circumstances				
					When the life of the mother is threatened	When pregnancy poses threat to mental or physical health of mother	In cases of foetal impairment	In cases of sexual assault, rape or incest	Allowed under other circumstances
Angola	Yes <sup>82</sup>	Yes	Yes	No	Yes	PH + MH <sup>83</sup>	Yes <sup>83</sup>	No <sup>83</sup>	No
Botswana	No <sup>84</sup>	Yes	No	No	Yes	PH + MH	Yes	Yes	No
Comoros	Yes	Yes	No	No	Yes	H	No	No	-
DRC	Yes <sup>87</sup>	Yes	No	No*	No <sup>88</sup>	No	No	No	No
Lesotho	Yes	Yes	Yes	No*	Yes <sup>89</sup>	H	Yes	Yes	No
Madagascar	Yes	Yes	No	No*	Yes <sup>90</sup>	No	No	No	No
Malawi	Yes	Yes	Yes	Yes	Yes <sup>91</sup>	No	No	No	No
Mauritius <sup>92</sup>	No	No <sup>93</sup>	No	No	Yes	PH + MH	Yes	Yes <sup>94</sup>	No
Mozambique	Yes	Yes	No	No	Yes	PH + MH	Yes	Yes <sup>95</sup>	Yes
Namibia	No	Yes	No	No*	Yes	PH	Yes	Yes	No
Seychelles	Yes	Yes	No	No	Yes	PH + MH	Yes	Yes	Yes <sup>96</sup>
South Africa	Yes	Yes	No	No*	Yes	PH + MH	Yes	Yes	Yes <sup>97</sup>
Swaziland	Yes <sup>98</sup>	Yes	Yes	Yes	Yes <sup>99</sup>	MH	-	Yes	No
Tanzania	No	Yes	No	No*	Yes	H	No	No	-
Zambia	Yes <sup>100</sup>	Yes	No	No*	Yes	PH + MH	Yes	No	Yes <sup>101</sup>
Zimbabwe	Yes <sup>102</sup>	Yes	No	No	Yes	PH	Yes	Yes	No

<sup>82</sup> Art. 21(f) provides 'To promote policies that will make primary health care universal and free'; Art. 77: 'The state shall promote and guarantee the measures needed to ensure the universal right to medical and health care, as well as the right to child care and maternity care, care in illness, disability, old age and in situations in which they are unable to work, in accordance with the law.'

<sup>83</sup> <http://srhr.org/abortion-policies/country/angola/>

<sup>84</sup> <http://srhr.org/abortion-policies/country/angola/>

<sup>85</sup> However, the Penal Code permits abortion in case of pregnancy as a result of crimes against freedom and sexual self-determination: <http://srhr.org/abortion-policies/country/angola/>

<sup>86</sup> It provides for protection from conduct injurious to health.

<sup>87</sup> Art. 53 provides that the state ensures the protection of the health of the population and Art. 42 protects youth against attacks on their health.

<sup>88</sup> Indication for abortion to save women's life by interpreting 'general principles of necessity'.

<sup>89</sup> There is no abortion law in Lesotho, although under the Penal Code Act of 2010 abortion is considered an offence against a person.

<sup>90</sup> The Penal Code contains no exceptions to abortion but saving the life of a woman as a necessity can be used as a defence. (See <https://www.womenonwaves.org/en/page/6131/madagascar-abortion-law>).

<sup>91</sup> Section 243 of the Penal Code allows abortion under the circumstances of saving the mother's life.



The SADC Gender Protocol **Barometer 2017** highlights the fact that SADC continues to experience high rates of maternal mortality, largely because of unsafe abortion practices, adolescent pregnancies and limited health facilities. Art. 26 of the SADC Gender and Development Protocol requires member states to implement legislative frameworks to enhance gender-sensitive, appropriate and affordable quality health with particular regard to reducing the maternal mortality ratio by 75% by 2015 and to address the sexual and reproductive needs of men and women. The **SADC Sexual and Reproductive Health Strategy for the SADC Region 2006–15**, developed by SADC ministers of health and senior officials, entails the development of detailed programme and project plans and the monitoring of implementation on the priority areas in the strategy. The priority areas included HIV and AIDS and its integration with SRH services; active discouragement of harmful practices such as FGM; adolescent and youth SRH; prevention and management of GVAW; safe motherhood; and prevention of abortion and management of complications resulting from unsafe abortion.

### *Trends in legal, policy and institutional reform*

**Constitutional provisions:** Twelve countries of the fifteen in the Southern African region recognise the right to health (care) and/or access to health services in their constitutions: Angola, DRC, Comoros, Lesotho, Madagascar, Malawi, Mozambique, Seychelles, South Africa, Swaziland, Zambia and Zimbabwe. Swaziland and Zimbabwe have constitutional provisions with a bearing on reproduction, motherhood or childbirth. South Africa's Constitution specifically forbids discrimination on the basis of pregnancy, as well as on the grounds of sexual orientation, among others. Four countries have no constitutional provisions with respect to women's right to health.

**Statutory law on reproductive health:** The legal frameworks for health in general, and SRHR specifically, are not as well developed as for the other rights areas in this report. In addition to constitutional provisions, some countries have specific laws promoting reproductive health and rights and contraception. Madagascar has Law No. 2011-002 on the Health Code concerning maternal health, family planning and expanded access to the complete range of health services for youth. Malawi's Gender Equality Act 2013 deals with the right to SRH services, family planning and contraception, and the duties of health officers, among others. In addition, the labour legislation of most countries makes provision for maternity and paternity leave. Mauritius has the Employment Rights Act 2008 on maternity rights and the Sex Discrimination Act 2002 on dismissal on the grounds of pregnancy. Seychelles' Employment (Conditions of Employment) (Amendment) Regulations 2015 address maternity rights and leave.

**Legal guarantees to safe abortion:** The vast majority of countries in the region allow for abortion to save a mother's life. DRC is the only country where abortion is prohibited altogether, though saving the life of a woman as a necessity can be used as a defence. In Madagascar and Malawi, it is allowed only to save the life of the mother.<sup>92,93</sup>

Thirteen countries provide for access to safe abortion when the health of the mother is in danger. Seven of them specifically articulate both physical and mental health in this context. Namibia and Zimbabwe are the only two that only mention physical health. Swaziland, by contrast, explicitly refers only to mental health. In 10 countries, foetal impairment is grounds to access safe abortion. Sexual assault, rape or incest is grounds to access safe abortion in nine countries: Botswana, Lesotho, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland and Zimbabwe.

<sup>92</sup> The Criminal Code (Amendment) Act 2012 provides the grounds for an abortion.

<sup>93</sup> Mauritius is preparing to launch CARMMA.

<sup>94</sup> Or in the case of sexual intercourse with a female under the age of 16.

<sup>95</sup> Allowed in the first 12 weeks, except in the case of rape, where the legal period can extend to 16 weeks.

<sup>96</sup> A woman's age or capacity to care for the child is taken into consideration.

<sup>97</sup> Abortion is available on demand.

<sup>98</sup> The Constitution states in S 27(4) that 'Motherhood and childhood are entitled to special care and assistance by society and the State.' S 32(3): 'The employer of a female worker shall accord that worker protection before and after child birth in accordance with law.' Art. 32 of the Constitution requires Parliament to enact laws to provide for the right of persons to work under satisfactory, safe and healthy conditions. Art. 29 (1) also provides that a child has the right to be protected from engaging in work that constitutes a threat to the health, education or development of that child. Art. 60(8): 'Without compromising quality the State shall promote free and compulsory basic education for all and shall take all practical measures to ensure the provision of basic health care services to the population.'

<sup>99</sup> The Constitutional Amendment of 2005 in Section 15 (5) provides for the circumstances under which abortion is permitted 'on such other grounds as Parliament may prescribe'. Thus, for this section, all responses are based on constitutional provisions as there is no law to operationalise the Constitution yet.

<sup>100</sup> Art. 112(d) provides as follows: 'The State shall endeavour to provide clean and safe water, adequate medical and health facilities and decent shelter for all persons, and take measures to constantly improve such facilities and amenities.'

<sup>101</sup> For economic reasons.

<sup>102</sup> Art. 29(1) provides that 'The State must take all practical measures to ensure the provision of basic, accessible and adequate health services throughout Zimbabwe.' Art. 52 provides that 'Every person has the right to bodily and psychological integrity, which includes the right – subject to any other provision of this Constitution, to make decisions concerning reproduction.'

The eight countries where legal guarantees are in line with the provisions of the Maputo Protocol and General Comment No. 2 are Botswana, Lesotho, Mauritius, Mozambique, Namibia, Seychelles, South Africa and Zimbabwe. In three of these, the provisions are more liberal than those in the Maputo Protocol. In Seychelles, a woman's age or capacity to care for the child is taken into consideration in allowing for access to safe abortion. In Mozambique, the Amendment to the Penal Code Legalising Abortion allows for unrestricted pregnancy termination and only the period of pregnancy is taken into consideration. In South Africa, the Choice on Termination of Pregnancy Act 1996 as amended by the Choice on Termination of Pregnancy Amendment Act 2008 (Act 1 of 2008) allows for abortion on request. Zambia allows for safe abortion on four of the five indicators, but not in case of sexual assault, rape or incest.

**Policy and institutional reforms on reproductive rights:** Even without laws on the right to reproductive health, the right to choose contraception and related matters, countries have established diverse and multidimensional varieties of policies for safe motherhood, family planning and maternal health. Maternal mortality is being addressed as a matter of priority in all countries, even though it remains a big challenge in the region. For the most part, government approaches in tackling maternal mortality in the region are diverse, ranging from campaigns around safe motherhood, guidelines to health personnel, provision of information on health institutions, provision of free services and audit and review processes, among others. In this regard, SADC statistics reveal that two thirds of SADC member states have made strides in reducing the rate of maternal mortality.<sup>boxxi</sup> Fifteen countries have launched a CARMMA campaign, and Mauritius is preparing to launch one. Countries that have SRH policies include Lesotho, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland and Zambia.<sup>boxxii</sup> The desk-based research did not reveal any policy instrument in Comoros that is specific to family planning.

While most countries are yet to embrace a rights-based approach to SRH, a few are undertaking affirmative action measures to widen services to vulnerable women. Zimbabwe has abolished fees for low-income groups and availed contraceptives and condoms for the rural population through the primary health care system.<sup>boxxiii</sup> Angola's Constitution establishes primary health care and in 2003 a law established health services to be delivered at primary as well as secondary and tertiary level. In South Africa, 24-hour services for high-risk pregnancies, as well as District Clinical Specialist Teams, have been established in public hospitals as part of primary health care.<sup>boxxiv</sup> Swaziland has integrated its SRH services with primary health care. All these initiatives are important for increasing poor and vulnerable women's access to much-needed services.

Access to SRH services for youths and *adolescents* is a challenging area. Art. 11 of the SADC Gender and Development Protocol enjoins states to ensure that the boy and girl child have equal access to information, education, services and facilities on SRHR. Despite this, contentions around adolescents seeking services for contraceptive use abound in several countries, and they often need parental consent to obtain such services.

Malawi stands out in this regard with a law on the age of consent to SRH services set at 12 years.<sup>boxxv</sup> Similarly, in South Africa under Section 129 the Children's Act 2005, a child may consent to his or her medical treatment without parental consent, if the child has the mental capacity and sufficient maturity to understand the benefits, risks and social and other implications of the treatment. This includes treatment under the Choice of Termination of Pregnancy Act.

Twelve of the Southern Africa countries were included in the global review of CSE.<sup>103</sup> In Malawi, Namibia, Seychelles, South Africa and Swaziland, CSE is reportedly provided as a stand-alone subject in primary and secondary education; it is mandatory and its quality reflects benchmarked standards. In six countries, CSE is integrated into mandatory subjects in primary and secondary education; its quality reflects benchmarked standards in DRC, Lesotho, Tanzania and Zambia and is under review in Botswana and Mozambique. In Angola and Zimbabwe, provision of CSE is reported to be 'in progress'. All 12 countries have a national policy on CSE in place.<sup>boxxvi</sup>

The ESA Commitment has contributed to the scaling-up of quality CSE in Southern Africa.<sup>104</sup> All Southern African countries, except for Angola, Comoros, DRC and Madagascar, report providing CSE in at least 40% of primary and secondary schools. Angola, Botswana, DRC, Madagascar, Mauritius, Namibia, South Africa, Swaziland, Tanzania and Zambia have developed national policies and/or strategies related to CSE for out-of-school youth.

In addition, the ESA Commitment set out to increase youth's access to youth-friendly SRH services. This is because, even where such services exist, they are not always accessible in a manner that is user-friendly for adolescents. This raises the risk of low health- and information-seeking behaviour among this vulnerable group, and overall contraceptive use is still low in the region.<sup>boxxvii</sup> Across Southern Africa, Botswana, DRC, Lesotho, Madagascar, Malawi, Mozambique, Namibia, South Africa, Swaziland, Tanzania and Zambia have guidelines and/or standards in place for adolescent- and youth-friendly health service delivery. All these countries also offer a standard minimum package of services that should be provided to youth and adolescents.<sup>boxxviii</sup>

<sup>103</sup> Three countries in the region not included are Comoros, Madagascar and Mauritius.

<sup>104</sup> Comoros is the only country in the Southern African region, as demarcated in this report, that is not part of the ESA Commitment.

Four of the fifteen countries in the Southern region *spend* more than 5% of their GDP on health. Of these, Angola does not meet the 15% of government budget target on health expenditures and Lesotho is making progress in this regard. Swaziland and Malawi not only meet the 5% of GDP target but also are the only two countries in this region that meet the 15% of government budget target. In addition to Lesotho, six other countries are making progress towards the 15% target: DRC, Madagascar, Namibia, South Africa, Tanzania and Zambia. Seychelles and South Africa have increased their investments in health personnel, which has translated into steadily decreasing rates of maternal mortality.

### Key gaps and contestations

A first gap is that only a minority of the countries in the Southern region have **legal provisions on women and girls' reproductive rights**, either in the Constitution or in specific statutory law. In most countries, SRHR is addressed in policies and strategies that lack a sound rights-based approach. With a view to providing reproductive health services, Southern African countries have put a lot of effort and resources into addressing systemic issues around service delivery, skilling health care workers and commodities and infrastructure development. Less emphasis is evident on rights-based frameworks, approaches and discourses. At the **societal level**, conservative attitudes and sensitivities around gender and sex differentials affect access to much-needed services for women and girls. Control of women's sexuality and lack of control by women over reproductive functions cannot be delinked from gender inequality and exacerbates their vulnerability in the region.

A second gap relates to ambiguities around the **minimum age of consent to sexual activities** and how this affects access to SRH information, education and services. In most countries, the minimum age of consent is defined by criminal law relating to sexual offences against children. By 2017, ages of sexual consent in Southern Africa varied, ranging from 13 years (Comoros) to 14 (Madagascar, Namibia) to 16 (Botswana, Lesotho, Malawi, Mauritius, South Africa, Swaziland, Zambia, Zimbabwe) to 18 (Mozambique, Seychelles).<sup>lxviii</sup> In some cases, the minimum age of consent is lower for girls than for boys. In Angola and DRC, the minimum age is 18 for boys but 16 and 14 for girls, respectively. The age of sexual consent, as well as its framing in relation to sexual offences, has implications for young persons who engage in consensual sex and wish or need to access SRH services. Legal barriers, combined with societal norms and taboos, intimidate them from seeking contraceptives and other SRH services. Most countries lack a clear policy on the appropriate age to seek such services. For example, the age of consent for HIV testing in SADC ranges from 12 to 18 years, yet early sexual debut and adolescent pregnancy requires reviewing the circumstances and age under/at which children should be tested.<sup>xc</sup> Similarly, few countries have policies on the rights of adolescent girls and boys to access SRH services.<sup>xcii</sup> Malawi and South Africa stand out in this regard, as seen above.

In some countries, progress has been made in reducing MMRs. In Seychelles and South Africa, maternal mortality has been decreasing, and Mauritius has consistently had a low MMR. Botswana also has one of the lower rates in the Southern region. Such progress in the **reduction of maternal mortality** has not been observed in all countries. DRC and Malawi have the two highest MMRs in the region, at 693 and 634 per 100,000 live births, respectively.<sup>xcii</sup> The **barriers** noted in this regard in the region include long distances to health centres, hence low deliveries at the hands of health professionals; limited skilled human resources; low contraceptive use; and lack of emergency obstetric services, among many other challenges.<sup>xciii</sup>

A fourth challenge to realising women and girls' reproductive rights is that in most countries reproductive health is largely viewed as a woman's issue—even though men have a say in women's access to reproductive health services and use of contraceptives, as well as the number and spacing of children. The **involvement of men** in promoting maternal health care is gaining traction in government and civil society quarters in the region. One of the main actors in the region, the Men Engage platform, is a continental initiative that has a presence in Botswana, Lesotho, Madagascar and Malawi. It focuses on the role of men in engaging men and boys in SRHR; the emphasis is on generating new ideas about gender and masculinity and learning healthier ways to relate to each other. The country chapters organise and advocate around promoting gender equality goals and objectives and engaging communities and governments for legal reform and changing norms.<sup>xciv</sup>

Abortion is among the more polarising issues in the area of SRH, arising from moral, religious and cultural taboos. Left unregulated, (unsafe) abortion contributes significantly to high MMRs in the region. It is in the area of **abortion laws** that the most **reticence** is seen in countries implementing reproductive health programmes. For example, in 2017 the Angolan government proposed changes to the Penal Code that would criminalise abortion entirely. After this, hundreds of Angolans marched the streets of Luanda in protest.<sup>xcv</sup> Another critical concern that merits attention is the legal response to those who do perform unsafe abortions; this requires governments to enforce the law against these providers.

### 7.3.5 Northern region

#### Trends, gaps and challenges

Legal and policy frameworks on reproductive rights in the Northern region show some similarities among countries, as well as some strong contrasts. Two of the seven countries in the region have two positive scores on constitutional provisions on the right to health and launching a CARMMA campaign. Unlike the other regions on the African continent, a minority of the Northern countries have launched a CARMMA campaign. With respect to legal guarantees to access safe abortion, restrictive abortion laws in Egypt, Libya and Mauritania, and to a lesser extent in Algeria, stand in contrast with legal provisions in Morocco, and especially the liberal abortion law in Tunisia.

**Table 7.14. Key legal and policy indicators in Northern Africa, reproductive rights and SRH**

Country	INDICATORS								
	Constitutional provision on health	Joined/ launched CARMMA campaign	Government funding for health >5% of GDP	Government funding for health >15% of general government expenditure	Legal access to safe abortion in specified circumstances				
					When the life of the mother is threatened	When pregnancy poses threat to mental or physical health of mother	In cases of foetal impairment	In cases of sexual assault, rape or incest	Allowed under other circumstances
Algeria	No	No	Yes	No	Yes	PH + MH <sup>105</sup>	No	No	No
Egypt	Yes	No <sup>106</sup>	No	No	No <sup>107</sup>	No	No	No	No
Libya	Yes <sup>108</sup>	No	No	No	Yes <sup>109</sup>	No	No	No	No
Mauritania	Yes <sup>110,111</sup>	Yes	No	No	No <sup>112</sup>	No	No	No <sup>113</sup>	No
Morocco	Yes <sup>114</sup>	-	-	-	Yes	PH	Yes	Yes	No
Tunisia	Yes	Yes	No	No*	Yes	PH + MH	Yes	Yes	Yes <sup>115</sup>
Sahrawi African Republic	Yes	-	-	-	-	-	-	-	-

<sup>105</sup> For this and threats to the life to the child, abortion is subject to spousal consent and notification of the administrative authorities.

<sup>106</sup> Egypt announced in October 2015 that it would launch CARMMA; however, reports confirming the launch were not found: [www.carmma.org/event/egypt-launch-carmma](http://www.carmma.org/event/egypt-launch-carmma)

<sup>107</sup> In Egypt, the 'Penal Code does not expressly allow abortions to be performed to save the life of the woman, but the general principles of criminal legislation allow abortions to be performed for this reason on condition of necessity. In addition, the condition of necessity is sometimes interpreted in Egypt as encompassing cases where the pregnancy may cause serious risks to the health of the pregnant woman as well as cases of foetal impairment' (cited from [www.un.org/esa/population/publications/abortion/doc/egypts1.doc](http://www.un.org/esa/population/publications/abortion/doc/egypts1.doc)).

<sup>108</sup> In addition there is in place Health Law No. 106 of 1973.

<sup>109</sup> While the Penal Code 1953 forbids it, Health Law (Law No. 106/1973) allows for an abortion if the medical specialist deems it necessary to save the life of the pregnant woman.

<sup>110</sup> Constitution of Mauritania (1991 rev. 2012) Art. 19: 'The citizens enjoy the same rights and the same duties vis-à-vis the Nation. They participate equally in the construction [edification] of the Fatherland and have right, under the same conditions, to sustainable development and to an environment balanced and respectful of health.'

<sup>111</sup> Constitution of Mauritania 1991 (Rev.2012) Art. 57: '[The following] are of the domain of the law: nationality, the status and the capacity of the persons, marriage, divorce, and inheritance; the general rules related to education and health.'

<sup>112</sup> Abortion is mostly illegal in Mauritania; it is allowed to save a woman's life 'under general principles of necessity'.

<sup>113</sup> According to the UN, the government of Mauritania stated back in 1987 that abortion could be performed in case of rape or incest; however, there is no available legislation to back this claim to date.

<sup>114</sup> Constitution 2011 Art. 31: 'The State, the public establishments and the territorial collectivities work for the mobilization of all the means available [disponibles] to facilitate the equal access of the citizens [feminine] and the citizens [masculine] to conditions that permit their enjoyment of the right to healthcare; to social protection, to medical coverage and to the mutual or organized joint and several liability of the State.'

<sup>115</sup> Allowed without restriction as to reason.

*Trends in legal, policy and institutional reform*

**Constitutional provisions:** The constitutions of Egypt and Tunisia explicitly include the right to health. Libya, Morocco and Western Sahara have a constitutional provision on the right to health care and to medical care. None of the countries has constitutional provisions specific to reproductive rights. Most of the states reviewed have constitutional provisions on equality and non-discrimination on the basis of sex or gender, which can be utilised to make the case for reproductive rights, including contraception and access to safe abortion care. These states include Algeria, Egypt, Libya, Mauritania, Morocco and Tunisia.

**Statutory law on reproductive health:** Of the Northern African states, Mauritania is the only one that has a law specific to reproductive health. In 2016, after years of advocacy, the Council of Ministers approved a new text for the Reproductive Health Law. This recognises reproductive health care as a universal human right by providing access for women to reproductive health services such as modern contraceptive methods. The new law goes further to ban FGM and all forms of GVAW.<sup>xcvi</sup> Libya's Health Law also addresses reproductive rights and health aspects.

**Legal guarantees to safe abortion:** All states have statutory laws that outline permissible and prohibited legal indications for access to abortion services. These are mostly within countries' penal codes. Of the countries reviewed, only Morocco and Tunisia allow abortions under all the conditions envisaged by the Maputo Protocol in Art. 14(2)(c). In 2016, Morocco amended the Penal Code to allow abortion in cases of rape or incest. Tunisia in particular is of notable mention as it has had one of the most liberal abortion laws in Africa and globally since 1965, allowing access to safe abortion without restriction as to reason.

In Mauritania, despite it having ratified the Maputo Protocol, and in Egypt, the law does not explicitly allow abortions to be performed to save the life of the mother. Abortion can be allowed only to save the life of the woman 'under general principles of necessity'.<sup>xcvii</sup> Algeria, Morocco and Tunisia allow for safe abortion when the mental and/or physical health of the mother is threatened. Egypt, Libya and Mauritania do not allow abortion when the health of the mother is in danger. Tunisia and Morocco are the only countries where abortion is allowed in cases of foetal impairment, and in Egypt the condition of necessity is sometimes interpreted to allow for this. Four of the seven countries do not permit access to safe abortion in cases of sexual assault, rape or incest (Algeria, Egypt, Libya and Mauritania). According to the UN, Mauritania has made a statement that abortion is allowed in cases of rape/incest; however, to date, there is no evidence supporting the availability of the legislation.

**Policy and institutional reforms on reproductive rights:** Policies, strategies and institutional measures specific to contraception were observed for all states except Libya. Some countries are doing well with regard to access to contraception. For instance, Algeria, Egypt and Tunisia all record a contraceptive prevalence rate of at least 60%. Egypt and Tunisia have publicly funded (free or heavily subsidised) access to contraception,<sup>xcviii</sup> and this is possibly linked to their contraceptive prevalence rates. Tunisia in particular has had a national family planning programme since 1966. While the initial objective of this was population control, it later shifted its orientation to focus on maternal, child and family health care. In Algeria, reproductive health and family planning services are available widely. Women are free to determine their contraceptive measures autonomously, and many receive antenatal care and deliver in a public health facility. Algeria reduced its MMR from 523,000 in 1990 to 289,000 by 2015.<sup>xcix</sup>

In most of the Northern countries, there is no comprehensive strategy to include the package of essential reproductive services within the primary health care system, as is best practice. Mauritania is an exception, as it has various policies and strategies on reproductive health. One example, which illustrates this effort, is the National Reproductive Health Strategy Documents (1999–2002, 2003–10 and 2011–15), which made safe motherhood, family planning, youth and adolescent SRH a key priority.<sup>c</sup> The government provides family planning services and offers contraceptives free of charge.<sup>ci</sup> Efforts are being made to make SRH services, including family planning, accessible for adolescents, for example in strengthening the capacity of providers of such services. Yet unmarried women continue to experience lack of access, with health centres requiring consent of a husband from married women. In addition, the law stipulates that sex is allowed only within marriage, and consequently does not define an age of sexual consent. This further hampers access to SRH services for those who are unmarried.<sup>cii</sup>

Some of the states reviewed have launched a CARMMA campaign (Egypt, Mauritania and Tunisia). In terms of health *financing*, Algeria is the only country in the region that is reported to be meeting the target of 5% of GDP for health funding. Regarding the other health financing indicator, of health expenditures at more than 15% of the government budget, Tunisia has the most positive profile and is making progress towards reaching the Abuja target.

## Key gaps and contestations

A first gap, as in the other regions on the African continent, relates to **weak or absent legal provisions** about women's right to reproductive health and/or reproductive rights. These are not explicitly captured in constitutional provisions, and only one country (Mauritania) has a specific law to this effect. A second gap is that, in some countries, **access** to reproductive health services is limited; Mauritania has a particularly poor contraceptive prevalence rate, at just 9%.

A third and related gap is the requirement for **third party consent** for women to access SRH health services. In Libya, monitors observe that women have access to family planning and contraceptives although they must seek spousal consent prior to seeking such services.<sup>ciii</sup> A fourth gap is the **limited access of adolescents and young people** to SRH services. In Morocco, a key challenge for young people is that access to services is restricted to married couples, despite evidence of early sexual activity in the country. This restriction makes it hard for young people to control their reproductive health, given a lack of information and education on SRHR.

A fifth gap and contestation are the restrictive **abortion** laws in the region. These restrictions do not concern just the limited grounds on which women and girls can access safe abortion. In Egypt, the law poses a **further requirement** that three physicians must certify the existence of an accepted indication for the performance of the abortion. The **husband's consent** is also required. These requirements are in contrast with the provisions in the Maputo Protocol and General Comment No. 2, and make access to safe abortion in Egypt extremely difficult. Spousal consent and notification of the administrative authorities are also required in Algeria to allow for abortion in cases where the life or the health of the mother is threatened. **Absence of guidelines** on providing safe abortion care and/or post-abortion care further constrains women and girls' access to safe abortions.



## 7.4 CASE STUDIES

The 13 case studies presented in the final section of this chapter on reproductive rights and SRH cover a range of topics, including access to contraceptives, family planning, sexual rights of minorities, maternal and child health, obstetric fistula, CSE and safe abortion. All start from a concern about poor SRH indicators and limited access to or uptake of SRH information and services, owing to discrimination, inadequate policies and legal frameworks or limited progress with regard to political commitments. In different ways, the cases bring in a rights perspective to SRH and women and girls' reproductive rights. As such, they represent and capture important achievements regarding creating space and acceptance of women and girls' rights, reducing the taboos and stigma around women's SRH.

The first set of cases covers initiatives to address women and girls' access to SRH services. The case study from Togo looks at a task-shifting approach to community health workers; the School of Husbands in Niger also operates at the community level by focusing on the engagement of men in SRH and family planning. The Ghana case study highlights how health insurance can be a critical entry point for ensuring access to contraceptives. The Cameroon case study highlights the innovative approaches developed to meet the SRH needs of SOGIE populations.

The second set of cases includes reviews of two faith-based initiatives for institutional and social norm change in support of increasing access to family planning and improving SRH.

The third set of cases reports on three regional initiatives—of ECOWAS and EAC, as well as the ESA Commitment on CSE—put in place to create an enabling policy environment for women and girls' reproductive rights and SRH. Through political engagement, action planning and joint monitoring systems, these initiatives have encouraged member states to take action on shared and persistent challenges in the areas of adolescent health, obstetric fistula and maternal and child health.

The fourth set of cases addresses women and girls' right to safe abortion. The studies look at change processes at different levels, including legal reform and change among health or legal professionals.

Some insights that can be drawn from the 13 quite varied case studies are as follows:

- The promotion and realisation of women and girls' reproductive rights and access to SRH often entail **long-term processes of legal reform, policy change and institutional transformation as well as social norm change**. Change and reform at all these levels and in all these areas is needed in order for women and girls to be able to enjoy the exercise of their SRHR.
- Most initiatives are successful when they entail **multidisciplinary coalitions or networks** so as to speak to different perspectives (e.g. medical, legal, social, cultural, religious) on sexuality and reproductive rights and SRH. These broad coalitions and networks play an important role in stimulating collaboration and articulating a shared vision and agenda, while promoting mutual understanding and bridging different perspectives.
- Most initiatives covered in these 13 case studies involve an element of **capacity-building and awareness-raising on women and girls' SRHR**. This underlines the importance of addressing and strengthening knowledge and attitudes within institutions, either among SRH service providers and health professionals, faith-based leaders and institutions, or among legal staff and judiciary officers. Such sensitisation processes often need time and must be done with care and respect.
- The different case studies show that work on sensitive or taboo issues is possible by using strategies that draw on existing **sources of legitimacy** such as statutory laws, charters or high-level commitments, as well as expertise, research and evidence-based studies, or religious sources. Specific frames and terms can open up space for increased acceptance of the need to address certain issues and to promote women and girls' reproductive rights and SRH.
- In some contested areas, initiatives often start on a small scale: they may include strategies of **internal change among professionals or target groups, low-profile cases or targeted actions in safe spaces**, before, or simultaneously with, externally oriented actions, media campaigns, political engagement or community outreach.

### Case study 15. Task shifting in SRH service delivery in Togo to reach more women with contraceptives

In response to high levels of unmet need among women in rural areas, the Association Togolaise pour le Bien-Etre Familial (ATBEF) started a pilot project to provide injectables via health community agents. This entailed a shifting of tasks from medical staff to community health agents, embedded in a sensitisation campaign at community level to generate support for the strategy. The pilot has now been expanded to other regions.

Low rates of contraceptive use among women in rural areas represent a challenge. Innovative approaches are called for to address such women's unmet need and to improve their SRH. In Togo, the contraceptive prevalence rate was 17% and unmet need was as high as 34%. For women in rural villages where there is no clinic, access to sexual and reproductive health care, and in particular contraceptives, is challenging, as they often lack transportation. They may also not have the support of their husband and relatives to access contraceptive methods.

Togo's national budget has insufficient resources to provide medical clinics in all communities to ensure access to SRH services and contraception for all women. Building on lessons learnt and initiatives in other countries, the country has thus sought other solutions. ATBEF employs two strategies to reach women in rural villages where there is no clinic: the provision of injectables by community health agents (agents de santé de communautaire, ASCs) and the use of mobile clinics.

ATBEF started to pilot the ASC approach in 2012. This entailed shifting tasks from medical staff to ASCs, who had previously only provided condoms and the contraceptive pill. In the pilot project, the ASCs were trained to provide injectables, which up to then had been offered by medical staff such as nurses, midwives and doctors. This gave greater access to injectables, free of charge, to women in those villages with more limited access to clinics and the medical staff there.

Injectables were chosen because it is relatively easy to train on their application, including for those without full medical training. Injectables are safe and effective, and also have other advantages for women who wish to use contraception. For example, the contraceptive pill is also effective but women indicated they sometimes forgot to take it on time, and also faced challenges with their husbands, who did not approve of women taking it. The injectable is more discrete and gives women more opportunities to space and time their pregnancies.

The ASCs were selected from within and by their communities. The criteria for election included a minimal schooling level, which served as a basis for their training. Credibility within the community was also important.

An important element in introducing the ASC approach was the sensitisation of communities. For a period of two to three months, community dialogues were organised in the villages, to provide explanations and information and raise awareness. The sensitisation was carried out together with a representative of the government clinic, as well as community leaders.

This campaign to sensitise the community took time and was important to convince village chiefs and also the village men of the approach. The sensitisation campaign also sought to engage men in reproductive health and family planning; participation of the village chief in the community dialogues, and as such his support to the ASC project, also contributed to husbands being more supportive of the use of contraceptives. One key issue raised was maternal mortality and morbidity that arises when pregnancies are not well spaced and timed.

The awareness-raising also added to the credibility and acceptance of the ASC and her services.

The Togolese government has identified the ASC approach as good practice, and is supporting its implementation elsewhere. The initial pilot took place in two districts; the project now operates in six regions and the government has expressed a commitment to adding three regions each year. Representatives from Burkina Faso and Senegal have shown an interest in the approach as well, and have come to visit the project to learn more about it.



## Case study 16. CSO advocacy for the integration of family planning in Ghana's National Health Insurance Scheme

In 2012, Ghana adopted the National Health Insurance Act, which entailed a commitment to including family planning in the benefit package. After several years of research and advocacy by a group of CSOs, this commitment will be realised through a pilot project in 2018, facilitating insured women's access to long-term family planning and gains in reproductive and maternal health.

Ghana's revised Population Policy of 1994 aimed to reduce the total fertility rate from 5.5 in 1993 to 3.0 by 2020. The policy also had the objective of achieving a contraceptive prevalence rate of 50% by 2020 and providing available, accessible and affordable family planning services. New models of financing have represented an important step in facilitating access to such services and supplies.

Ghana is one of the first Sub-Saharan African countries to have introduced national health insurance, in 2003, to improve equity in access to health care and secure financial risk protection against the high costs of health services for all Ghanaians.<sup>116</sup> This insurance has a single benefit package, which initially did not include family planning, as other programmes covered this. Based on a costing study in 2011, the National Population Council made the case for including family planning commodities and services in the benefit package. In 2012, the government committed to this by passing the National Health Insurance Act 852/30.<sup>117</sup> At that point, a group of NGOs and CSOs engaged in a process of political and social mobilisation to support the implementation of this commitment.

The advocacy group used three strategies simultaneously to move the project forward. First, it lobbied for and provided technical support to regulatory change. An expansion of the benefit package required revision of the Legislative Instrument that provided the government with operational guidelines, including increased funds to purchase family planning commodities and services. An advocacy group consisting of 14 CSOs and NGOs<sup>117</sup> was invited to provide inputs into consultative reviews coordinated by the Family Health Division of Ghana Health Services. The group also lobbied the Parliamentary Select Committee on Health by developing and discussing a position paper anticipating reception of the draft Legislative Instrument.<sup>118</sup> It also engaged informally with the NHIS Technical Review Committee to track the status of the adoption and negotiation process. In 2016, the NHIS Technical Review Committee and the Parliamentary Select Committee on Health endorsed the draft Legislative Instrument, which is now awaiting approval from the Cabinet and Parliament.

Second, the advocacy group undertook an information and sensitisation campaign targeting religious, traditional and cultural leaders on family planning and the need for the passage of the Legislative Instrument. This was combined with TV and radio discussions to reach a wider public.

The third strategy entailed advocacy to start a pilot project to test different financing options and approaches to enable the inclusion of family planning in the NHIS benefit package.<sup>118</sup> The overall objective of this is to expand access among Ghanaian women to quality-assured contraceptive services in public and private facilities. This pilot will help determine the optimal provider-payment system and strengthen the long-term sustainability of the NHIS.<sup>118</sup> It will also provide learning on the effective inclusion of contraception in the NHIS benefit package, and hence inform the finalisation of the Legislative Instrument. Only long-term methods (intrauterine device, implants, vasectomy and tubal ligation) and injectables are covered, as they are clinical methods that can be provided and technically monitored by health personnel. Short-term contraceptive methods, such as the oral contraceptive pill, condoms and injectables, are more affordable and more difficult to track, and not cost-effective in terms of the administrative burden. Apart from testing different financing options the pilot will include complementary outreach and communication strategies to reach poor and vulnerable populations and activities to improve provider quality.<sup>117, 118</sup>

<sup>116</sup> For efficiency reasons, we use the term National Health Insurance Scheme (NHIS) in this case study. Act 650 (2003, replaced by a new version in 2012) provided the legislative backing for the establishment of a National Health Insurance Fund to be managed by a National Health Insurance Authority in pursuit of the stated aim through the medium of an NHIS. Act 650 (2003) was followed by the passage of Legislative Instrument 1809 in 2004, which detailed the regulations under which the NHIS was to operate, paving the way for actual implementation of the NHIS in 2005. The Legislative Instrument also defines the benefit package. It can be found here: [www.social-protection.org/gimi/gess/RessourcePDF.action;jsessionid=knECH1XUVI5fAXZX3vwHvFcf5H7ATV\\_TqLB8tCo46ape3DPVrLJd!-1017928187?id=11967](http://www.social-protection.org/gimi/gess/RessourcePDF.action;jsessionid=knECH1XUVI5fAXZX3vwHvFcf5H7ATV_TqLB8tCo46ape3DPVrLJd!-1017928187?id=11967)

<sup>117</sup> Including the Planned Parenthood Association of Ghana, Muslim Family Counselling Services, the Alliance for Reproductive Health Rights and the Coalition of NGOs in Health, supported by FP2020.

<sup>118</sup> The pilot intervention commenced on 1 May 2018 in six selected municipalities and districts across the country. It has been developed by Marie Stopes International Ghana and the National Population Council and funded by the UK Department for International Development.

One of the strengths of the campaign was that organisations from different backgrounds were able to develop a joint agenda, overcoming differences in perspectives and approaches.<sup>119</sup> They were driven by a shared sense of urgency to act when four years had elapsed since the passing of Act 852/30. Together, they effectively exploited their networks of professionals and practitioners to access key policy-makers, while mobilising the media and raising public awareness. Another strength was the continued engagement with a broad range of stakeholders, including initial opponents of the inclusion of family planning in the NHIS. Debates were held on, among others, the costs involved and the type of services to cover (long- or short-term contraceptives). The group also successfully connected provision of family planning services to population growth and the 'demographic dividend', and made links to Ghana's transformational leadership in global health.

A key challenge is that the NHIS has been criticised for its limited (though increasing) coverage, in particularly of the poor and those in the informal sector. The question is whether and how the new initiative will be able to reach different groups of women, such as uninsured or poor women, adolescent girls and unmarried women. In addition, coverage of long-term family planning methods will meet the needs of a large group of women but not those of women who prefer short-term methods. Furthermore, adoption and continued use of family planning methods will depend on the quality of counselling and care. Nevertheless, the inclusion of family planning in the benefit package still represents an opportunity to empower women regarding choice in birth planning and spacing.

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<sup>119</sup> Partners include non-governmental, private sector, faith-based, human rights-based and health provider organisations: [www.partners-popdev.org/wp-content/uploads/2017/11/GHANA-ROLE-OF-CIVIL-SOCIETY-IN-FAMILY-PLANNING.pdf](http://www.partners-popdev.org/wp-content/uploads/2017/11/GHANA-ROLE-OF-CIVIL-SOCIETY-IN-FAMILY-PLANNING.pdf)

## Case study 17. The 'School for Husbands' in Niger

Through the organisation of regular information and discussion meetings with men in Niger on reproductive health and nutrition, improvements have been recorded in service uptake, alongside shifts in gender stereotypes, roles and responsibilities.

Niger has the highest rate of maternal mortality in the world: it is estimated that a woman dies giving birth every two hours. The MMR in 2015 was 533 deaths per 100,000 live births, compared with 873 in 1990.<sup>cxix</sup> It is estimated that around 74% of women in Niger are illiterate and 80% are married by the age of 18. Men are seen as the heads of the household,<sup>cx</sup> and, although GVAW is very common throughout the country, it is not often reported and is seen as generally accepted within the community.<sup>cxii</sup>

A study commissioned by UNFPA on obstacles to the promotion of reproductive health in Zinder region enabled a better picture of maternal mortality in Niger.<sup>cxiii</sup> This revealed several obstacles to the use of reproductive health services and reiterated that involving men would be very beneficial for the health of women and children in Niger.<sup>cxiii</sup> In 2008, UNFPA Niger put in place an initiative called 'School for Husbands' (*Ecole des maris*), setting up 11 schools in two health districts in Zinder, targeting especially vulnerable areas with relatively low reproductive health indicators.<sup>cxiv</sup> The idea behind the School for Husbands was to teach men about the importance of family planning, health and nutrition so that, together with their wives, they could make knowledgeable decisions for the well-being of the whole family.<sup>cxv</sup>

The School for Husbands is a space for discussion and decision-making based on a spirit of voluntary membership. There is no 'leader': all members are equal and work in a non-hierarchical framework so that everyone assumes a part of the responsibilities. Men wishing to become members must meet the following conditions: be married, be a husband whose wife (wives) uses reproductive health services, be at least 25 years of age (this would be the husband), be there voluntarily, accept that his wife participates in associative structures, be available, have good morality, be a person who cultivates harmony within his family and be a husband who supports his family.<sup>cxvi</sup>

The men meet in groups of between eight and twelve members twice a month, supervised by the head of the health district of the locality. The discussions are centred around maternal health, and information is provided on how to deal with issues such as antenatal consultation, early marriage, attendance at health centres and family planning. This interaction is important because it helps in understanding what the men attending think about topics or issues related to maternal health and to educate them on and address any unhelpful practices. The school also encourages men to be involved in domestic chores by helping their wives with day-to-day duties such as cleaning, washing the dishes, washing the clothes and taking care of the children.<sup>cxvii</sup> This initiative is bringing about real change to families in Niger: many more men are now carrying out jobs traditionally designated as female. This in turn is creating happier households and healthier women and children.<sup>cxviii</sup>

The success of the School for Husbands since its launch in 2007 has been remarkable. It started in only eight localities in Zinder; today, the entire region is covered, with 130 schools. Some strong results have been recorded. For example, in rural Bandé, south of Zinder, the family planning utilisation rate increased from 2% in 2007 to 20% in 2011. The rate of antenatal care reached 88% in 2012, from 29% in 2006. Similarly, in Zinder region as a whole, the rate of childbirth assisted by medical staff was 43% in 2012, compared with 8% in 2006.<sup>cxix</sup> In places where the School for Husbands exists, the rate of childbirths attended by skilled healthcare personnel has doubled.<sup>cxx</sup> Men also express changes: Laminu, a father of four who attended the school for three years, said 'I've learned a lot of things. I've learned how to give my wife advice about exclusive nursing. I help her with housework. I take the child[ren] when she is cooking.'<sup>cxxi</sup> The School for Husbands has improved communication within households around family planning and the benefits of using health services. It has also proven that, when men have a better understanding of the health of their wives and children, this results in lower maternal mortality and healthier children.<sup>cxvii</sup>

## Case study 18. Meeting diversity needs in SRH in Cameroon

The Cameroon National Association for Family Welfare (CAMNAFAW) implemented an innovative project to create space for lesbian, gay, bisexual, transgender and intersex (LGBTI) persons' SRH rights. The project approach entailed organisational learning and change and the development of diversity-sensitive health services. Grounded in the IPPF Declaration on Sexual Rights, the project facilitated social norm change among NGO staff, senior management and health providers and empowered LGBTI persons through peer support groups.

Strong gender-based norms and views on sexuality often do not allow for sexual relations between people of the same sex. In many African nations, such strong norms and values persist, and laws that criminalise same-sex consensual sexual relations are prevalent.<sup>120</sup> These are associated with high levels of discrimination, stigma and sometimes hostile environments towards LGBTI persons. Based on their sexual orientation or gender identity and expression, LGBTI persons can face various forms of discrimination and violence, such as physical abuse, 'corrective rape' or imprisonment. This legal and social marginalisation makes it more difficult to access SRH services and information, increasing the risk of STIs, including HIV.<sup>121</sup>

Such a hostile environment is present in Cameroon, with the country's Penal Code considering same-sex sexual relations between consenting individuals a criminal offence. Art. 347 of the Penal Code outlaws same-sex sexual relations, which can be penalised by six months up to five years of imprisonment and a fine of 20,000 up to 200,000 FCFA. At the same time, HIV prevalence among men who have sex with men (MSM) is among the highest in the world, with 37.2% of MSM infected. Data on HIV prevalence and other SRH indicators among other subgroups within the LGBTI community is lacking and difficult to find.<sup>cxiii</sup>

In recognition of the need to meet the SRHR needs of LGBTI persons, CAMNAFAW implemented an innovative project called Meeting SRH Diversity Needs (MESDINE).<sup>122</sup> CAMNAFAW is one of the key organisations providing a full range of SRH services in the country. The overall goal of project was 'to contribute towards improvement of the SRHR of the LGBTI in Yaoundé, Cameroon'. In order to achieve this, the project articulated three objectives:

1. To increase institutional commitment and readiness at the member association and among partners of CAMNAFAW to address the SRHR needs of sexually diverse populations.
2. To improve the knowledge, awareness and protection of 1,000 LGBTI persons to address personal risk reduction and safer sex strategies.
3. To increase the number of LGBTI clients (an estimated 375 clients) who use SRH counselling and services offered by the member association and other service delivery partners.

Four different strategies were used to implement the MESDINE project, contributing to different levels of social norms change involving both beneficiaries and project staff:

1. Mobilisation and co-opting of beneficiary population to gain trust and raise awareness on the project;
2. Capacity-building activities to increase the knowledge of staff, volunteers and beneficiaries on sexuality, sexual health and rights. This focus was an innovative aspect of the project, informed by the IPPF Declaration on Sexual Rights (see Box 7.5), modified and adapted for use by peer educators and staff in sessions and discussions with the targeted groups;
3. Provision of medical services to the beneficiary population; and
4. Monitoring and evaluation of the project throughout implementation by using data to reflect and feedback on progress.

<sup>120</sup> An overview of sexual orientation laws, including criminalisation, protection and recognition, is available in Carroll, A. and Mendos, L.R. (2017). State Sponsored Homophobia 2017: A World Survey of Sexual Orientation Laws: Criminalization, Protection and Recognition. Geneva: ILGA. The report is accompanied by a number of maps and charts.

<sup>121</sup> Discrimination, violence and human rights violations on the basis of sexual orientation or gender identity are observed and condemned in General Comment No. 1 to the Maputo Protocol, 2012 (para. 4); General Comment No. 2, 2014 (para. 12); and Resolution 275 of the ACHPR on 'Protection against Violence and Other Human Rights Violations against Persons on the Basis of Their Real or Imputed Sexual Orientation or Gender Identity', 2014. (See Chapters 8, 7, and 5 respectively.)

<sup>122</sup> The project was implemented from January 2008 up to December 2010, supported by the IPPF Innovation Fund. In 2011, the MESDINE project was evaluated and a report was published (IPPF, 2011. 'The Innovation Fund and CAMNAFAW 2011. Meeting SRH Diversity needs (MESDINE) Project'. Final Evaluation February 2011.) CAMNAFAW is now receiving funds from the Global Fund to Fight AIDS, Tuberculosis and Malaria.

**Box 7.5. IPPF Declaration on Sexual Rights**

A panel on sexual rights was created in 2006 to guide and support IPPF in developing a Declaration on Sexual Rights. This Declaration is grounded in core international human rights instruments, standards and additional entitlements related to human sexuality. It is informed by findings and recommendations of UN treaty bodies and UN special rapporteurs. The Declaration was presented by the panel and approved by the Governing Council in May 2008. It has three parts: a Preamble, followed by seven guiding principles and ten sexual rights.

**Preamble**

This introduces the Declaration in relation to IPPF's mission and vision and international documents and agreements and outlines the intention of the human rights framework.

**Guiding principles**

1. Sexuality is an integral part of the personhood of every human being. For this reason, a favourable environment in which everyone may enjoy all sexual rights as part of the process of development must be created.
2. The rights and protections guaranteed to people under age 18 differ from those of adults, and must take into account the evolving capacities of the individual child to exercise rights on his or her own behalf.
3. Non-discrimination underlines all human rights protection and promotion.
4. Sexuality, and pleasure deriving from it, is a central aspect of being human, whether or not a person chooses to reproduce.
5. Ensuring sexual rights for all includes a commitment to freedom and protection from harm.
6. Sexual rights may be subject only to those limitations determined by law for the purpose of securing due recognition and respect for the rights and freedoms of others and the general welfare in a democratic society.
7. The obligations to respect, protect and fulfil apply to all sexual rights and freedoms.

**Sexual rights**

1. Right to equality, equal protection of the law and freedom from all forms of discrimination based on sex, sexuality or gender;
2. Right to participation for all persons, regardless of sex, sexuality or gender;
3. Rights to life, liberty, security of the person and bodily integrity;
4. Right to privacy;
5. Right to personal autonomy and recognition before the law;
6. Right to freedom of thought, opinion and expression; right to association;
7. Right to health and to the benefits of scientific progress;
8. Right to education and information;
9. Right to choose whether or not to marry and to found and plan a family, and to decide whether or not, how and when, to have children;
10. Right to accountability and redress.

Source: IPPF. (2008). Sexual Rights: An IPPF Declaration. [https://www.ippf.org/sites/default/files/sexualrightsiippfdeclaration\\_1.pdf](https://www.ippf.org/sites/default/files/sexualrightsiippfdeclaration_1.pdf)

Under the first objective, awareness and commitment to diversity needs and sexual rights grew among senior management and staff through learning sessions. It proved essential to have open conversations to challenge potential discriminatory organisational policies and prevailing attitudes, beliefs and myths about sexuality. The CAMNAFAW statutes were amended by including LGBTI as a priority target group. The project also contributed to recognition of CAMNAFAW as a regional leader in sexual rights, and strengthened partnerships with NGOs and government in raising awareness of the importance of providing LGBTI with access to SRH services.

Under Objective 2, peer support groups were successful and scaled up in response to high demand, with a total of 12 support groups established. Condoms and lubricants were distributed widely and offered at a 50% discount to make them more affordable to beneficiaries. Knowledge of safe sex practices reportedly increased as a result of the peer support groups and information sessions as well as the provision of information, education and communication materials. Lastly, beneficiaries became more aware of their rights, and this positively affected their self-esteem and reduced self-stigmatisation, depression and mental health problems.

Under Objective 3, service provision to LGBTI people grew significantly. The project saw an increase of 49% in the number of LGBTI persons accessing SRH services. A total of 1,856 LGBTI clients were provided with 4,508 services over the three-year project span. In addition, service provision was LGBTI-friendly and focused on LGBTI needs through the creation of a safe and non-judgemental environment for all LGBTI clients. Lastly, clinical service providers meetings were coordinated to exchange experiences, harmonise prices and evaluate provider needs.

The experience has revealed a number of challenges related to working with marginalised and discriminated groups such as LGBTI persons. Programmes will require intense investment of staff time in order to access and build relationships and trust with these groups. In addition, counselling and support for staff is necessary as staff themselves can be affected by stigma and discrimination as a result of their work with highly sensitive and taboo issues. Related to this is the fact that introducing new staff in such programmes can be challenging, as there is a need for a large and continuous investment in sensitisation and learning of (new) staff members to ensure the rights of LGBTI clients are guaranteed. Another insight is that the costs of access to services were found to be a real barrier as many LGBTI persons find it hard to find or keep employment. Related, the MESDINE project faced financial constraints because of the rapid increase in demand, leading to a strain on resources.

## Case study 19. The Caravan: a strategy to educate Muslim religious leaders and communities on family planning

The Caravan is a faith-based initiative to stimulate social norm change among faith leaders and their institutions and communities. A multidisciplinary team of experts travels, as in a caravan, to different areas to deliberate with religious leaders on reproductive health and population issues, including family planning. The Caravan makes it possible to address misconceptions about, and resistance against, family planning and motivates Muslim religious leaders and communities to become champions of family planning. It has been implemented in over five countries in Africa.

The role of religious leaders is not restricted to performing religious duties; it also includes educating people on various areas, including on medical, social, cultural and religious issues. Family planning has been a sensitive issue among religious leaders and communities and is sometimes interpreted as a method imposing family limitation and population control, and working against Islam.

In travelling seminars, or 'caravans', on family planning, a multidisciplinary team of experts travels to an area to deliberate with religious leaders on reproductive health and population issues, including family planning. The aim is to increase acceptance of reproductive health as a community responsibility and to increase uptake of SRH services. The first seminar was held in Indonesia; this was followed by seminars in Egypt, Morocco, Yemen, Somalia, Senegal, Gambia, Nigeria, Kenya, Tajikistan and Azerbaijan, and with Muslim minorities in Thailand and the Philippines. While the first seminars focused on family planning, consequent ones have had a broader scope, including issues related to reproductive health, gender and health, child marriage and FGM, GVAW and adolescent health, taking into account the critical challenges in particular settings and international policies.

Caravans are facilitated by a group of experts with backgrounds in demography, medicine, social sciences and theology. Each expert prepares a presentation that deals with family planning (or another topic) from their perspective. Depending on their expertise, they may address demographic aspects of overpopulation; the impact of frequent pregnancies, lack of spacing and young age at childbirth on the health of the mother; and the value of small families and the comparative advantages for education and working opportunities. Theologians talk about the Islamic perspective, supported by authenticated texts from the Quran and the Hadith. For each caravan, time is taken to establish the group, select the experts, share and debate perspectives among experts and come to an agreement regarding the presentations and information materials and facilitation methods. At the end of the caravan, the expert group formulates recommendations.

The caravan approach has been particularly effective because it was developed and tested by a renowned institute, the International Islamic Centre for Population Studies and Research of Al-Azhar University.<sup>123</sup> Since Al-Azhar University is the most prestigious and the oldest in the Muslim world, religious leaders in the respective Muslim countries are open to advice and willing to receive the caravan and implement its recommendations. The reputation of the Centre also means that caravans in many countries are patronised by presidents or deputy-presidents (Indonesia, Somalia) or high-ranking officials, who actively support and legitimise the seminars.

In August 2015, the Supreme Council of Kenya Muslims and the Faith to Action Network in partnership with Al-Azhar University organised a learning caravan in the counties of Mombasa, Kilifi and Lamu. The caravan included processions, training workshops,<sup>124</sup> sessions at the mosques, sermons and seminars, meetings and discussions with government officials and service providers in public and private health facilities aimed at generating support for SRHR advocacy, policy-influencing and embracing reproductive health programming in line with the Islamic faith. Multiple topics were addressed, such as family planning, safe motherhood, harmful traditional practices and adolescent pregnancy. For each of these, supporting audio-visual and written materials were developed.

By combining medical and theological points of view to complement each other, the Caravan has helped dispel rumours and correct misconceptions about family planning. The theological perspective has been particularly helpful in informing participants about texts in the Quran related to reproductive health. According to a facilitator, 'Where beliefs are so strong, people tend to listen better to a religious leader than to a medical person.' The Quran, for instance, emphasises that people are given the power to think for themselves and have the choice to take responsibility. The medical perspective complements this with insights on the risks of having too many, too soon, too early or too late pregnancies. Maternal and child health and family health and well-being are taken as a starting point to discuss issues related to reproductive health. Rather than 'family planning', the term 'birth spacing' or 'child spacing' is used adopted as a socially and culturally accepted term.

<sup>123</sup> The Centre was created in 1975 in collaboration with UNFPA. Its aim is to conduct scientific research and publish and communicate reliable information to religious officials and leaders in Islamic countries: <https://alazhar-iicpsr.org>

<sup>124</sup> For example training of Muslim clergy on child spacing (family planning), FGM, early marriage and modern contraception. Videos part 1 <https://www.youtube.com/watch?v=YyVWabFZuxo> and part 2 [https://www.youtube.com/watch?v=NBvD\\_2Vx7SO](https://www.youtube.com/watch?v=NBvD_2Vx7SO)



In 2017, an evaluation of the Caravan took place. This reported, among other things, an increase in the uptake of family planning services in Supreme Council of Kenya Muslims facilities; an increase in budget for family planning at county government level; and the adoption by 63 imams of a joint commitment in support of child spacing. The project has also resulted in the awarding of scholarships to 20 Muslim clergy to study for 2 months at Al-Azhar on women's rights and child spacing and 20 academic scholarships for religious and other courses related to reproductive health.

## Case study 20. Council of Anglican Provinces of Africa makes an institutional commitment to promote family planning

In 2017, the Council of Anglican Provinces of Africa (CAPA) adopted a resolution on family health and family planning services and information. This resolution was shared with all the 13 provinces, dioceses and departments of Anglican churches in Africa, reaching over 36 African countries. Follow-up initiatives have been undertaken in, among others, Ghana for institutional change and Uganda for revision of the theological curriculum and advocacy in policy and budgeting processes in Mityana diocese.

CAPA is a continental faith-based organisation established in 1979 that coordinates and creates space for primates and other church leaders to engender fellowship and articulates issues affecting the church and communities across the region. CAPA operates through 13 Anglican provinces, representing 36 African countries.<sup>125</sup> Decisions of the Council are shared with all structures and institutions of the Anglican Church in Africa. These recommendations and resolutions offer guidance to the provinces and dioceses and reach over 40 million followers. On 10 May 2017, the CAPA Standing Committee met in Kitwe, Zambia, and adopted a resolution calling on the Anglican Church to actively promote family planning services and information. The resolution states:

*'The Council of Anglican Provinces of Africa Standing Committee meeting at Kitwe, Zambia on the 10<sup>th</sup> May 2017 deliberated on the impact of large populations on the meager resources both at family and national levels and notes that this is partly responsible for the impoverished living that characterizes the continent and the degradation of the environment. In keeping with CAPA's mission of building thriving families and communities on the continent and our stewardship role of mother nature, it was resolved that CAPA Provinces take responsibility for enabling efforts towards a campaign for child spacing and responsible stewardship of the environment on the continent of Africa.'*

Adoption of the resolution followed a process in which religious leaders from churches in different African countries shared their experiences and raised their voices on the importance of addressing family planning and family health. This long-term internal process within CAPA was important to building ownership and buy-in of family planning services and information to improve the life and health of the continent's people.

The resolution allowed for and further stimulated initiatives in different provinces with respect to family planning services and information. In Ghana, a regional meeting of 35 senior clergy, including primates and bishops, was held in August 2017 to identify ways to make the recommendation operational. The consultation was informed by the experiences of Bishop Kaziimba of Uganda and Reverend Andrew of Rwanda related to their dioceses' family planning interventions, as well as a detailed report of the Anglican health system in Ghana. The consultation led to the development of an institutional change plan to address the issues that had come up.

An important input was a mapping of adolescent pregnancies in Ghana, with data collected in nine dioceses. CAPA repeatedly met with religious leaders in Accra, including Archbishop Albert Chama, and agreed to incorporate family planning into its agenda. The plan included a reinforcement of the commitment of all relevant stakeholders to work collaboratively and in consultative forums on strategies to reduce high rates of adolescent pregnancy in Ghana. It also included an in-depth assessment to inform the development of innovative programmes for adolescents.

In Uganda, two important initiatives concern advocacy for family planning in Mityana diocese the revision of the theological curriculum. In the first, the Church of Uganda convened and educated faith leaders and encouraged them to advocate the district government and their congregations on family planning. In 2017, Mityana diocese together with the Faith to Action Network engaged the District Health Office to prepare and launch a District Family Planning Costed Implementation Plan. This aims to accelerate universal access to family planning services in order to increase the modern contraceptive prevalence rate and reduce unmet need. Continuous information-sharing with and education of district decision-makers contributed to a tripling of the district budget for family planning, and hence increased people's access to family planning services. Mityana diocese engaged local government representatives as well as other civil society stakeholders in 23 technical meetings and consultations to develop the plan, which also included a gender budgeting session. The launch of the plan offered the opportunity to gain the commitment of not only six senior district officials but also Anglican and Muslim faith leaders. The diocese organised five interfaith meetings to join voices in promoting family planning. The diocese also instigated processes of social accountability with local leaders and citizens, on, for instance, identified shortages in contraceptives or raising awareness and increasing demand for family planning.

<sup>125</sup> Burundi, Central Africa (Botswana, Malawi, Zambia, Zimbabwe), Congo Republic, Indian Ocean (Madagascar, Seychelles, Mauritius), Kenya, Nigeria, Rwanda, Southern Africa (Lesotho, Mozambique, Namibia, South Africa, Swaziland), Sudan, Tanzania, Uganda and West Africa (Ghana, Cameroon, Togo, Sierra Leone, Liberia), plus the Diocese of Egypt: <http://capa-hq.org/>

In the second important initiative, the Church of Uganda engaged the Uganda Christian University (UCU) School of Divinity and Theology to strengthen components in its curriculum on SRH and family planning. The dean of the UCU School of Health Sciences and Theology agreed to review the curriculum to include family planning as a foundation course. The revised curriculum engaged the House of Bishops and has been approved by the National Council for Education. The revised foundation course has significant potential, considering that graduates from UCU take on roles as clergy and lay leaders across the country. The new curriculum aims to equip religious leaders with skills and knowledge so they can start ministering on these subjects to their future congregations.

## Case study 21. The ESA Commitment on Comprehensive Sexuality Education

This case shows the commitment of ESA states to the realisation of women and girls' SRHR, with a focus on access to comprehensive sexuality information and education. The initiative has created an enabling political environment for local, national and regional campaigns and interventions, with close collaboration required between state and civil society actors. This is illustrated by experiences related to opportunities and challenges in Swaziland.

The ESA region continues to have the highest prevalence of HIV in the world, with nearly half of the estimated 2 million new HIV infections globally in 2014.<sup>cxv</sup> Girls and young women are particularly vulnerable: HIV prevalence among young women aged 15–24 years is twice as high as the rate among their male counterparts.<sup>cxvi</sup> In addition, unintended pregnancies continue to be a major public health issue, with 25% of women aged 20–24 years in the region reporting a birth before age 18.<sup>cxvii</sup> CSE has been proven to improve adolescent and youth health, well-being and dignity through delaying initiation of sexual intercourse, increased use of condoms and contraception, decreased number of sexual partners, improved attitudes related to SRHR and reduced risk-taking.<sup>cxviii</sup>

In 2013, ministers of health and education from 20 countries<sup>126</sup> across ESA met to discuss challenges for young people in accessing CSE and youth-friendly SRH services, including HIV services. This meeting resulted in the signing of the Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People in ESA. In this so-called 'ESA Commitment', these 20 countries agreed to work towards a vision of 'young Africans who are global citizens of the future who are educated, healthy, resilient, socially responsible, informed decision-makers and with the capacity to contribute to their community, country and region'.<sup>cxix</sup> More specifically, the countries committed to:

1. Work together on a common agenda for all adolescents and young people to deliver CSE and youth-friendly SRH services;
2. Urgently review—and where necessary amend—existing laws and policies on age of consent, child protection and teacher codes of conduct to improve independent access to SRH services for adolescents and young people and to protect children;
3. Make an AIDS-free future a reality by investing in effective, combination prevention strategies;
4. Maximise the protective effect of education through Education for All by keeping children and young people in school;
5. Initiate and scale up age-appropriate CSE during primary school education;
6. Ensure the design and delivery of CSE and SRH programmes include ample participation by communities and families;
7. Integrate and scale up adolescent- and youth-friendly HIV and SRH services;
8. Ensure health services are adolescent- and youth-friendly, non-judgemental and confidential and reach adolescents and young people when they need it most;
9. Strengthen gender equality and rights within education and health services;
10. Mobilise national and external resources.

To respect these commitments, the countries set targets to be reached by the end of 2015 and by the end of 2020 (see Table 7.15). Owing to its multi-sectoral nature, the ESA Commitment requires that participating states work in a collaborative, harmonious way with civil society actors to develop, implement, monitor and evaluate the stipulated interventions. Progress on the implementation of the ESA Commitment was tracked in a 2013–2015 progress review;<sup>cxix</sup> a second progress report is being prepared (see also Section 7.3, which includes findings of the progress review in the Eastern and Southern regions).

<sup>126</sup> Angola, Botswana, Burundi, DRC, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, South Africa, South Sudan, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.

Table 7.15. Targets to be achieved on the ESA Commitment by 2015 and 2020

Targets to be achieved by end-2015	Good quality CSE curriculum framework in place and implemented in all 20 countries
	Pre- and in-service SRH and CSE training for teachers and health and social workers in place and implemented in all 20 countries
	Decrease by 50% in number of adolescents and young people who do not have access to adolescent- and youth-friendly SRH services (including HIV) that are equitable, accessible, acceptable, appropriate and effective
Targets to be achieved by end-2020	Eliminate all new HIV infections among adolescents and young people (aged 10–24),
	Increase to 95% the number of adolescents and young people aged 10–24 who demonstrate comprehensive HIV prevention knowledge levels
	Reduce early and unintended pregnancies among young people by 75%
	Eliminate GVAW
	Eliminate child marriage
	Increase the number of all schools and teacher training institutions that provide CSE to 75%

Swaziland is one of the countries that have demonstrated both opportunities and challenges in the implementation of the ESA Commitment. Swaziland provides CSE as a stand-alone, mandatory subject in upper-primary and secondary levels.<sup>cxix</sup> State and non-state actors collaborated in rolling out and capacitating service providers on new standards for youth-friendliness in SRH service delivery, and, similarly, worked hand-in-hand to develop and implement a CSE programme for out-of-school youth. When it came time to track initial progress in realising the targets, the Ministry of Health led the process in a transparent, inclusive manner, seeking feedback from—and distributing the final results to—all the relevant stakeholders.

There have also been challenges, for instance with respect to the manuals for out-of-school CSE. The NGO tasked to deliver this, the Family Life Association of Swaziland (FLAS), was mandated to use a specific manual, despite having substantial reservations about its comprehensiveness. For example, the manual fails to adopt a rights-based approach—a critical component of CSE according to UNESCO's International Technical Guidance on the subject. It excludes mention of sexual diversity and gender orientation, omits the topic of abortion and skims over content on unplanned pregnancy.

Meanwhile, collaboration between the government and civil society actors also broke down in relation to the second progress report. Although states had agreed to allow civil society to coordinate the evaluation process, the response from UN agencies and state actors to the required data collection activities was very low. FLAS had secured the mandate to undertake these activities but it was revealed to FLAS at the moment the report had to be submitted that Swaziland had not agreed to allow civil society to undertake this process on, what it viewed, was its behalf. It is not clear now whether the government has submitted a second regional progress report; if it has, the view of Swaziland's civil society's views are not captured.

## Case study 22. EAC Open Health Initiative

The EAC undertook a three-year initiative to enhance access of stakeholders to data on reproductive, maternal, neonatal, child and adolescent health (RMNCAH). This Open health Initiative contributed to an enabling policy environment that allows for enhanced state accountability with regard to targets to reduce maternal and child mortality. This initiative is of particular importance in the context of the underreporting on progress regarding women's rights.

The EAC addresses reproductive health issues among other broader health policy matters. This mandate is derived from Art. 118 of the EAC Treaty, which provides for stronger regional cooperation on health. Its mandate in this regard relates to coordination of policy development, policy review and consensus-building among partner states. In general, the EAC Secretariat, the executive arm of the Community, is not involved in direct implementation but rather facilitates policy dialogue and development of strategies that seek to catalyse the adoption and implementation of good practice policies at country level. The EAC Secretariat is mandated to monitor and follow up on the status of implementation of regionally agreed interventions and report on the same to the policy-making organs, which include the Sectoral Council of Ministers responsible for Health.

It is in line with this mandate that the EAC developed a project known as the EAC Open Health Initiative (EAC OHI). This three-year initiative was premised on the principle of open governance, and financed by the Norwegian Agency for Development Cooperation. The project focused on women and children's health. It aimed to reduce maternal and infant mortality while also enhancing access to data and information for better results, and to provide stronger oversight of results and resources for women and children's health within the EAC in line with the then MDGs on maternal and child health. The EAC set out to create a policy environment that would support reduction of maternal and child mortality from preventable causes through increasing the use of innovative approaches and strengthening accountability.

Towards this, the EAC was involved in various innovative approaches. It developed a regional data warehouse, linked to DHS-based national health information systems of the partner states. This data warehouse facilitated the collection of RMNCAH data on output, impact and policy levels. This fed into the project objectives to enhance access to information for stakeholders and included information such as that related to the tracking of all births and maternal and child deaths.

The EAC also developed and launched a regional RMNCAH scorecard, which is an advocacy and accountability tool for communicating progress on key global, regional and national commitments on the basis of agreed indicators. The scorecard's innovation is derived from its simplicity: it is colour coded to illustrate progress. For instance, green indicates that the desired target has been reached, yellow indicates progress is on course and red shows that the target has not been reached at all. Using this scorecard, countries are able to observe and monitor their own performance while at the same time comparing it with that of other countries. This regional instrument catalysed the development of similar scorecards by partner states. The national scorecard is cascaded to the subnational level so as to be able to identify subnational (district, province, country, etc.) problems. For instance, the scorecard can help reveal that maternal mortality is particularly high in a certain area and therefore influence the response. In addition to RMNCAH indicators, HIV and AIDS, tuberculosis and financing aspects were also later added to the scorecards.

The EAC OHI also facilitated the development of a resource-tracking tool to assist countries to implement detailed tracking of all government and donor resources related to RMNCAH. This intervention fed into the project's objective of enhancing accountability. When countries were undertaking their National AIDS Spending Assessment, for instance, the EAC provided government and other related stakeholders with the resource-tracking tool in order to collect data. In some countries, such as Burundi, this exercise revealed previously unknown funding to health initiatives. Tracking serves to eliminate duplication of efforts (such as between government and non-state actors) and the information gathered facilitates more effective planning for all concerned parties.

While the EAC OHI project has come to an end, the EAC has integrated its objectives and some key interventions into its health programmes, in particular through the EAC RMNCAH Policy Guidelines, the EAC RMNCAH Strategic Plan 2016–21 and the Swedish government-supported EAC Integrated Health Programme. The resource-tracking tool has been implemented at country level, and the EAC continues to prioritise national assessment processes through the scorecard. Lessons from the resource-tracking tool have been valuable to improving the EAC's engagement with National Health Accounts.

The scorecard's in-country uptake and utilisation has been particularly successful, with decision-makers and key stakeholders lauding its innovation and simplicity in revealing information that is often hidden or difficult to access. High-level policy-makers such as ministers find it easier to use the scorecards than voluminous reports for quick reference. This has facilitated the process of securing additional commitment and resources in maternal health services. The scorecard enhances evidence-based advocacy on RMNCAH and HIV and AIDS issues. The EAC projects that this ease of access to information will trigger dialogue, enhancing plurality (effective broad-based participation of stakeholders) in policy development processes. Such dialogue will improve the quality of policies and decisions on how to invest in these. This means service delivery mechanisms will be better resourced and organised and people will be able to receive services they need with better quality, which will translate into better health status.



## Case study 23. ECOWAS move to eradicate obstetric fistula In West Africa

ECOWAS initiated a campaign and Regional Action Plan to prevent, treat and support victims of obstetric fistula. This case study showcases the importance of a multi-sectoral approach and the impact on the ground through member state mobilisation.

The MMR in West Africa remains among the highest in the world. Although it declined from 749 maternal deaths per 100,000 live births in 2010 to 679 in 2015, it remains higher than in other parts of Africa.<sup>cxixi</sup> ECOWAS is also one of the regions worst affected by obstetric fistula.<sup>cxixii</sup> Obstetric fistula occurs when a woman goes through days of labour and, during the long hours of contractions, the baby's head continuously pushes against her pelvis, which leads to the development of a hole in the birth canal.<sup>cxixiii</sup> If an obstetric fistula occurs between the bladder and the vagina (a vesico-vaginal fistula), urine will flow continuously. If it happens between the bladder and the rectum (a rectovaginal fistula), the woman can no longer control the movement of her intestines.<sup>cxixiv</sup>

Many women who suffer from obstetric fistula are rejected not only by their husband but also by the community. Stigmatisation and isolation prevent them from seeking help. When properly taken care of, obstetric fistula can heal completely in 80–90% of cases. However, most women cannot afford the high cost of the repair surgery, which is around \$400.<sup>cxixv</sup> The main causes of obstetric fistula are lack of health facilities during childbirth, skilled birth attendants and emergency obstetric care. Other causes, such as poverty, illiteracy and early and child marriage, are indirectly linked to the occurrence of obstetric fistula in developing countries. Harmful practices such as FGM are also an important factor. In West Africa, women who suffer from obstetric fistula are often young (15–24 years), and they often live in rural areas with little or no education and no 'financial independence'.<sup>cxixvi</sup>

In 2010, the ECOWAS Gender Development Centre (EGDC) launched an initiative to combat obstetric fistula in West Africa in response to its debilitating social and economic effects on women and girls in the region.<sup>cxixvii</sup> The initiative aims to 'improve the sexual and reproductive health of girls and women with obstetric fistula in order to enable them to lead worthy productive and reproductive lives and contribute to the development of the ECOWAS region'.<sup>cxixviii</sup> It also seeks to provide treatment and care for women and girls with obstetric fistula and help them return to productive and reproductive lives through skills training and financial support. Through this initiative, ECOWAS hopes to completely eradicate obstetric fistula in the West Africa.<sup>cxixix</sup>

Since the launch of the campaign, the EGDC has been working with specialists to provide surgery and to offer both psychological and financial assistance to victims, as well as to conduct sensitisation campaigns to combat obstetric fistula in the region. To date, 12 ECOWAS member states are covered by the initiative (not Cape Verde, Liberia and Sierra Leone).<sup>cxli</sup> Most of the 12 countries have developed national strategies to combat obstetric fistula. Nine have put in place annual action plans in order to operationalise these strategies.

In order to facilitate implementation of the obstetric fistula campaign, the EGDC has put in place a national committee in each country, which consists of:<sup>cxlii</sup>

- A representative of the EGDC;
- A representative of the West African Health Organisation;
- A representative of the ministry responsible for gender issues;
- A representative of the ministry of health;
- A representative of the ECOWAS National Unit;
- A representative of the medical corps operating in the field (gynaecologist or surgeon);
- A representative of the most active national NGOs involved in the fight against obstetric fistula;
- A social development officer (social worker).

Since the launch of the campaign, there have been great efforts to establish Reference Care Centres in countries like Côte d'Ivoire, Ghana, Niger and Senegal, to allow obstetric fistula patients to receive treatment in their own country. In Ghana, the EGDC provided financial support for around 155 cases of fistula repairs in 2016.<sup>cxliii</sup>

In 2015, the ECOWAS Regional Action Plan for Fighting Obstetric Fistula in West Africa for 2016–19 was developed, originating from the 'need to determine a complete and detailed regional framework that leads towards a strategy of elimination and prevention of obstetric fistula in the ECOWAS region'. This aims to provide a response that is holistic, integrated and sustainable and that forms a part of existing strategies already developed by members to reduce maternal mortality, for example.<sup>cxliiii</sup> Moreover, it encourages a multi-sectoral approach to addressing obstetric fistula on both the national and the regional levels, and recognises the promotion of human rights as an essential component in the fight against obstetric fistula.<sup>cxliiv</sup>

The Regional Action Plan was developed through a largely participatory approach that included key actors involved in responses to obstetric fistula in the ECOWAS member states. The starting point came from results the EDGC received as part of the implementation of its financial and medical support programme for victims of obstetric fistula in the ECOWAS member states, and evidence generated through an obstetric fistula situational analysis conducted in 2010 and updated in 2013 and 2015.<sup>cxlv</sup> This led to the identification of three strategic points, plus a transversal one:<sup>cxlvi</sup>

1. Prevention of obstetric fistula through public awareness campaigns regarding causes and impacts on the social and reproductive lives of the victims;
2. Comprehensive care of obstetric fistula victims in all ECOWAS member states;
3. Socioeconomic reinsertion of victims cured of or having recovered from obstetric fistula;
4. Coordination, monitoring and evaluation and operational research in the field of obstetric fistula for all ECOWAS member states.

For the period 2016–19, the Regional Action Plan aims to secure geographical coverage of all countries in the ECOWAS region.<sup>cxlvii</sup> The strategy seeks to extend the range of services, adapted to all levels of the health structure through relevant and effective strategic and operational options.<sup>cxlviii</sup>

## Case study 24. Reforming abortion law in Rwanda

A coalition of CSOs successfully advocated for law reform in Rwanda, to allow women to realise their rights to safe abortion. Initial reservations to the Maputo Protocol were lifted and the Penal Code has been aligned with the Maputo Protocol through concerted action and petitioning, the use of media and constructive engagement with the government. The coalition continues to document the limitations women face in practice in accessing safe abortion.

Rwanda was one of the first states to ratify the Maputo Protocol, doing so as early as 2004. In ratifying it, it entered a reservation to Art. 14(2)(c) of the Maputo Protocol, which authorises safe abortion in several instances. At the time of this reservation, abortion was generally presumed to be illegal, given the country's highly restrictive Penal Code of 1977. The reservation therefore had the effect of further burdening the legal environment with regard to abortion with an air of restriction and illegality. This environment led many women to resort to unsafe abortions, risking their lives, health and liberty in the event that they were apprehended.

In 2012, civil society actors—the Great Lakes Initiative for Human Rights & Development together with the Health Development Initiative and Ihorere Munyarwanda Organisation—developed a collaborative campaign. The objectives of this included enhancing access to safe and legal abortions.

The campaign utilised various strategies. First, it was an evidence-based initiative. Studies were undertaken to establish statistics, for instance, on the numbers of young women dying from unsafe abortions. Second, it was a consortium-based campaign, which broadened its voice and enhanced ownership. For example, different members would sign on for various petitions or interventions. Third, the actors had existing good relations with the government and used this influence to ensure the initiative had a multi-stakeholder perspective. Finally, the use of media (TV, radio, print) presented a dual advantage, on the one hand sensitising the media themselves on the campaign issues and on the other hand getting the issues reported on and covered.

The campaign resulted in the lifting of Rwanda's reservation to Art. 14(2)(c) of the Maputo Protocol. This was all the more impactful because Rwanda is a monist state. Art. 190 of its Constitution provides that 'international treaties and agreements which have been conclusively adopted in accordance with the provisions of law shall be more binding than organic laws and ordinary laws'.

It is also worthwhile noting that the Penal Code also went through reform in 2012 and its provisions in Art. 165 were expanded to permit abortions in instances of rape, incest, forced marriage and risk to the health of the woman or the foetus. The reformed law also included a requirement that the woman present to a doctor a court order recognising one of the authorised grounds for abortion.

These sets of legal reforms, by virtue of the lifted reservation and the expansion of abortion grounds in the Penal Code, should ideally mean women are in a better place to assert their rights to a safe abortion. However, in practice, this case study also points to the limitations of the law in addressing women's rights violations. On the ground, the cumbersome requirement in the Penal Code has rendered legal abortion virtually inaccessible. Women continue to suffer restricted access to abortions because they, judges and health care professionals are unaware of the law; even where women are aware, they do not have the resources to find a lawyer, a provider and a judge as prerequisites to accessing abortion services.<sup>cxlix</sup>

As a result, most women still end up resorting to what are then perceived as 'illegal' abortions, leading to arrests and unjust imprisonment. In fact, 'nearly a quarter of the female prison population in [sampled] five prisons' comprised women and girls incarcerated for illegal abortions.<sup>cl</sup> The CEDAW Committee, in its latest concluding observations on Rwanda, also noted that 'an alarming number of women are serving prison sentences for abortion-related offences, many of whom were arrested when seeking emergency health care following abortion complications'.<sup>cll</sup> A review of the Penal Code is currently on-going, aimed at removing the onerous requirements prior to accessing an abortion. What is also clear is that, even this law reform is not sufficient on its own; the government and civil society actors will need to engage in extensive advocacy to ensure both rights-holders and duty-bearers, such as health professionals, are engaged in enhancing awareness and access to safe abortion services.

## Case study 25. Using coalition-building to advance abortion rights in Uganda

**A multidisciplinary coalition of CSOs contributed to norm change among health professionals regarding safe abortion services in Uganda. By applying a harm reduction model, and by legally supporting health professionals facing stigma and criminalisation in a restrictive legal context, the coalition was able to strengthen the commitment of health professionals to addressing the reality of women facing unwanted pregnancies.**

Unsafe abortion is one of the key causes of maternal mortality in Uganda and indeed in Africa as a whole. Almost 10% of maternal deaths in Africa are the result of unsafe abortion. Morbidity is also a concern: about 1.6 million women in the region are treated annually for complications from unsafe abortion.<sup>clii</sup> Unsafe abortions compromise women's rights to life, health, reproductive health, dignity and freedom from cruel, inhuman and degrading treatment among others.

To address this issue, the Centre for Health Human Rights and Development (CEHURD) established a coalition with the vision that no woman or girl should suffer or die from unsafe abortion. The coalition is made of over 15 organisations and individuals in Uganda, including representatives of legal, service delivery, grassroots, communications, youth, women's rights and health consumer organisations.<sup>127</sup>

The aim was to achieve coordination and collaboration between the many actors working on abortion but doing so surreptitiously, resulting in an ineffective response as well as duplication of efforts. Actors working on policy, service delivery, stigma reduction, community sensitisation and women's empowerment are all interlinked yet, before the coalition, they were working in silos. Now, actors who were working on seemingly different issues have a platform to engage in dialogue and to work together and have therefore expressed more willingness to work on safe abortion openly.

The strategic entry point for the coalition draws on the fact that it is multidisciplinary in nature and therefore has a holistic approach towards addressing safe abortion, ranging from policy development to service provision, advocacy, stigma reduction and community sensitisation. Other strategies the coalition uses include influencing policy development as well as implementation, legal reform efforts and undertaking value clarification and attitude transformation (VCAT) for key stakeholders. VCATs are interventions that include trained facilitators leading diverse stakeholders through a process conducted in an emotionally safe environment in which they examine their personal values, attitudes and actions related to abortion. An interesting element is the coalition's engagement with the media, which is two-pronged: training the media but also giving out small grants for media organisations to develop human interest stories.

One innovative strategy, in light of the legally restrictive environment for abortion access in Uganda, that the coalition is undertaking entails the use of the harm reduction model. This is a pragmatic approach that seeks to ensure women have information about safe abortion so that, rather than choosing crude methods, they will opt for safer methods such as the use of abortion drugs. This will reduce the rate of mortalities and morbidities associated with unsafe abortion. The coalition has initiated the harm reduction model among providers both private and public, and there are plans to nationalise this approach.

The work of the coalition has resulted in various levels of impact, as evidenced by the increased and diverse number of interventions aiming to increase stakeholder knowledge on available options to counter recourse to unsafe abortions. These interventions are being implemented in both the public and the private sector. On the social level, the coalition has been able to nationalise the discussion on abortion while also shaping the narrative. For instance, a media audit has revealed that, as a result of trainings, the media are now more objective in their reporting, and there are more well-researched and analytical stories related to abortion than in the past. While abortion care and advocacy has traditionally been associated with stigma, stakeholders, particularly providers, have gained both knowledge and confidence, and this tends to lead to increased service provision.

The coalition has also had legal impacts. It has established a legal support network for the provision of legal services to providers who are being harassed, extorted or wrongfully arrested for provision of abortion services as a result of stigma and the perceived illegality of abortion. The coalition is also poised (various on-going litigation) to develop jurisprudence that discusses abortion and other SRH rights in Uganda: all authoritative jurisprudence on abortion presently is pre-colonial in nature and inappropriate for today's context. Related to the legal framework, the coalition has also been instrumental in the development of policies. For instance, it drafted standards and guidelines on reducing maternal morbidity and mortality through unsafe abortion.

<sup>127</sup> Center for Health Human Rights and Development, HEPS Uganda, Uganda Women's Network, Akina Maam Wa Afrika, Association of Obstetricians and Gynecologists of Uganda, Chapter 4, Alliance of Women Advocating for Change, Reach a Hand Uganda, Private Midwives Association, Human Rights Awareness and Promotion Forum, Femme Alliance, Action for Integrated Development, Marie Stopes Uganda, Law Uganda, Institute for Social Development, Global Coalition for Women Against AIDS, Reproductive Health Uganda.

Uganda is, however, experiencing policy degradation, with major policies either stayed or disowned by the country's Ministry of Health. The most notable policies that have faced this fate are the standards and guidelines for reducing morbidity and mortality from unsafe abortion (2015) and the national guidelines and service standards for SRHR (2017). The coalition is currently involved in advocacy efforts to ensure these critical policy documents are reinstated and operationalised. The coalition has also contributed to the building of a large body of knowledge, with national-level dissemination through trainings, different online platforms and strategic impact litigation.

The most notable impact that has been registered is improved understanding among health service providers about the legal and policy environment for the provision of abortion services. Stigma among providers has also been addressed, and this has translated into attitude transformation, leading to a willingness among providers to undergo training and also to provide quality, non-judgemental services to women seeking abortions.

## Case study 26. The 'Medicalised Abortion' Campaign in Senegal

An advocacy group in Senegal put unsafe abortion on the public agenda and advocated for legal change respecting the provisions of the Maputo Protocol. The Ministry of Health sparked the debate by collecting data on unwanted pregnancies and practices related to unsafe abortion. Its warning on the implications of unsafe abortion was picked up by jurists and CSOs.

Senegal has one of the most restrictive laws on abortion in the West Africa region. Art. 305 of the Penal Code prohibits abortion. 'Whoever, by food, drink, medicine, labor, violence or any other means, has procured or attempted to procure the abortion of a pregnant woman, whether she has consented or not, shall be punished by imprisonment from one year to five years and a fine of 20,000 to 100,000 CFA'.<sup>cliii</sup>

Art. 35 of Senegal's Code of Medical Ethics grants abortion for a single exception: 'Therapeutic abortion can only be performed if this is the only way to safeguard the life of the mother.' In addition, this very limited exception is accompanied by extremely expensive procedural conditions: three different doctors (a prescribing physician and two medical inspectors) must certify that only such an intervention can save the mother's life. One of the consulting physicians must be on the designated list of experts, established by the court. A protocol on the decision taken must then be sent by registered mail to the President of the Order of Physicians. Finally, 'If the doctor, because of his convictions, believes that he is forbidden to advise to perform the abortion, he can withdraw by ensuring the continuity of care by a qualified colleague'.<sup>cliv</sup>

Despite the restrictive abortion law, it was estimated in 2012 that 51,500 induced abortions, mostly hidden and life-threatening, took place in the country; this translates into 17 abortions per 1,000 women between 15 and 44 years old.<sup>clv</sup> In 2015, a reported 9% of imprisoned women were incarcerated on charges of infanticide and 3% on charges of clandestine abortion.<sup>clvi</sup> The Ministry of Health published in 2008 an analysis that found that clandestine abortions, which are widely practised, were the fifth leading cause of maternal deaths in the country. Faced with the weight of numbers of unsafe abortions and the high MMR, the Ministry of Health initiated the evaluation of the situation of unwanted pregnancies and unsafe abortions in Senegal between April and May 2010. The study showed an increase in the number of cases of unwanted pregnancy, rape, incest and infanticide.<sup>clvii</sup> Based on a study conducted by health personnel across the country, the ministry then recommended raising awareness about the risks of abortion (death, prison).

In 2013, the Association of Senegalese Jurists (Association des Juristes Sénégalaises, AJS) and other CSOs established a multidisciplinary network of lawyers, sociologists, medical personnel and activists, named the Taskforce for Safe Abortion.<sup>128</sup> The goal of the campaign is to obtain permission for abortion more in line with the cases provided for by the Maputo Protocol, such as rape and incest.<sup>clviii</sup> Later on, the Taskforce took the name of the Advocacy Committee for Access to Medicalised Abortion in Senegal (Comité de Plaidoyer pour Accès à l'Avortement Médicalisé in Sénégal). The term 'medicalised abortion' is used to refer to safe abortion;<sup>129</sup> this term was opted for to promote people to affiliate with the campaign's cause, because of the beliefs of many people in the country that what happens in a medical centre is legal and well done (according to a respondent from the AJS).

The committee planned a 120-day awareness campaign<sup>clix</sup> and set up 4 working groups, targeting religious leaders, young people, parliamentarians and the media. During the 120-day awareness campaign, which finally extended to 12 months, the working group targeting religious leaders and young people merged to form a community group. The campaign's awareness-raising activities reached almost 800 people, including 650 young people aged 15–24 years. This sparked interest among young people, who asked for more sensitisation and information activities on medicalised abortion. Young people have also positioned themselves as ambassadors for medicalised abortion in cases of rape or incest. Youth as well as religious and community leaders and other members of the community are better able to explain the different conditions cited for medicalised abortion and to explain advanced arguments. Religious leaders are delivering writings on the position of Islam regarding rape and incest, and are committed to preaching sermons around the issue.

The establishment of an advocacy committee for access to medicalised abortion has undergone various stages in a restrictive legal environment.<sup>clx</sup> At first, its actions were not sufficiently known, but in the past five years the committee has not only attracted the attention of the authorities but also succeeded in expanding the debate to communities.

<sup>128</sup> The current members and partners of the Taskforce are Association des Juristes Sénégalaises, Association des Femmes Médecins du Sénégal, Association Sénégalaise pour le Bien-Etre Familial, Association Nationale des Infirmiers et Infirmières diplômés d'Etat du Sénégal, Association des Journalistes contre les Viols et Abus, Association Nationale des Sages-Femmes d'Etat du Sénégal, Comité de Lutte contre les Violences faites aux Femmes, Fédération des Associations Féminines du Sénégal, Groupe pour l'Etude et l'Enseignement de la Population, Institut des Droits de l'Homme et de la Paix, Réseau Islam et Population, Réseau Siggil Jigeeen, Marie Stopes International, Population Council, Direction de la Santé de la Reproduction et de la Survie de l'Enfant, Rencontre Africaine pour la Défense des Droits de l'Homme, Wildaf (Femmes Droit et Développement), and Personnes Physiques Ressources.

<sup>129</sup> This use of the term 'medical abortion' is different from the WHO meaning, where medical abortion is differentiated from surgical abortion and both are part of safe abortion (see Section 7.1.3, Box 7.1). Medical abortion in the Senegalese context is used to mean that 'women can end their pregnancy safely with the assistance of a health worker in case of sexual assault, rape, incest and when the pregnancy endangers the mental or physical health of the mother', as mentioned in Art. 14 of the Maputo Protocol.

The advocacy campaign ended with a proposal for a law on medicalised abortion to the minister of justice, whose concern is to reach a consensus, which would allow for the development of a law text that would be accepted by the majority of the Senegalese population. Since the law on access to safe abortion has not yet been passed, the Ministry of Health cannot take action in this regard. The Ministry of Justice is working hard but cultural and religious issues still represent a blockage.

Although the laws have not yet been changed in favour of medicalised abortion, the different strategies adopted have contributed to moving the process forward and building shared understanding. The committee has also carried out important activities with government, parliamentary and religious authorities. It has also stimulated greater adherence to respect for the right to reproductive health of women and girls enshrined in the Convention and the international and regional legal instruments to which Senegal has acceded. These activities have helped intensify public debate on the issue, reversing the previous situation of abortion as a taboo subject.

However, challenges remain in terms of access to safe abortion in cases of rape and incest and when the health or life of the mother is threatened. Having signed the Maputo Protocol, which authorises abortion in cases of rape or incest, Senegal has the obligation to harmonise its domestic legislation with its international and regional commitments in order to respect the fundamental rights of women and girls.



## Case study 27. Enhancing judicial capacities on abortion rights in Kenya

The articulation of abortion provisions in penal and criminal codes gives safe abortion a criminal rather than a human rights perspective. In response to this, and anticipating future litigation, a handbook has been written and trainings conducted with judiciary officers, to raise their knowledge and awareness of the need to apply a human rights perspective in interpreting abortion laws.

As is evident in the national legal and policy framework analysis in this chapter, abortion laws in Africa are largely to be found within penal and criminal codes, because abortion was historically criminalised. Even in countries that have reformed and liberalised their abortion laws, this is sometimes done within those very penal codes, with permissible grounds for abortion listed as exceptions to what is otherwise deemed 'criminal conduct'. Notably, abortion laws in some countries, like Kenya and Uganda, are also governed by the Constitution, which requires legal interpretation through either judicial precedence or legislation on abortion rights—which in many cases is yet to happen. These circumstances ostensibly also influence the mind-sets of providers and law enforcement officials, as they give abortion provision an air of criminality where there are legal exceptions.

Similarly, a gap was observed—that judicial officers previously interacted with abortion only from a criminalisation perspective and therefore might not have the perspectives required to safeguard abortion rights. This led to the development of a handbook to raise judges' awareness of the human rights obligations associated with abortion<sup>130</sup> and subsequent trainings with judicial officers. The trainings addressed the role restrictive legal frameworks had in the burden of unsafe abortion faced by many women who are unable to access safe abortion services. They explored the human rights basis and the public health perspective of abortion. The emphasis was on raising judicial officers' awareness of the need to apply a human rights perspective in interpreting abortion laws. Also highlighted was how abortion laws could be barriers and the link between these laws and unsafe abortions. States have an obligation to respect, protect and fulfil women's rights to abortion; the action highlighted this and the role of judicial officers in meeting these obligations.

Stakeholders working on reproductive health rights in Kenya find themselves increasingly needing to move to court to defend the right to abortion, which is guaranteed in the 2010 Constitution but still suffers threats owing to old mind-sets. The interesting element of this action therefore is that Ipas anticipated this upsurge in litigation while at the same time observing the problem that judicial officers' previous interactions with abortion were mostly from a criminalisation perspective. The handbook and the subsequent trainings therefore served to prepare the ground for abortion-related litigation by enhancing judicial capacities to appreciate abortion cases from a rights perspective. The intended impact is that abortion rights will be secured in courts as well as unreasonable legal and administrative barriers being lifted, towards enhanced access to legal and safe abortions. The handbook and the trainings have contributed to more open conversations within the judiciary on abortion, which have also been captured by the media.<sup>clxi</sup>

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## Chapter 7

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