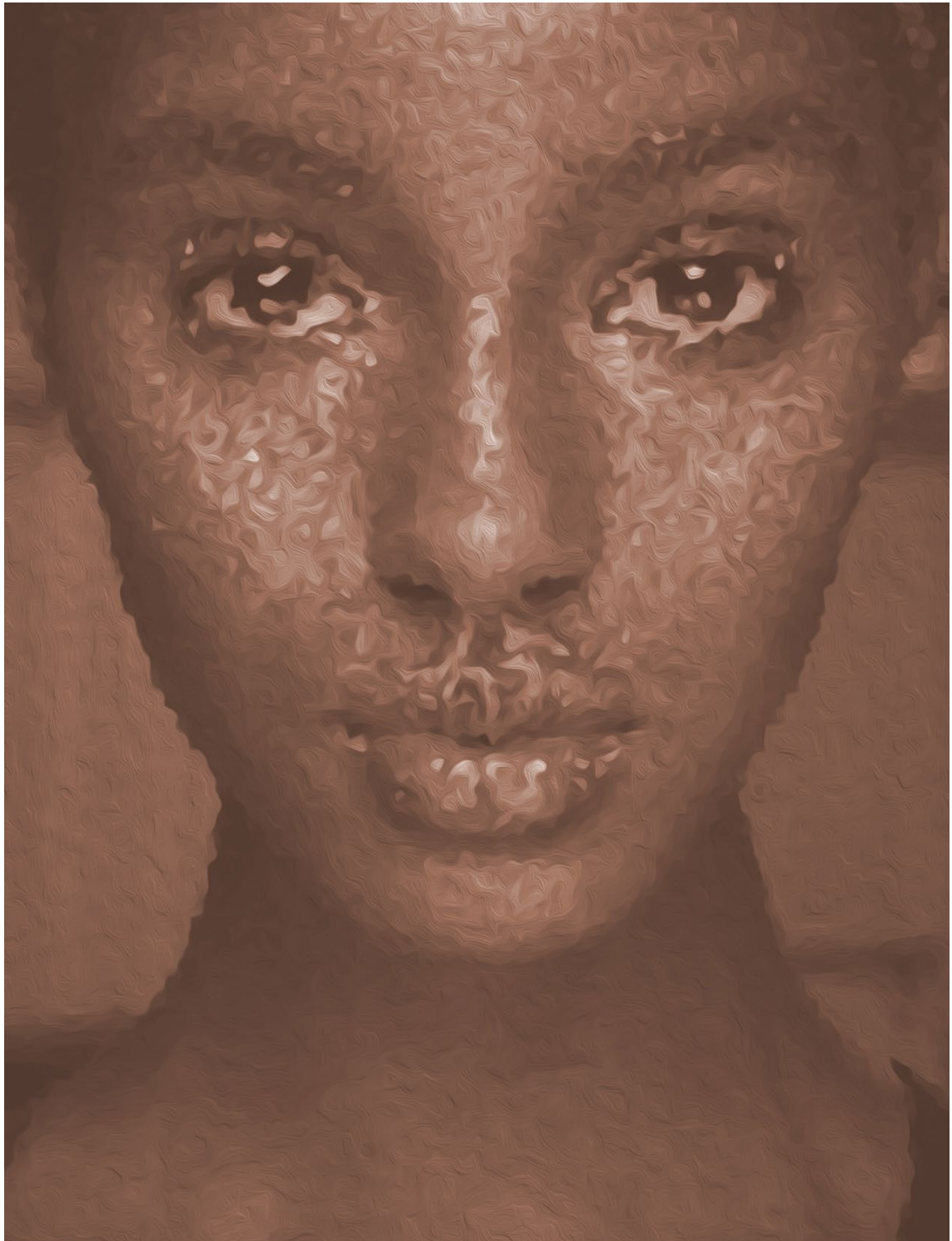


THE STATE OF AFRICAN WOMEN REPORT

Key Findings

JUNE 2018



The State of African Women Report

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This report was developed and published in the context of the State of African Women project, implemented by a consortium of eight partners.

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PREFACE

The 'State of the African Woman' Report marks a major milestone in the three-year advocacy, communication and awareness raising campaign project that focuses on increasing civil society's contributions to promote the implementation of the African Union policy frameworks. The project is implemented at the global, continental, regional, national and sub-national levels by a consortium that includes International Planned Parenthood Federation Africa Region (IPPFAR), International Planned Parenthood Federation European Network (IPPFEN), Organisation of African First Ladies Against HIV/AIDS (OAFLA), Deutsche Stiftung Weltbevölkerung (DSW), Royal Tropical Institute (KIT) Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), Faith to Action Network (F2A), and the Young Women Christian Association Kenya (YWCA). Within this consortium, KIT has led and worked with a team of African Women Researchers to develop the 'State of African Women' Report.

The consortium works towards the advancement, realization and extension of rights and seeks to influence legal and social norms through greater transparency and public pressure on duty bearers. Whilst comprehensive mechanisms exist to document status of ratification and domestication of policies like the of the Maputo Protocol and the Maputo Plan of Action; this intervention recognizes the untapped potential of CSOs, Youth, Journalists, Parliamentarians, Religious Leaders and First Ladies as mediators and advocates; and appreciates their latent ability to further push for the implementation of existing provisions.

The 'State of African The African Women' Report provides vital information that supports the strengthening of CSO advocacy efforts. It is the result of a context specific analysis that monitors and reports on the different levels of implementation of key continental rights instruments. The findings strengthen CSOs' knowledge and capacity, and promotes their meaningful participation in decision-making processes. With increased access to knowledge and understanding of policy gaps and contestations, CSOs including Young people are better prepared to influence the positioning and implementation of legal and social norms. They are also better-equipped and enabled to hold decision makers to account for their policy commitments through evidence and a stronger civil society voice. The potential for a long lasting and far reaching impact in Africa is huge.

The Steering Committee Members of the State of African Women Campaign Project hereby note that the findings highlighted in this report justifies, befits and serves the 'Right By Her' Campaign profile and needs. Our sincere hope is that advocacy professionals across Africa will utilize this evidence-based piece and further develop learning instruments through repackaging the information into policy briefs and communication products.

It is our sincere belief that a broad spectrum of stakeholders in gender, health, rights and development will utilize these findings in their deliberations and will reflect on practical solutions in leadership, policy, practice, and innovation for the advancement of Aspiration 6 of Agenda 2063.

'An Africa whose development is People-Driven, Relying on the Potential of African People, Especially its Women and Youth.'

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FOREWORD



Lucien Kouakou
Regional Director, IPPFAR

Member States of the African Union are signatories to various International Conventions and Declarations that seek to improve the health of women, men and children on the continent. Whilst there are already comprehensive mechanisms in place that document the status of ratification and domestication of the Maputo Protocol and the Maputo Plan of Action, fewer publications and processes have explored in detail, how rights and gender approaches are implemented in practice; as well as the challenges that CSOs face in mediating between duty bearers and rights holders.

The 'State of the African Women' Report has undertaken to systematically, analytically and contextually document current and emerging challenges that continue to burden rights bearers despite the existence of progressive and protective policy frameworks. This knowledge is vital for evidence-based advocacy, key decision making and strengthening dialogue between state and non-state actors. I believe that this report will provide inspiration to the entire Gender Equality and SRHR movement in Africa, to rekindle the momentum in advancing and accelerating implementation of provisions enshrined in our continental policy frameworks and instruments. The 'State of the African Women' Report has projected considerable analytical evidence on the impact that the Maputo Plan of Action and Maputo Protocol has had on sub-regional and national policies. It is clear that domestication of provisions is necessary for the improvement of lives and livelihoods of the continent's citizens. It is my firm belief that this report will go a long way in supporting key decision makers both in the policy and social realms to further and more consciously implement these provisions to address Africa's unfinished SRHR business.

It is my earnest hope that policy makers, parliamentarians, development partners, media, youth and African citizens at large will find this report useful in catalyzing the continental work of securing, realizing and extending the rights of women and girls. I wish to assure all readers that IPPFAR and the SoAWC Consortia Members, supported by thousands of volunteers, champions and staff, will continue to deliver on the mammoth task of disseminating the findings and supporting utilization of the same in policy spaces across the continent.

I also wish to thank all the state and non-state actors, the team of researchers as well as the larger civil society constituency in Africa for their invaluable participation throughout the development of this report.

I extend my sincere gratitude to all those who contributed tirelessly in numerous ways to put this report together.

Sincerely,

Lucien Kouakou
Regional Director
IPPF Africa Region

ACKNOWLEDGEMENTS

This State of African Women report is a clear example of what can be realised when standing on the shoulders of giants. It is a testimony to the voices, achievements and courage of women and girls across the continent who challenge discrimination and inequality. It also reflects the vast knowledge, experiences and efforts of countless women and girls who are deeply committed to and engaged in realising women and girls' rights in the past, present and future.

We would like to express our sincere gratitude to the project development team that was led by Matthias Brucker in 2016 when the State of the African Woman project was designed. We sincerely thank the many individuals who were contacted, interviewed, and who shared information, insights, and critical views that proved indispensable to this report. This includes representatives and staff at the different Regional Economic Communities, as well as women's rights and SRHR organisations, activists, youth leaders, faith-based organisations and leaders at the continental, regional, national and community levels. We are also grateful to the 42 participants of the Regional Research Workshop (December 5-6, 2017, Nairobi). Their active engagement allowed this report to be more comprehensive, grounded and in-depth. A special word of thanks also goes to Tabitha Griffith Saoyo and Sofia Rajab-Leteipan for taking detailed notes of the rich conversations during the workshop.

The final version of the report has benefitted from the critical reading and thoughtful feedback of four external reviewers. We would like to extend our appreciation in this regard to Dr. Eunice Brookman-Amissah, Dr. Rose Oronje, Sifisosami Dube and Sofia Rajab-Leteipan. Their reviews, provided in a very short time, elevated this report.

Throughout the development of this report, the contributions from consortium partners were also of high value, from the report outline, via the initial and full drafts of the chapters, to the final report. We would like to thank Emma Bowa, Anne Sizomu, Nathalie Nkoume, Cesaire Pooda, Bibiane Mbaye, Eunice Murambi, Mark Okundi, Tina Lubayo, John Robert Ekapu, Susan Wamarwa, Paulin Tra, Peter Munene, Vitalis Mukhebi, Hanna Mekonnen, Macharia Karanja, Gina Wharton, Julia Millauer, Lorena Fuehr, Rena Föhr, Alice Bridgwood, Andrea Oliveira, and their colleagues in their respective organisations, for their insightful comments, ideas and feedback along the way. Throughout the drafting of the report, Nathalie Nkoume and Peter Munene stood out in providing guidance and direction which was highly appreciated.

We have been lucky to work with a passionate core team of researchers that authored this report. Rainatou Sow, Laura Nyirinkindi, Mariam Mamunyu, Elsbet Lodenstein and Marlies Visser, you all brought a vast experience, a high level of ambition and a hard-working mentality to our team. There is so much more to say, but here we thank you for your energy and open mind, and your willingness to learn together, so that the whole could be larger than the sum of its parts. We are also grateful to Sandra Quintero for her thorough contributions in the desk review and early writing phase. We also thank Peguy Ndonko for his efforts in the initial data collection in one of the regions.

A special word of appreciation goes to Margaret Roo Griffith for her thorough editing of the full report text, and her flexible and supportive way of working. We are also grateful for the efforts of Kaz Kapusiak, and Rena Föhr and her colleagues, for the design and publication of the report. Much appreciation is extended to James Ngechu whose flexibility has been indispensable in the final stages of the publication of the report. Thank you also to Prof. Dr Anna van der Vleuten, for the day-to-day support and advice, and for providing an academic home.

Anouka van Eerdewijk and Caroline Kwamboka N.

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ACRONYMS

AADPD	Addis Ababa Declaration of Population and Development
ACEWRC	African Committee of Experts on the Rights and Welfare of the Child
ACHPR	African Commission on Human and Peoples' Rights
ARV	Antiretroviral Therapy
AU	African Union
CAR	Central African Republic
CARMMA	Campaigns on Ending Child Marriage, Maternal Mortality
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CEN-SAD	Community of Sahel-Saharan States
COMESA	Common Market for Eastern and Southern Africa
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organization
DRC	Democratic Republic of the Congo
EAC	East African Community
EANNASO	Eastern Africa National Networks of AIDS Service Organisations
ECCAS	Economic Community of Central African States
ECOFEP	ECOWAS Female Parliamentarians Association
ECOWAS	Economic Community of West African States
EU	European Union
FEMCOM	Federation of National Associations of Women in Business in Eastern and Southern Africa
FGM	Female Genital Mutilation
GVAW	Gender-based Violence Against Women
HIV	Human Immunodeficiency Virus
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
IGAD	Intergovernmental Authority on Development
INGO	International Non-Governmental Organisation
IPPF	International Planned Parenthood Federation
IPPFAR	International Planned Parenthood Federation Africa Region

IPV	Intimate Partner Violence
MARWOPNET	Mano River Women's Peace Network
MERF	Monitoring, Evaluation and Reporting Framework
MPoA	Maputo Plan of Action
MTCT	Mother-to-Child Transmission
NAP	National Action Plan
NGO	Non-Governmental Organisation
NOPSWECO	Network on Peace and Security for Women in the ECOWAS Region
PAC	Post-Abortion Care
PITC	Provider-Initiated Testing and Counselling
PoA	Plan of Action
REC	Regional Economic Communities
ROAJELF	Benin and the West African Network of Young Women Leaders
SAC	Safe Abortion Care
SADC	Southern African Development Community
SDG	Sustainable Development Goal
SGBV	Sexual and gender-based violence
SOAWC	State of the African Woman Campaign
SOGIE	Sexual orientation or gender identity or expression
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
UMA	Arab Maghreb Union (Union du Maghreb arabe)
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNSCR	United Nations Security Council Resolutions
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

GLOSSARY

Health is ‘a state of complete physical, mental and social well-being, and is not merely the absence of disease or infirmity’.

Reproductive health ‘is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant’ (ICPD PoA, Para. 72, 1994).

Reproductive health ‘also includes **sexual health**, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases’ (ICPD PoA, Para. 72, 1994). Sexual health is ‘a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled’ (WHO, 2006).^x

Reproductive rights ‘embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents’ (ICPD PoA, Para. 7.3; see also ICPD+5 review).

Sexual rights, in a similar vein, ‘embrace certain human rights that are already recognized in international and regional human rights documents and other consensus documents and in national laws’ (WHO, 2006, updated 2010, and WHO 2015).^{xi} This means that ‘the application of existing human rights to sexuality and sexual health constitute sexual rights. Sexual rights protect all people’s rights to fulfil and express their sexuality and enjoy sexual health, with due regard for the rights of others and within a framework of protection against discrimination’.^{xii} More specifically, the ‘rights critical to the realization of sexual health include: the rights to equality and non-discrimination; the right to be free from torture or to cruel, inhumane or degrading treatment or punishment; the right to privacy, the rights to the highest attainable standard of health (including sexual health) and social security; the right to marry and to found a family and enter into marriage with the free and full consent of the intending spouses, and to equality in and at the dissolution of marriage; the right to decide the number and spacing of one’s children; the rights to information, as well as education; the rights to freedom of opinion and expression; and the right to an effective remedy for violations of fundamental rights. The responsible exercise of human rights requires that all persons respect the rights of others’.

SOGIE refers to sexual orientation and gender identity and expression.

Discrimination against women means ‘any distinction, exclusion or restriction or any differential treatment based on sex and whose objectives or effects compromise or destroy the recognition, enjoyment or the exercise by women, regardless of their marital status, of human rights and fundamental freedoms in all spheres of life’. (Maputo Protocol, Article 1)

Women means ‘persons of female gender, including girls’. (Maputo Protocol, Article 1)

Child means ‘a human being aged below 18 years of age, even if majority is attained earlier under national law’. (African Children’s Charter, Article 2)

Youth or young people are defined as ‘every person between the ages of 15 and 35 years’. (African Youth Charter, definitions)

Adolescents are individuals between 10 and 19 years old, in the transition phase from childhood to adulthood.

Violence against women means ‘all acts perpetrated against women which cause or could cause them physical, sexual, psychological, and economic harm, including the threat to take such acts; or to undertake the imposition of arbitrary restrictions on or deprivation of fundamental freedoms in private or public life in peace time and during situations of armed conflicts or of war’ (Maputo Protocol, Article 1).

Gender-based violence against women refers to ‘all acts perpetrated against women which cause or could cause them physical, sexual, psychological, and economic harm, including the threat to take such acts; or to undertake the imposition of arbitrary restrictions on or deprivation of fundamental freedoms in private or public life in peace time and during situations of armed conflicts or of war’, and concerns ‘violence that is directed against women because she is a woman or that affects women disproportionately’ (combining the definitions on violence against women from Maputo Protocol, Article 1; and gender-based violence from CEDAW General Recommendation No. 19 and No. 35).

Sexual violence means ‘any non-consensual sexual act, a threat or attempt to perform such an act, or compelling someone else to perform such an act on a third person. These acts are considered as non-consensual when they involve violence, the threat of violence, or coercion. Coercion can be the result of psychological pressure, undue influence, detention, abuse of power or someone taking advantage of a coercive environment, or the inability of an individual to freely consent. This definition must be applied irrespective of the sex or gender of the victim and the perpetrator, and of the relationship between the victim and the perpetrator’ (Guidelines on Combatting Sexual Violence and Its Consequences in Africa, ACHPR 2017, section 3.1, definitions).

Sexual and gender-based violence (SGBV) refers to ‘any act that is perpetrated against a person’s will and is based on gender norms and unequal power relationships. It includes physical, emotional or psychological and sexual violence, and denial of resources or access to services. Violence includes threats of violence and coercion. SGBV inflicts harm on women, girls, men and boys and is a severe violation of several human rights’ (UNHCR Emergency Handbook).

Sexual harassment is ‘harassment of a person because of her or his sex, as by making unwelcome sexual advances or otherwise engaging in sexist practices that cause the victim loss of income, mental anguish and the like’. It is a form of sexual violence. (UN Women. 2012. ‘Glossary of Terms from Programming Essentials and Monitoring and Evaluation Sections’.

Trafficking in persons refers to the ‘recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. **Exploitation** shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs’. (Protocol to Prevent, Suppress and Punish Trafficking in persons especially Women and Children, supplementing the UN Convention against Transnational organized Crime (2000); also known as the Palermo Protocol, Article 3a).

Voluntary counselling and testing (VCT) is client-initiated and refers to individuals actively seeking HIV testing and counselling services because they wish to learn about their status.

Provider-initiated testing and counselling (PITC) is HIV testing and counselling that is recommended by health-care providers to persons attending health care facilities as a standard component of medical care, and with the purpose of enabling clinical decisions to be made and/or the provision of specific medical services. PITC needs to have an 'opt-out', as patients have the right to decline the recommendation of HIV testing and counselling if they do not wish the testing to be performed.

Mandatory or forced testing concern compulsory testing of individuals, without their informed consent. Mandatory testing has been reported in the context of visa applications, pre-employment screening, scholarships or fellowship applications, insurance purposes or bank loans, as well as for sex workers, or for military personnel. HIV testing can also be mandatory for pregnant women, and there are also trends of mandatory pre-marital testing (of both women and men).

Mother-to-child transmission (MTCT) is the transmission of HIV from a mother to her child during pregnancy, labour, delivery or breast-feeding.

Harmful practices are 'all behaviour, attitudes and/or practices which negatively affect the fundamental rights of women and girls, such as their right to life, health, dignity, education and physical integrity'. (Maputo Protocol, Article 1g)

Marriage means 'formal and informal unions between men and women recognised under any system of law, custom, society or religion'. (Joint General Comment, p. 3)

Betrothal means 'an engagement or a promise to marry. It can also refer to the act of promising or offering a child or young person in marriage, whether by a parent, guardian or family elder'. (Joint General Comment, p. 4)

Free and full consent in the context of marriage entails 'non-coercive agreement to the marriage with full understanding of the consequences of giving consent' (Joint General Comment, p. 4). Full consent implies total consent of the person consenting, and cannot be supplemented or cured with the addition of parental consent given on behalf of a child.

Child marriage is 'a marriage in which either one of the parties, or both, is or was a child under the age of 18 at the time of union'. (Joint General Comment ACHPR and ACERWC on Ending Child Marriage, point 6, page 4).

Female Genital Mutilation (FGM) concerns 'the practice of partially or wholly removing the external female genitalia or otherwise injuring the female genital organs for non-medical and non-health related reasons'. (CEDAW & CRC (2014) Joint General Recommendation No. 31 of the Committee on the Elimination of Discrimination against Women/General Comment No. 18 of the Committee on the Rights of the Child on harmful practices General Comment/recommendation CEDAW, point 19 (Part VI.A.19, page 6)

Harmful practices include a wide range of practices that constitute a form of discrimination that disproportionately affects women and girls, and often amounts to GVAW. They are often based on cultural or socio-conventional norms and deeply rooted in gender inequalities and discriminatory values. Harmful practices are those conducted for non-therapeutic purposes. This report focuses on child marriage and FGM, given among others their high prevalence in African countries and their strong inter-linkages in certain contexts.

Child marriages are often deeply entrenched in cultural, religious and social norms of unequal gendered power relations, and are an expression of societal control and regulation of women's sexuality and reproductive functions. Weak legal and administrative systems, as well as legal pluralism, contribute to the continued practice of child marriage. Lack of education contributes to child marriage; in turn, child marriage leads to low education of girls. Child marriage affects the health of girls, and especially their SRHR.

Female genital mutilation is a human rights violation and involves specific violence against women's physical integrity, and her right to life, dignity, equality and freedom from torture. FGM can be of Type I, II, III or IV. The first three types differ as to whether the clitoris and/or the inner labia have been cut off, and whether the wound has been sewn or not (infibulation). Type IV refers to all other harmful practices, which include pricking, piercing, pulling, cutting, scraping and burning of female genitalia. FGM has long-lasting effects on the reproductive organs of girls and women, and all four types of FGM represent a direct risk to their health and life. FGM is strongly affected by cultural and social norms of female subordination and control over women and girls' sexuality and reproduction. Child marriage and FGM are also highly interrelated, and child marriage is prevalent in countries where FGM is practised.

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'. (WHO, 1992)

Family planning/contraception means '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'. The General Comments No.2 refer to 'family planning/contraception'; this report uses contraception.

Comprehensive sexuality education (CSE) is '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'. (UNESCO, UNAIDS, UNFPA, UNICEF & WHO (2018). International Technical Guidance on Sexuality Education. An evidence-informed approach)

Sexuality is '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'. (WHO 2018, Defining sexual health)

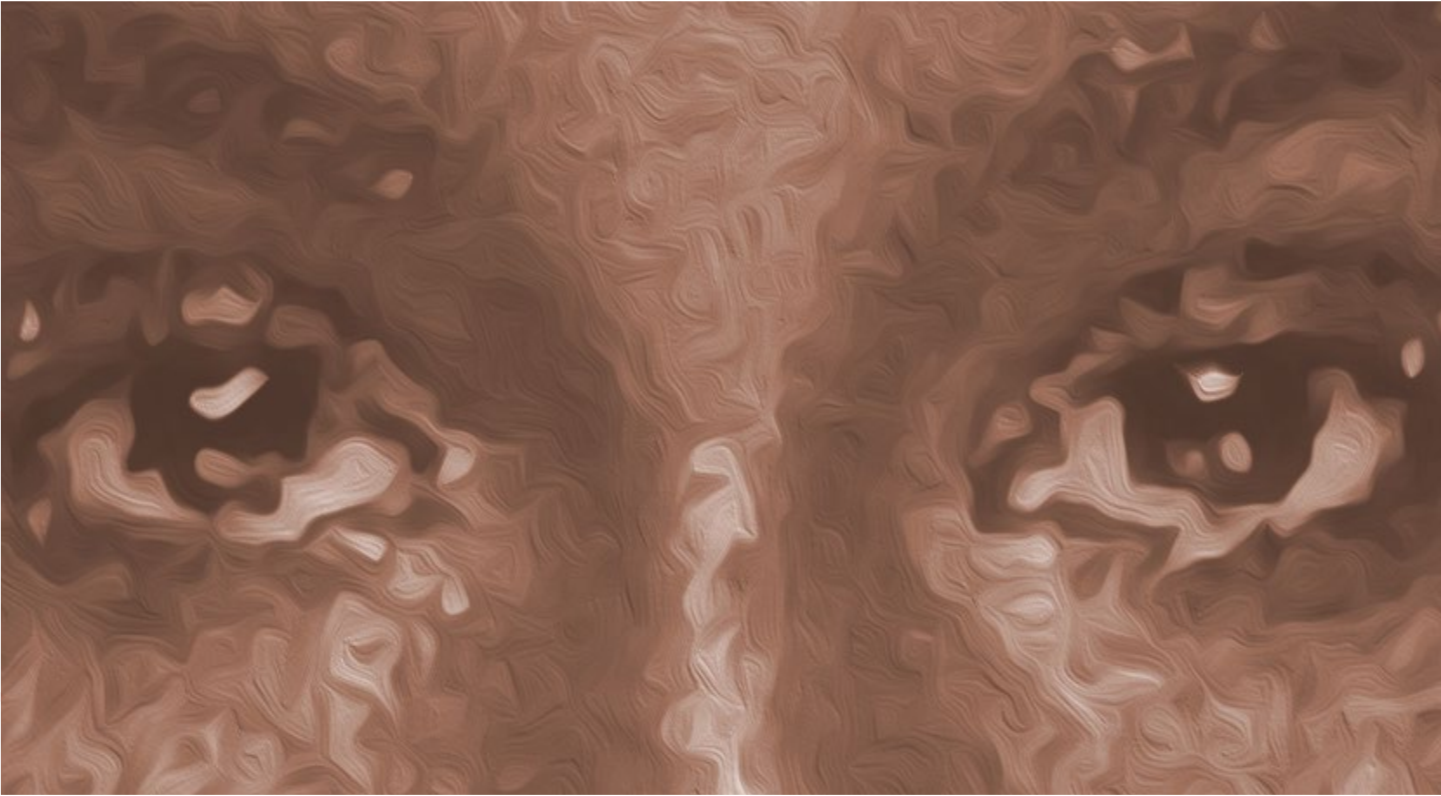
Safe abortion refers to 'safe abortion services provided through specific medicines or methods, with all the necessary information and the informed consent of concerned individuals, by primary, secondary and tertiary level health professionals, trained in safe abortion, in line with the WHO standards.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

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, 2012; page 18)

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, 2012; page 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 (D&E)'. (WHO (2012) Safe Abortion: Technical and Policy Guidance for health systems, 2012; page iv)

1 INTRODUCTION



BACKGROUND

Health and bodily integrity lie at the heart of well-being for all. Sexual and reproductive health and rights are critical elements of health and bodily integrity, especially for women and girls. Poor health and violations of bodily integrity are not only poor development outcomes, but also violations of fundamental human rights. Healthy and well-spaced and timed pregnancies, together with protection from infections with HIV, and other sexually transmitted diseases, have a large impact on women and girls' health and lives. In order for that impact to be positive, women and girls need to have the freedom to make choices about fertility, pregnancies, contraception and on how to protect themselves and be protected from HIV and other STIs. Access to sexual and reproductive health services as well as comprehensive information and education is indispensable to support women and girls in making these choices.

For that impact to be positive and women and girls' health and bodily integrity to be promoted and realised, they need to be able to choose and decide on sexual partners and relations, and when desired, on their marriage partner. And it requires that women and girls are free from violence, discrimination and coercion, and in particular are free from child marriage, female genital mutilation and other harmful practices. That points to the need to challenge gender inequalities and patriarchal norms and practices, and to promote gender equitable relations that respect and promote consent, freedom and choice of all women and girls. These gender relations manifest themselves in intimate relations, marriage, and communities, as well as in interactions with health service providers or police or judiciary officers.

This year marks the fifteenth anniversary of the Maputo Protocol, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, adopted in 2003. This anniversary offers an excellent opportunity to take stock of gaps and contestations around the realisation of women and girls' rights, and to identify where progress needs to be accelerated. The upcoming 25-year review of the ICPD (International Conference on Population and Development, ICPD+25) also calls for review of progress made. This review, especially in connection to the five-year review of the Addis Ababa Declaration of Population and Development in Africa Beyond 2014 (AADPD+5), provides the moment to see where progress has stalled, and what the unfinished business is for the near future in realising women and girls' sexual and reproductive health and rights.

Achieving full gender equality in all spheres of life is a critical element of the 'aspirations of the Africa we want' articulated in Agenda 2063. Addressing the unfinished agenda is also key to realising the SDGs, and in particular SDG Three and Five. Sexual and reproductive health as well as financing for health systems are key priorities to meeting SDG Three (to promote healthy lives and promote well-being for all at all ages). In order to meet SDG Five (to achieve gender equality and empower all women and girls), more efforts are needed to end gender-based violence against women and girls, as well as harmful practices, such as child marriage and FGM. It also requires women and girls being able to make decisions about sexual relations and partners, and about choice of contraception and access to and use of SRH services and information.

Addressing this unfinished business is of pivotal importance as we embark on the last three years of the Africa Women's Decade (2010-20), that aims to hold government to account on their continental and international commitments for gender equality and women and girls' empowerment. This State of African Women report aims to contribute to the realisation and promotion of women and girls' rights, in particular in SRHR, by raising awareness of the commitments and tracking progress made towards their full implementation.

1.2 THE STATE OF AFRICAN WOMEN REPORT AND THE RIGHT BY HER CAMPAIGN

This State of African Women report is published as part of the State of African Women Campaign (SOAWC) project, whose overall objective is to contribute to securing, realising and extending women's rights enshrined in African Union (AU) policies in African countries. The project is being implemented by a consortium of eight organisations, under the lead of the International Planned Parenthood Federation Africa Region (IPPFAR).¹ The SOAWC project has two intermediate objectives. The first is to influence legal and social norms on women's rights through greater transparency and public pressure on duty-bearers. The second is to hold decision-makers to account for their policy commitments on women's and girls' rights through a stronger civil society voice and meaningful participation in decision-making.

At the heart of the SOAWC project is the Right By Her campaign, which focuses on increasing civil society's contribution to implementation of the African commitments on women and girls' rights in sexual and reproductive health and rights (SRHR). The Right By Her campaign focuses in particular on implementation of the AU's Maputo Protocol (the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa) and the Maputo Plan of Action (MPoA), which is the implementation framework for the Continental Policy Framework on SRHR. The campaign seeks to strengthen implementation of the Maputo Protocol and the MPoA at four decision-making levels across Africa: continental, regional, national and subnational. It does so by strengthening civil society organisations (CSOs) in two aspects: in terms of knowledge on women and girls' rights in SRHR and in terms of advocacy strategies and capacity to meaningfully participate in decision-making processes. As such, the SOAWC project aims to enhance CSOs' potential to have a long-lasting and far-reaching impact.

The Right By Her campaign focuses on **four specific rights areas**:

1. Gender-based violence against women (GVAW)
2. Harmful practices (in particular child marriage and female genital mutilation, FGM)
3. Reproductive rights and sexual and reproductive health (SRH)
4. HIV and AIDS

Alongside the four rights areas, this report takes into account four cross-cutting issues: peace and security; education and training; participation of women in political and decision-making processes; and marginalised and vulnerable groups of women or girls (in particular adolescent girls and young women, elderly women, women with disabilities, women in distress, and individuals marginalised on the basis of their sexual orientation or gender identity or expression, SOGIE).

¹ The project is funded under the EU.

Figure 1. The four core rights area of this report, with the cross-cutting issues

CORE RIGHTS



1.3 WHY THIS STATE OF AFRICAN WOMEN REPORT?

The current status of ratification and domestication of the Maputo Protocol and the MPoA is already being tracked and documented in existing mechanisms and in earlier reports and publications. Few of these explore the pathways by means of which rights are operationalised in practice, through laws, policies, administration, budgets and programmes. More insight is needed into what has to be done to accelerate implementation, monitoring and reporting on key rights instruments and political commitments regarding women and girls' rights in SRHR. This insight is vital to further strengthening of CSO advocacy efforts. It will also be valuable to states and regional and continental organisations and bodies in contributing to the realisation of women and girls' rights. Analysis of gaps and opportunities across countries and regions, and deeper understanding of the challenges currently faced in implementation, will inform the prioritisation of key rights areas and advocacy strategies in the different regions and levels.

The report complements existing reports and reviews by:

- Focusing specifically on **SRHR** issues, and doing this in a comprehensive and holistic way
- Bringing in and strengthening a **gender and rights perspective**, by integrally linking SRHR to women and girls' human rights and addressing them from a perspective of eliminating discrimination of women and girls
- Looking at the role of and trends in **Regional Economic Communities (RECs)** in Africa in advancing and realising women and girls' rights in SRHR, and
- Looking at **strategies of change**, and the role of a range of change agents, including continental, regional, national and subnational state and non-state actors across Africa in the domestication and implementation of continental and regional commitments; in particular highlighting the role of CSOs as mediators between duty-bearers and rights-holders.

1.4 AUDIENCE AND OBJECTIVES

The State of Africa Women report and the Right By Her campaign aim to reach a broad **audience** of African multipliers and opinion-formers on continental, regional and national legal and policy commitments on women and girls' rights in SRHR in African countries. This audience includes parliamentarians, first ladies, journalists, religious leaders and youth leaders, as well as women's rights and/or SRHR organisations and faith-based organisations. It also aims to reach representatives of the AU and the RECs, national-level government decision-makers, and European and international donors. The report seeks to offer knowledge and perspectives that may assist these different audiences in further promoting women and girls' rights in SRHR. The targeted audience of the report may have varying levels of knowledge on the relevant continental commitments (the Maputo Protocol, the MPoA) and may not necessarily be well versed or specialists in gender and rights analysis.

Box 1. Audience of the report

1. African multipliers and opinion-formers including parliamentarians, first ladies, journalists, religious leaders, youth leaders, feminist organisations and activists, and representatives of CSOs (including women's rights, SRHR, child rights and faith-based organisations)
2. AU and REC representatives including high-level political decision-makers, as well as technocrats and thematic experts
3. National (and subnational) government decision-makers
4. EU (Brussels) and donors

Taking into account the various audiences, the **objectives** of the report are:

1. To **raise awareness** about the Maputo Protocol and Plan of Action as continental commitments for women's and girls' rights in SRHR
2. To **review the status and implementation** of the Maputo Protocol and Plan of Action, with specific focus on women's and girls' rights in SRHR
3. To provide and **strengthen a gender and rights perspective** on the implementation of these continental commitments, and to strengthen understanding of women and girls' realities and of how women's and girls' rights can be secured, realised and extended
4. To inform and **strengthen effective advocacy efforts and strategies of CSOs and African multipliers and opinion-formers** towards implementation of the Maputo Protocol and Plan of Action and the realisation of women and girls' rights in SRHR

The report presents an overview of the current status of continental norms in realising women and girls' rights in SRHR and their ratification and domestication in countries across African sub-regions, taking into account multiple levels of governance. It also looks at the role of RECs in this.

More precisely, the report will:



- Provide information and background on the Maputo Protocol and Maputo Plan of Action, in particular about the **continental commitments on women's and girls' rights in SRHR**
- Provide clarification on how continental commitments are relevant in women and girls' lives, and why and how a **human rights perspective** is important



- Provide insight into the **ratification and domestication** of continental commitments on women's and girls' rights in SRHR
- Provide insight into the role of **RECs** on the continent in the realisation of women and girls' rights in SRHR
- Provide information on and insight into the domestication and translation of continental commitments on women's and girls' rights in SRHR, in **national-level legislative, policy and institutional frameworks**
- Provide insight into the role of CSOs, RECs and national-level governments in bringing about and contributing to **legal and social norm change** towards the realisation of women and girls' rights in SRHR



- Provide an analysis of **gaps and opportunities in the implementation** of continental commitments and realisation of women's and girls' rights in SRHR, to help identify advocacy priorities and effective advocacy strategies, tailored to the different regions

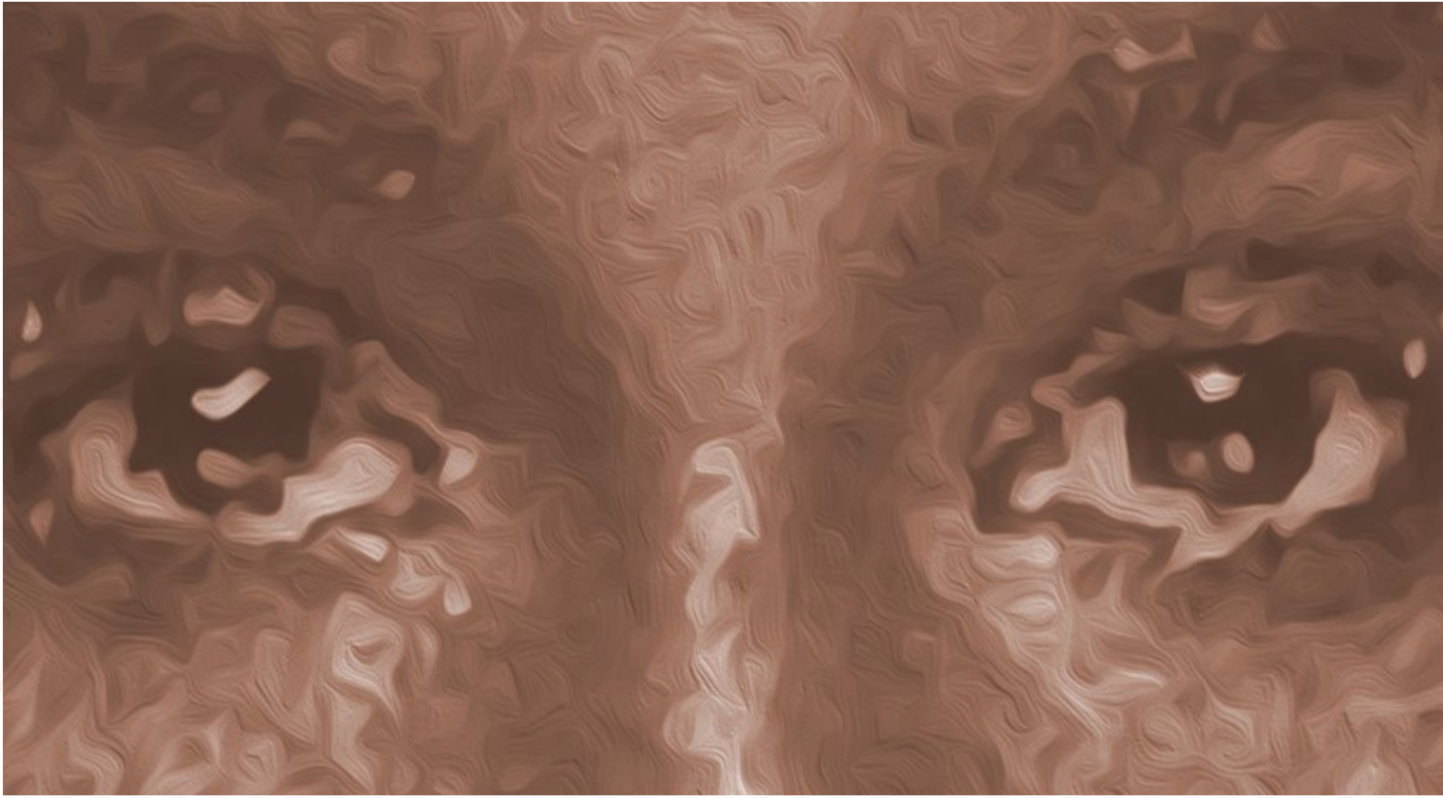
1.5 REPORT OUTLINE

This State of African Women report has nine chapters. The introductory chapter is followed by chapter 2 that offers the conceptual frameworks on women and girls' rights in SRHR. Chapter 3 then discuss the methodology of the data collection and analysis. Chapter 4 presents the key findings on the African Union normative and institutional framework on women and girls' rights and SRHR. Chapter 5 shifts the attention to the Regional Economic Communities (RECs) and discusses their normative and institutional frameworks on women and girls' rights and SRHR.

The chapters 6 to 9 focus on the four core rights areas of the report. Chapter 6 addresses gender-based violence against women (GVAW), and chapter 7 concerns harmful practices. Chapter 8 continues with reproductive rights and SRH, and chapter 9 addresses HIV and AIDS. These four rights area chapters follow the same structure: they all start with key findings on prevalence of the issue. They then go on to present the continental commitments regarding this issue, in a concise but comprehensive explanation of the provisions and obligations of the Maputo Protocol and other relevant continental commitments. This is then followed by a review and discussion of the domestication and implementation at the national level. This includes an overview of main trends in legal, policy and institutional reform, as well as identification of key gaps and contestations. Each chapter ends with a set of recommendations.

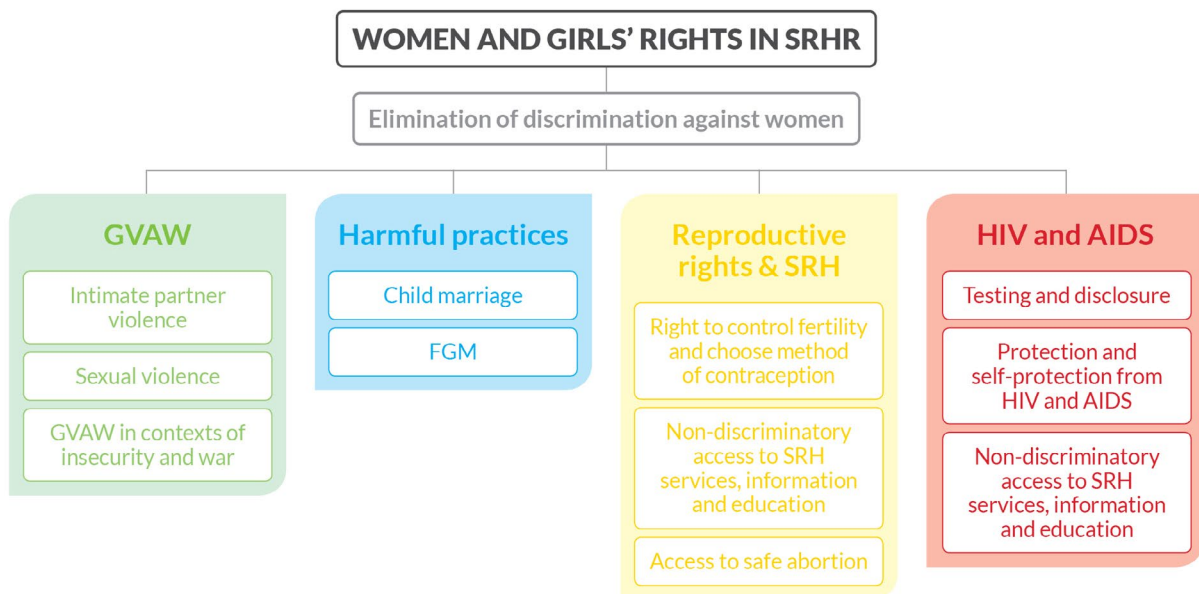
This Key Findings report is a shorter version of the full State of African Women report. The content presented here is a summary of the more detailed full report. That means that those reader who want more insight and a more in-depth reading of the points raised in this Key Findings report can consult the full report for more details. The full report has been set up in a modular way, which allows different readers to take different pathways of reading it, depending on their core interests.

2 WOMEN AND GIRLS' RIGHTS AND SRHR



This report focuses on women and girls' rights in SRHR, and within that on four core rights areas: gender-based violence against women (GVAW), harmful practices (in particular child marriage and FGM), reproductive rights and SRH, and HIV and AIDS. The choice of and approach to these four rights areas are grounded in a comprehensive and integrated understanding of **women and girls' SRHR**, which is in turn integrally linked to the elimination of discrimination against women and girls. This chapter briefly explains the conceptual basis of the report. Figure 2 visualises this conceptual framework.¹

Figure 2. Women and girls' SRHR and the four rights in this State of Africa Women report



SRHR is at the heart of the Continental Policy Framework on SRHR of 2006, which seeks to further implementation of the Programme of Action (PoA) of the International Conference on Population and Development (ICPD), which took place in Cairo in 1994. In the African regional ICPD+20 review, the Addis Ababa Declaration on Population and Development beyond 2014 recognizes that 'sexual and reproductive health and rights are not only essential to the realization of social justice, but are central to the achievement of global, regional and national commitments for sustainable development', and continues to commit to 'enact and enforce laws and policies within national political and legal frameworks to respect and protect sexual and reproductive health and rights of all individuals'.ⁱ

Reproductive health and sexual health are to be understood in relation to the definition of **health** as 'a state of complete physical, mental and social well-being, and is not merely the absence of disease or infirmity'.ⁱⁱ The right to the highest attainable standard of physical and mental health is articulated in the International Covenant on Economic, Social and Cultural Rights¹ (ICESCR) (Art. 12.1).ⁱⁱⁱ The Maputo Protocol provides that 'the right to health of women, including sexual and reproductive health, is respected and promoted' (Art. 14). General Comment No. 2 on the Maputo Protocol reaffirms the ICESCR, according to which:

'the right to health entails both freedoms and rights. **Freedoms** include the right for human beings to control their own health and their own body, including the right to sexual and reproductive freedom, as well as the right to integrity, including the right not to be subjected to torture and not to be subjected, without their consent, to medical treatment or experiment. On the other hand, **rights** include the right of access to a system of health protection that guarantees equally to everyone the possibility to enjoy the best health condition possible.'^{iv}

¹ This is grounded in Art. 25 of the UN Universal Declaration of Human Rights of 1948, which states that 'Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services.'

Reproductive health and sexual health are an integral part of health, integrally linked to the right to health. Attaining and maintaining reproductive and sexual health therefore implies respecting and promoting fundamental **human rights of women and girls**. These include 'their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence'. Reproductive and sexual health also implies that people are able to pursue and have a satisfying, pleasurable and safe sex life, free from coercion, discrimination and violence. Sexual and reproductive rights refer to existing human rights and norms applied to reproduction and sexuality, which include 'freedom, equality, privacy, autonomy, integrity and dignity of all people' and guarantee that everyone can enjoy sexual and reproductive freedom, free from any coercion, discrimination or violence and within a context respectful of dignity.^{vii} SRHR, in its comprehensive and holistic sense, is central and fundamental to people's health and well-being.

SRHR is integrally linked to the promotion of **respectful and equitable gender relations**, and to the elimination of discrimination against women and girls. SRHR cannot be realised without equitable relationships between women and men in matters related to sexuality and reproduction. This requires mutual respect, consent and shared responsibility. Men and boys' attitudes and behaviours are key determinants of gender relations and hence of the realisation of women and girls' SRHR.^{viii} Moreover, neglect and violation of women and girls' SRHR constrain their opportunities and participation in the public and private spheres, including in education, economic and political life. The realisation of women and girls' SRHR is a crucial and important basis for their enjoyment of other rights.^{ix} This report is based on this understanding of SRHR and the definitions, as presented in Box 2 below.

Box 1.2. Definitions of reproductive health, sexual health, reproductive rights and sexual rights

Reproductive health 'is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant' (ICPD PoA, Para. 72).

The same article of the ICPD PoA states that reproductive health 'also includes **sexual health**, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases'. Sexual health is 'a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled' (WHO, 2006).^x

Reproductive rights 'embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents' (ICPD PoA, Para. 7.3; see also ICPD+5 review).³

³ The ICPD+5 review added to this that, 'In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community. The promotion of the responsible exercise of those rights for all people should be the fundamental basis for government- and community-supported policies and programmes in the area of reproductive health, including family planning' (para. 3); www.unfpa.org/sites/default/files/event-pdf/key_actions_en.pdf

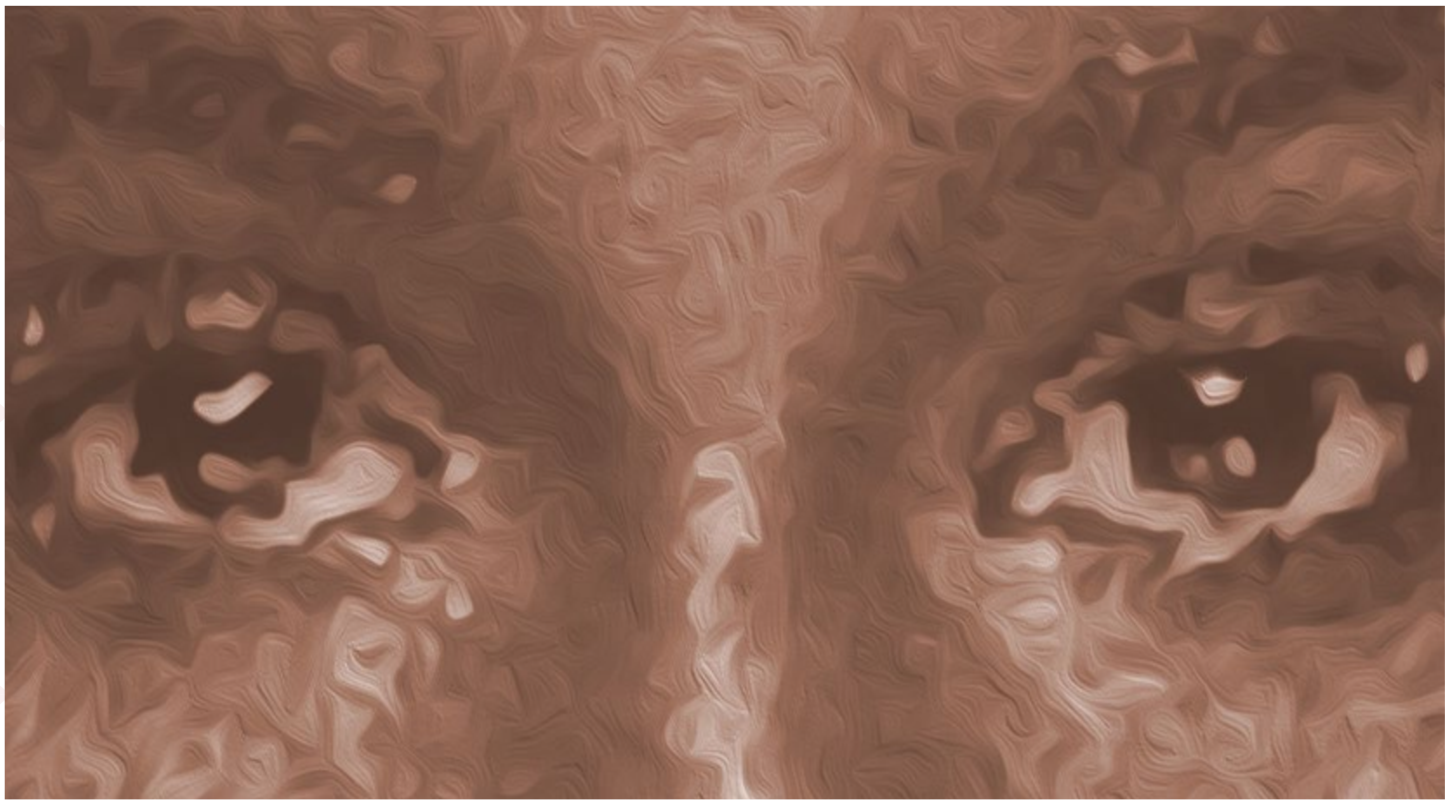
Sexual rights, in a similar vein, 'embrace certain human rights that are already recognized in international and regional human rights documents and other consensus documents and in national laws' (WHO, 2006, updated 2010, and WHO 2015).^{xi} This means that 'the application of existing human rights to sexuality and sexual health constitute sexual rights. Sexual rights protect all people's rights to fulfil and express their sexuality and enjoy sexual health, with due regard for the rights of others and within a framework of protection against discrimination'.^{xii} More specifically, the 'rights critical to the realization of sexual health include: the rights to equality and non-discrimination; the right to be free from torture or to cruel, inhumane or degrading treatment or punishment; the right to privacy, the rights to the highest attainable standard of health (including sexual health) and social security; the right to marry and to found a family and enter into marriage with the free and full consent of the intending spouses, and to equality in and at the dissolution of marriage; the right to decide the number and spacing of one's children; the rights to information, as well as education; the rights to freedom of opinion and expression; and the right to an effective remedy for violations of fundamental rights. The responsible exercise of human rights requires that all persons respect the rights of others'.^{xiii}

SRHR represents the comprehensive and holistic umbrella under which this report puts the spotlight on the selected rights areas of gender-based violence against women (GVAW), harmful practices, reproductive rights and SRH, and HIV and AIDS. Aspects of sexual and reproductive health, as well as of sexual and reproductive rights, cut across and are integral to all of these four rights areas. Respect of bodily integrity, and being able to decide whether to be sexually active or not, to choose one's sexual partners and to engage in consensual sexual relations, lie at the heart of all these four rights areas. Access to services and information on SRH and sexuality, including comprehensive sexuality education (CSE), delivered in a non-discriminatory way, is crucial to realising the highest attainable standard of health. Freedom from coercion, discrimination and violence, in making decisions on sexuality and reproduction, and in accessing SRH services and information, is critical in this.

This also points to the importance of prevention of and protection against GVAW, including intimate partner violence, and to the critical impact of harmful practices such as child marriage and FGM on women and girls' SRHR. Informed consent, privacy, respect and confidentiality in accessing SRH services and information are also at the heart of realising women and girls' SRHR. This counts for all women and girls, including those belonging to vulnerable groups, such as girls, adolescents and young women, women with disabilities, refugee, migrant and internally displaced women, and elderly women—and irrespective of sexual orientation and gender identity and expression (SOGIE). These marginalised and vulnerable groups are often exposed to violations of their rights and to restrictions on accessing SRH information and services, as well as access to justice.⁴ The holistic nature of SRHR also means the four rights areas that are central in this report are highly interlinked. It is for this reason that the report approaches these four rights areas through the lens of women's and girls' rights in SRHR and from a perspective of eliminating discrimination against women and girls.

⁴ African Commission on Human and Peoples' Rights (ACHPR) Resolution 275 observes and condemns violence and human rights violations on the basis of sexual orientation or gender identity (see also Chapter 6): www.achpr.org/sessions/55th/resolutions/275/

3 METHODOLOGY



3.1 STUDY DESIGN AND RESEARCH PROCESS

The design of the study for this report was developed on the basis of a consortium Project Planning Meeting (May 2017), followed by a Design Workshop held by the core research team (June 2017). These resulted in a report outline that was shared with the consortium for feedback and finalised in August 2017. The report outline and its accompanying protocol for data collection were implemented from August 2017 onwards. The collection of the data, and especially the analysis and the drafting of the report, has been an iterative process, in which the analytical framework has deepened and the drafting of the report text has taken shape.

The data collection, analysis and report drafting were further shaped by discussions, inputs and feedback from both consortium partners and external stakeholders. On 5–6 December 2017, a Regional Research Workshop was held in Nairobi, Kenya. This hosted 42 organisations and activists from different regions of the continent working on the promotion and realisation of women and girls' rights in SRHR. The Regional Research Workshop aimed to strengthen the data collection, analysis and recommendations of the report, and saw the initial findings of the report shared and presented for feedback and comments. The workshop also aimed to provide a space for sharing and learning among the participants with respect to strategies to realise women and girls' rights. On 19 December 2017, a Debriefing Meeting was organised with the European partners of the consortium to share the initial findings of the report and collect their feedback, comments and inputs.

On the basis of the Regional Research Workshop and the Debriefing Meeting, the research team proceeded to further develop and finalise the report chapters. On 5–9 February 2018, the research team met for in-depth discussion of the findings and conclusions, and for alignment with regard to final revisions of the chapter drafts. On this basis, a full draft of the report was prepared between February and April 2018. This full draft was subjected to three mechanisms of feedback and validation.

First, the consortium members shared feedback and comments, both by e-mail and in an Advocacy Meeting in April 2018. Second, four external reviewers were invited to conduct a thorough and critical review of the report; these four external reviewers were all African specialists in the field, and reflected the different rights areas and regions of the continent. They shared their comments and feedback between mid-April and early May. Third, and simultaneously, key findings of the report were shared with external stakeholders in a range of regional, continental and international meetings. These external presentations also offered highly valuable feedback for the final revisions of the report. On the basis of these three feedback and validation mechanisms, the final version of the report was developed in April and May 2018. Throughout the study and report writing process, key specialists from the consortium have provided editorial guidance.

The data collection and analysis for this report covered four main aspects: the study of (1) continental normative frameworks, (2) frameworks of the RECs, (3) national legal and policy frameworks, and (4) the case studies. For the first, on continental normative frameworks, data was collected through desk research. This desk research also included a review of existing secondary data on prevalence and key issues related to the four rights areas (and discussed in the first section of each rights area chapter). For the latter three aspects, the methodology for data collection and analysis is briefly presented here.

3.2 METHODOLOGY FOR THE REGIONAL ECONOMIC COMMUNITIES

Data collection and analysis targeted eight RECs: the Common Market for Eastern and Southern Africa (COMESA), the Community of Sahel-Saharan States (CEN-SAD), the East African Community (EAC), the Economic Community of Central African States (ECCAS), the Economic Community of West African States (ECOWAS), Intergovernmental Authority on Development (IGAD), the Southern African Development Community (SADC) and the Arab Maghreb Union (Union du Maghreb arabe (UMA)).

Of particular importance in filling up knowledge gaps were the RECs' websites and databases, many of which provided information on the status of RECs, key treaties, policies, plans and strategic frameworks. The desk review of the RECs was conducted alongside contacting relevant departments of the RECs and the AU to determine what programmes they had that related to the selected rights areas of primary interest to the report. Subsequently, contact was made with the relevant departments in charge of gender equality and women and girls' rights at COMESA, EAC, ECCAS, ECOWAS, IGAD and SADC. The RECs commendably provided a supportive environment for strategic engagement on the gender issues under consideration.

Visits were made to COMESA, EAC, ECOWAS and SADC, where key informant interviews and focus group discussions were held with relevant officials. These officials also shared literature on updated policies and strategies as well as progress reports. Overall, the field visits to the RECs elicited information and perspectives that would not readily have been otherwise attained. For CEN-SAD, ECCAS, IGAD and UMA, visits did not take place. In the case of IGAD, contacts were established by e-mail and phone, and relevant data was collected in this way. With ECCAS, multiple efforts were made and entries were explored to collect more information on the gender unit's work, but to no avail; the analysis is consequently based on what could be identified through desk research. In the case of both UMA and CEN-SAD, the desk review indicated a low level of activity, for different reasons. A visit was considered of little additional value, as the desk review did not indicate presence of a relevant gender infrastructure or gender equality and women and girls' rights initiatives to learn more about.

3.3 METHODOLOGY FOR NATIONAL LEGAL AND POLICY FRAMEWORKS

For each of the four rights area, data was collected at national level regarding countries' legal, policy and institutional frameworks. The data collection for this relied on in-country primary sources of law such as constitutions and legislation, government websites reporting on their policy and institutional measures (e.g. ministerial websites), state reports to various treaty monitoring bodies, UN and other authoritative international non-governmental organisation (INGO)-run country databases and sources, non-governmental organisation (NGO) reports and other online sources (see Annex 1 for an overview of selected data sources on national legal and policy frameworks).

The data and analysis have undergone various verification steps. To begin with, the data collected was counterchecked against a number of sources for consistency. The data was also the subject of verification and discussion during the Regional Research Workshop.⁵ The data collection and analysis on national legal and policy framework was challenged by the unavailability of comprehensive data sources on the various rights areas, which made the data collection process lengthy and arduous. In some cases, available databases were found to be outdated or limited in terms of the time period they covered.

This Key Findings report presents a set of maps on legal and policy frameworks regarding specific rights areas. These maps are built on a set of legal and policy indicators that emerged from the elaborate national-level datasets. For each rights area, we formulated five to seven indicators that capture key aspects of the domestication of the provisions and obligations in the Maputo Protocol and related relevant commitments and. These indicators are explained at the start of the sections 6.3, 7.3, 8.3 and 9.3. A detailed explanation of these legal and policy indicators is provided in Annex 2. The interpretation of the maps is explained in the legend accompanying each map.

⁵ Participants of the Regional Research Workshop reviewed the data collected from their country to verify and/or correct it, and offered further information.

All countries have been scored on these legal and policy indicators. The detailed scoring per indicator and rights area is available in the full report chapters, where they are accompanied by a narrative analysis. This Key Findings version of the report presents the continental and regional overview tables only, and these compile the scores of the countries per region. The composition of these regional units is explained in Annex 3.

Two observations need to be made regarding these legal and policy indicators. First, they are all indicators of whether a certain constitutional or legal provision, or a particular policy, is in place. The legal and policy indicators themselves do not capture the extent to which these legal and policy frameworks are subsequently implemented. Second, in some cases it proved highly challenging to identify legal and policy indicators that were both relevant and feasible. It is, for instance, much easier to establish what the legal age of marriage is than to see whether a country guarantees women's right to control her fertility and choose a method of contraception. Some critical rights concerns are not easily traced in national laws and policies, and certainly not in a comparative analysis of data on all African countries. This needs to be born in mind when considering the indicators. In several instances, the report uses existing secondary comparative data and analysis to support and complement the primary data we collected ourselves.

3.4 METHODOLOGY FOR CASE STUDIES

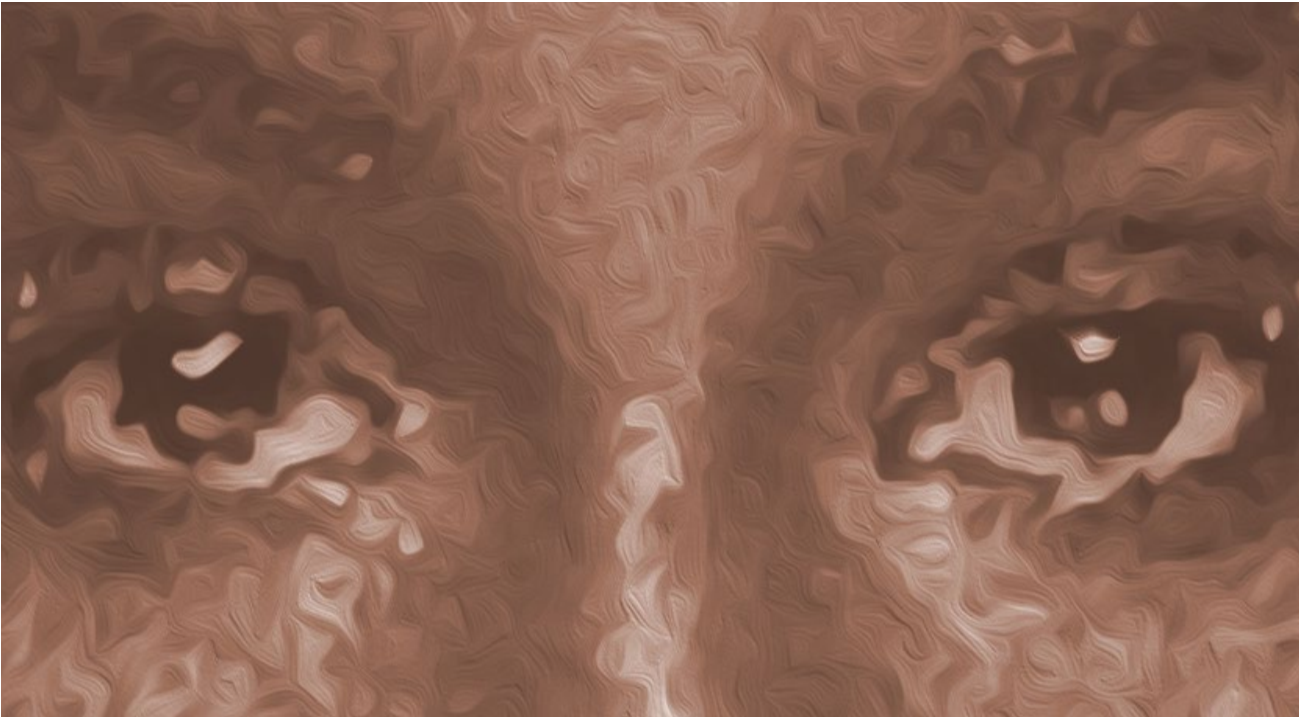
The full report includes a large set of case studies. The purpose of the case studies is to give an insight into the different initiatives and strategies used by different groups, actors and organisations to realise women and girls' rights and to advance the women's rights agenda. They show and reflect what is happening across the continent, at various levels and in a range of arenas, to promote, protect and expand women and girls' rights in SRHR. As such, the case studies deepen and extend the analysis of the four rights areas in specific contexts and at specific levels, while emphasising strategies of change. These case studies can inform and inspire CSOs and activists, African multipliers and opinion-formers, as well as policy-makers, about the range of strategies that can be pursued to advance the implementation of women and girls' rights in SRHR in Africa. As such, they provide a sense of the possible.

This Key Findings version refers to the insights from the case studies in section 4.2. The case studies themselves are not included in this Key Findings version. Table 2 gives an overview of the case studies, clustered per rights area. More details on the methodology for collecting and writing the case studies is available in the full report.

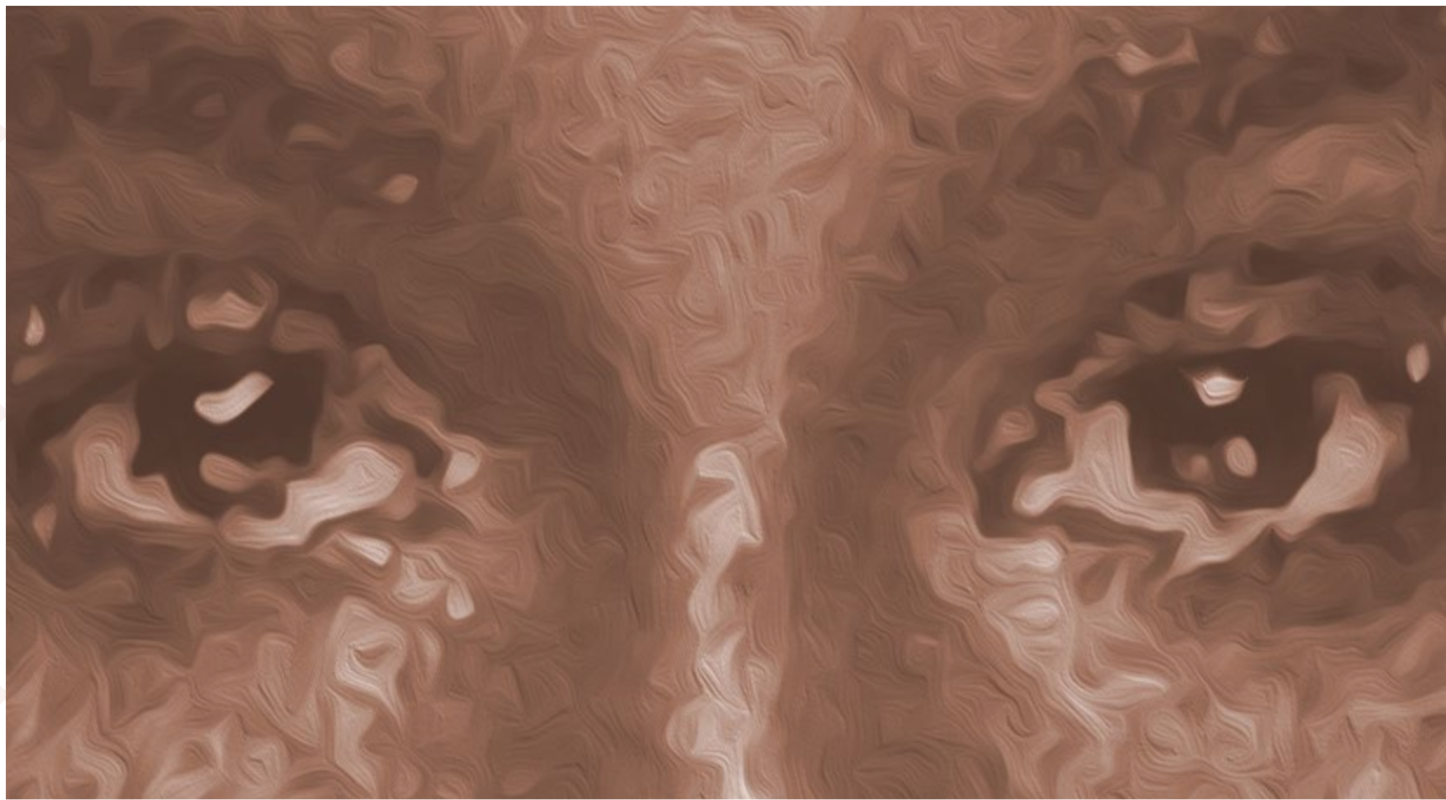
⁶ Participants of the Regional Research Workshop reviewed the data collected from their country to verify and/or correct it, and offered further information.

Table 1. Overview of case studies in full State of African Women report

Case study number	Title of case study
Gender-based violence against women (GVAW)	
Case study 1	State accountability for sexual violence in Kenya: the 160 Girls project
Case study 2	Revenge porn in Zimbabwe: image-based sexual violence and social media
Case study 3	ECOWAS Court makes first judgment on Maputo Protocol in favour of four Nigerian women
Case study 4	Great Lakes region civil society initiative to garner sub-regional political commitment to addressing GVAW
Case study 5	Shukumisa Campaign: Sonke Gender Justice Advocates for state accountability for sexual violence in South Africa
Case study 6	Cross-sector coordination in the management of sexual violence: Kenya's Sexual Offences Act implementation workshop
Case study 7	The Safe Ride Campaign: making travel safe for women and girls in South Africa
Harmful practices	
Case study 8	Rape, abduction and forced marriage in Ethiopia: a girl pursues justice at the ACHPR
Case study 9	SADC adopts model law on child marriage
Case study 10	Malawi Ending Child Marriage Campaign: When elders and youth converge around common goals
Case study 11	Ending child marriage in Tanzania
Case study 12	Youth leadership in ending child marriage and violence against children in Madagascar
Case study 13	Sierra Leone: mobilising chiefs and religious leaders to address FGM
Case study 14	Faith-based approach to tackling FGM in Kenya
Reproductive rights and SRH	
Case study 15	Task shifting in SRH service delivery in Togo to reach more women with contraceptives
Case study 16	CSO advocacy for the integration of family planning in Ghana's national health insurance scheme
Case study 17	The 'School for Husbands' in Niger
Case study 18	Meeting diversity needs in SRH in Cameroon
Case study 19	The Caravan: a strategy to educate faith based leaders and communities on Family Planning
Case study 20	Council of Anglican Provinces in Africa makes an institutional commitment to promote family planning
Case study 21	The Eastern and Southern Africa Commitment on Comprehensive Sexuality Education
Case study 22	EAC Open Health Initiative
Case study 23	ECOWAS moves to eradicate obstetric fistula In West Africa
Case study 24	Reforming abortion law in Rwanda
Case study 25	Using coalition-building to advance abortion rights in Uganda
Case study 26	The 'Medicalised Abortion' Campaign in Senegal
Case study 27	Enhancing judicial capacities on abortion rights in Kenya
HIV and AIDS	
Case study 28	East African Community HIV Prevention and Management Act
Case study 29	Free To Shine Campaign
Case study 30	'Gundo-So': The Bambara Chamber of Confidences—empowering women living with HIV regarding serostatus disclosure
Case study 31	Social Accountability in Malawi and Women Living with HIV: Our Bodies, Our Lives Campaign for Better ARVs in Malawi
Case study 32	Namibian court rules against forced sterilisation of people living with HIV and AIDS
Case study 33	HIV-related forced sterilisation in Kenya



4 WOMEN AND GIRLS' RIGHTS AND SRHR AT THE AFRICAN UNION



The AU has a strong and comprehensive normative and institutional framework on gender equality and women and girls' rights, one that continues to evolve and become stronger. The **Solemn Declaration on Gender Equality in Africa**, the **Maputo Protocol** and the soon to be adopted **AU Gender Strategy** are key components of this normative framework. In addition, the Continental Policy Framework on SRHR, and its translation into the **Maputo Plan of Action (MPoA)**, offers guidance to African states on the implementation of the International Conference on Population and Development Programme of Action (ICPD PoA) (UN 1994), as well as the Abuja Declaration (AU 2001). The implementation of the ICPD PoA in Africa was reviewed, and led to the **Addis Ababa Declaration** on Population and Development in Africa beyond 2014. **Africa Women's Decade** is also important to furthering gender equality and women and girls' rights, as are the continental Campaigns on Ending Child Marriage, Maternal Mortality (CARMMA) and Gender Is My Agenda and the recently launched Free to Shine.

4.1 THE MAPUTO PROTOCOL AND MAPUTO PLAN OF ACTION

The Maputo Protocol is a ground-breaking protocol on women and girls' human rights, both within Africa and beyond, and was adopted in 2003 and came into force in 2005. This Protocol to the African Charter on Human's and Peoples' Rights on the Rights of Women in Africa compensates for shortcomings in the African Charter (1981) with respect to women and girls' rights. It includes 32 articles on women and girls' rights, and provides an explicit definition of **discrimination against women**, which was missing in the African Charter. Discrimination against women means 'any distinction, exclusion or restriction or any differential treatment based on sex and whose objectives or effects compromise or destroy the recognition, enjoyment or the exercise by women, regardless of their marital status, of human rights and fundamental freedoms in all spheres of life'. Women's rights organisations have played a key role in adoption of the Maputo Protocol, and continue to play a critical role in its further ratification, domestication and implementation.

The **progressive and innovative** character of the Maputo Protocol lies in, among other things, the legal prohibition of FGM and the prohibition of forced marriage and marriage of girls under 18. It also provides for the eradication of all forms of GVAW, in public and private spheres, and for the legal protection of adolescent girls from abuse and sexual harassment. The Maputo Protocol articulates women and girls' right to health, including SRH, and their reproductive rights. It is the first protocol to recognise women and girls' access to safe abortion under specific conditions as a human right. It is also the first international human rights instrument to refer to HIV and AIDS explicitly. The Maputo Protocol's value also lies in its explicit references to vulnerable and marginalised groups, including adolescents, widows, elderly women, women with disabilities, poor women and migrant and refugee women.

Fifty-two countries have signed the Maputo Protocol. Forty-one of these have ratified it. Seven countries have **ratified** with reservations, often concerning women and girls' rights on SRHR issues, especially in relation to marriage or access to safe abortion.¹²

- The 11 countries that have not (yet) ratified the Maputo Protocol are Burundi, CAR, Chad, Eritrea, Madagascar, Niger, São Tomé and Príncipe, Somalia, Sudan, Tunisia and Western Sahara.
- Three countries have not signed the Protocol: Botswana, Egypt and Morocco.
- The countries that have ratified with reservations are Cameroon, Kenya, Mauritius, Namibia, South Africa, South Sudan and Uganda (see Annex 4).

¹² As Ethiopia's ratification has been announced but not yet formally deposited at the time of printing, it is not known whether the country has ratified with reservations.

The African Commission on Human and Peoples' Rights (ACHPR) has a protective and promotion mandate vis-à-vis the Maputo Protocol. Under the protective mandate, violations of human rights can be brought to the attention of the ACHPR through litigation (see Case study 8 on the ACHPR case from Ethiopia). Litigation at the ACHPR has been limited, however; in addition, the ACHPR's has missed opportunities for developing and expanding substantial jurisprudence for women and girls' rights protection. Under its promotional mandate, the ACHPR has a number of mechanisms. One of these is the Special Rapporteur on the Rights of Women in Africa, who has been trail-blazing in standard setting.

Under this promotional mandate, the ACHPR has adopted three **General Comments** as well as **Guidelines** on specific topics; these provide interpretative guidance to member states on the Maputo Protocol provisions and the required state response on women and girls' rights. This report refers to General Comment No. 1 (adopted 2012, on HIV and women's rights), General Comment No. 2 (adopted 2014, on rights to reproductive freedom, family planning education and safe abortion) and the Joint General Comment of the ACHPR and ACEWRC (adopted 2017, on ending child marriage). It also refers to the Guidelines on Combatting Sexual Violence and its Consequences in Africa, adopted by the ACHPR in 2017. These General Comments and Guidelines have specific and comprehensive guidance on the obligations of states for implementation.

In 2009, the ACHPR also adopted the Guidelines for Reporting under the Maputo Protocol, to assist member states in drafting periodic reports. At the end of 2017, nine countries had reported on implementation of the Maputo Protocol: Burkina Faso, DRC, Malawi, Mauritania, Namibia, Nigeria, Rwanda, Senegal and South Africa.

The 2006 Continental Policy Framework on SRHR provides guidance on policy formulation and implementation by African states in relation to the ICPD PoA (1994). Its eight priorities include contraceptive use, HIV and AIDS, adolescent reproductive health, unsafe abortion, FGM and GVAW. Low budgetary allocations to health were identified as key constraints. In the Abuja Declaration, already adopted by the AU in 2001, African states pledged to allocate a minimum of 15% of their annual budget to strengthening the health sector. The **MPoA** is the operationalising tool of the Continental Policy Framework on SRHR, and the second and revised one was formulated for the period 2016–2030. The revised MPoA has formulated 10 key strategies; one of these is ensuring gender equality, women and girls' empowerment and respect of human rights. The 2014 Addis Ababa declaration recognised how SRHR were essential to realising social justice as well as sustainable development.

Constraints to **implementation** of the MPoA include weak political commitment and leadership, inadequate financing for health and high donor dependency, as well as inadequate health legislation, weak health systems and limited empowerment of women and girls (see also Map 4 on health expenditures, discussed in more detail below).

Implementation of the Maputo Protocol has been affected by low awareness and knowledge of the Protocol, as well as limited state reporting. It is further affected by continued contestations related to women and girls' rights and culture and patriarchal norms and structures, which are frequently invoked to justify violations of women and girls' rights. There is growing awareness and consensus of the importance of social norm change to respect and realise women and girls' rights, in particular around SRHR, as well as their access to justice. In the context of Africa Women's Decade, it has also been noted that systematic assessment of progress on ambitious commitments of the AU has been weak. Moreover, whereas progress has taken place, it is limited and highly uneven, and the realisation of women and girls' rights on the ground remains disappointing.

Recommendations

- Botswana, Egypt and Morocco to **sign** and ratify the Maputo protocol
- The 11 countries that have signed but not yet **ratified** the Maputo Protocol to proceed and do so (Burundi, CAR, Chad, Eritrea, Madagascar, Niger, São Tomé and Príncipe, Somalia, Sudan, Tunisia and Western Sahara)
- Countries that have ratified with reservations to **lift these reservations**, especially in cases where their national legal framework has been revised and gives the same legal protection as the Maputo Protocol, bearing in mind Article 31.¹³
- Member states that have ratified the Maputo Protocol, to domesticate it in national legal, policy and institutional frameworks and other necessary measures, and **bring their national legal, policy and institutional frameworks in line** with the Protocol provisions and obligations.
- Member states to fulfil their obligation on **periodic reporting** on implementation of the Maputo protocol, in line with the *Guidelines for Reporting under the Maputo Protocol adopted by the ACHPR*
- Member states that have submitted period reports on the implementation of the Maputo Protocol to **implement the concluding observations** of the ACHPR
- Increase **awareness** of the General Comments of the ACHPR, as well as the Guidelines adopted on reporting and the *Guidelines on Combatting Sexual Violence and its Consequences in Africa*
- To further implement the Maputo Plan of Action by, amongst others, **strengthening health systems and health legislation**.
- African states to live up to their commitments on the **Abuja Declaration** to allocate 15% of their annual budget to health
- CSOs to further **utilise the entry points** for advocacy at the ACHPR, including litigation, shadow reporting, and follow-up on concluding observations on state reports, among others
- Strengthen the **popularisation and monitoring of Africa Women's Decade**
- Further strengthen continental campaigns, and especially their implementation at national level, for example with guidelines, support and resources
- Support and strengthen the collection of **reliable, accurate and comprehensive data** on multiple aspects of women and girls' rights in SRHR, in particular sensitive or taboo issues which have a strong impact on women and girls' SRHR. Specific attention is needed for harmonised and accurate data on multiple forms of GVAW and harmful practices, as well as maternal mortality and morbidity, adolescent pregnancies and unmet need, unsafe abortion, and HIV and AIDS prevalence and rights violations for women and girls broadly as well as key population and marginalised groups in particular.
- Better data requires **institutional strengthening** for harmonised data collection, registration and information systems at multiple levels, including **sub-national levels** (including health facilities, police stations, birth and marriage registration systems) and in **national and multi-country** monitoring systems.
- In order to be able to track progress in implementation, **legal and policy indicators** need to be further developed, to capture key normative commitments from the Maputo Protocol and Maputo Plan of Action and their translation into national level legal and policy frameworks.

¹³ Article 31 (on the Status of the Present Protocol) provides that 'none of the provisions of the present Protocol shall affect more favourable provisions for the realisation of the rights of women contained in the national legislation of States Parties or in any other regional, continental or international conventions, treaties or agreements applicable in these States Parties'.

4.2 STRATEGIES FOR CHANGE

The thirty-three case studies presented in this report cover a wide range of initiatives, change agents and strategies pursued to promote, expand and realise women and girls' rights in SRHR. These include legal and policy initiatives of RECs and other regional initiatives, as well as various examples of national level legal or policy reform in different rights areas, including the lifting of reservations. They also include litigation responding to violations of women and girls' rights, including public interest cases, at national, regional as well as continental level, leading to justice for women and girls, increased awareness as well as legal reform. Other case studies capture strategies of promoting and sustaining social norm change supportive of women and girls' rights, in urban as well as rural communities. Several cases also focus on reducing stigma and breaking the silence on taboos around specific rights issues and exclusions of vulnerable and marginalised groups.

Many cases capture the work of women's rights and feminist organisations and activists, at community, national, regional or continental level, engaged in pushing for legal reform, in mobilising communities, in implementing or supporting the implementation of legal and policy frameworks, or monitoring progress in their implementation. Youth champions and young women leaders also feature prominently in several cases. Other cases concern SRHR organisations or programmes implementing innovative approaches to realising the rights in SRHR of women, girls and marginalised groups. Several case studies capture experiences of engaging men and boys as change agents in the promotion and realisation of women and girls' rights in SRHR. Faith-based organisations and faith leaders also feature in multiple cases, facilitating or initiating institutional or social norm change supporting the realisation of women and girls' rights, either within religious institutions, in communities and sub-national policy processes, or in national legal and policy reform.

The lessons that can be learned from this diverse set of case studies include:

- That **civil society, and women and girls' rights organisations** in particular, are critical actors in promoting and monitoring legal, policy and institutional reform on each of the four rights areas (GVAW, harmful practices, reproductive rights and SRH, and HIV and AIDS).
- That it is critical to advance and support **women and girls' leadership and participation** in political and decision-making processes on aspects that affect their lives and concern their rights in SRHR and beyond.
- That **youth champions and youth leaders** play an important role in advocating for adolescents and young people's rights in SRHR.
- That important initiatives to raising awareness and promoting institutional and social norms change towards women and girls' rights are facilitated and initiated by **faith-based organisations and progressive faith leaders**.
- That change towards realizing women and girls' rights in SRHR often requires **internal and institutional change**, in terms of awareness and attitudes among professionals working in a sector, policy makers and authorities in a certain field, or specific faith-based communities or authorities, and then grow and gain traction.
- That legal, policy or institutional change is critical but not enough to realise and expand women and girls' rights in SRHR; these need to be complemented with **challenging of gender inequalities and patriarchal hierarchies, norms and practices**.
- That **multi-disciplinary** coalitions and networks provide powerful opportunities for transformative and sustainable change, and play a central role in legal and policy reform as well as social norm change. Such impact happens when women's rights and SRHR activists and organisations, with youth leaders, faith-based organisations and leaders, broader civil society as well as governmental actors join forces and work around shared agendas.

- In addition, **collaboration and coordination** between stakeholders, both state and non-state actors, along medical as well as legal service delivery and justice chains is critical in implementation of legal and policy frameworks and translating these into changed practice on the ground and actual changes in women and girls' lives.
- That **cross-national and regional exchange and initiatives** allow for sharing of practices and critical and constructive learning among a range of civil society and other actors on strategies that lead to women and girls' rights being promoted, realised and expanded.



5 WOMEN AND GIRLS' RIGHTS AND SRHR AT THE REGIONAL ECONOMIC COMMUNITIES



The AU recognises eight RECs as pillars in the regional integration process, which includes economic as well as broader integration, including social development and governance. The RECs differ in their roles and structures, and also in the progress they have made so far. They are increasingly involved in gender equality and women and girls' rights agendas, where their roles, commitments and progress also vary.

- Five of the eight RECs have a normative and institutional framework on gender equality and women and girls' rights in place: ECOWAS, EAC, IGAD, SADC and COMESA. These RECs differ in terms of the strengths, opportunities and challenges within their normative and institutional frameworks.
- ECCAS has taken some initiatives and made some declarations on gender equality and women and girls' rights, but there is no gender equality and/or women and girls' rights framework, protocol or strategy. ECCAS has a gender unit.
- UMA and CEN-SAD are not highly active as RECs, for different reasons. This low level of activity is reflected in the absence of gender equality and/or women and girls' rights normative and institutional frameworks.

In addition to the RECs, other regional initiatives and frameworks are active in terms of protecting and promoting women and girls' rights and gender equality. The International Conference of the Great Lakes Region has adopted the Kampala Declaration, which has been celebrated for providing a strong regional framework on GVAW in that region (see case study 4 in chapter 5). Another initiative is the Eastern and Southern Africa Commitment on Comprehensive Sexuality Education, in which the ministers of health of 20 countries have committed to a common agenda for all adolescents and young people to deliver comprehensive sexuality education (CSE) and youth-friendly SRH services (see case study XX in chapter 7).

The **key findings** on the strengths, challenges and opportunities in ECOWAS, EAC, IGAD, SADC and COMESA are as follows:

- The treaties of these five RECs contain important provisions and commitments with respect to gender equality and women and girls' rights. Most RECs provide for the importance of gender mainstreaming and women's participation, and in more or less explicit ways on the elimination of discrimination against women.
- All five RECs have a *normative framework on gender equality and/or women and girls' rights* in place. These are binding commitments in the case of ECOWAS (Supplementary Act of 2015), SADC (Protocol on Gender and Development, updated in 2016) and COMESA (Revised Gender Policy of 2016). For EAC, the Gender Equality Bill is to be passed, and this will be binding once this happens. The IGAD Gender Policy Framework is not binding. Most normative frameworks are recent or have recently been updated and amended, to align with the SDGs, Agenda 2063 and other key continental and international agendas and frameworks.
- New steps in these recently formulated and/or updated and revised gender equality normative frameworks relate to the formulation of *monitoring frameworks and tracking mechanisms*. These are most advanced in SADC, with its strong Monitoring, Evaluation and Reporting Framework (MERF), and the targets articulated in the SADC Protocol on Gender and Development. COMESA also has an annual reporting mechanism, and is developing an implementation and tracking matrix. ECOWAS, EAC and IGAD are to formulate and put in place a monitoring framework and mechanism.
- The five RECs have other commitments and frameworks relevant to women and girls' rights and SRHR. These include frameworks on *HIV and AIDS and SRHR, as well as on women, peace and security*.
- Each of these five RECs has a *gender infrastructure* in place, which vary in size, capacity and mandate. In most cases, these suffer from limitations in terms of financial and human resources, and this undermines their potential to realise and monitor full implementation of their commitments on gender equality and women and girls' rights.

- *Regional advocacy networks* are active at the level of the RECs. There are differences in the focus, nature and strength of these across the RECs.
- The level of *civil society engagement* through regional advocacy networks varies by REC. The most active involvement in REC policy processes is observed in SADC and EAC, and to a lesser extent in ECOWAS. Civil society engagement is limited in COMESA and IGAD. EAC is the only REC that has a formal framework for civil society engagement: the Consultative Dialogue Framework.
- ECOWAS has a Court of Justice in place, to which not only states but also individuals can file cases (see Case study 3 in Chapter 5). EAC also has a Court of Justice, but this has not been utilised yet for women and girls' rights issues. The Tribunal of SADC has been suspended.

With the normative framework and gender infrastructure in place in these five RECs, the **key opportunities** that present themselves for realising women and girls' rights and gender equality include:

- *Harmonisation* of legal and policy framework in the respective regions: the legal reform instruments for this include the use of model laws in SADC (Case study 9 in Chapter 6 on SADC Model Law on Child Marriage) and the EAC Bills and Acts that are directly translated into national-level law and policies (Case study XX in Chapter 8 on the EAC HIV Act)
- *Regional coordination* of policies occurring in many RECs. One example is the ECOWAS Regional Action Plan to combat obstetric fistula (see Case study XX in Chapter 7)
- *Monitoring and accountability* on REC commitments, for instance in the monitoring frameworks of the RECs themselves and/or civil society barometers (e.g. the Gender Alliance Barometer in SADC and the recent EAC Gender Equality and Development Barometer developed by EASSI)
- Regional courts where cases can be filed, especially in ECOWAS, where individuals have taken complaints to court (see Case study 3 in Chapter 5 on the ECOWAS Court case on GVAW in Nigeria)

Recommendations

- Strengthen **implementation** frameworks and plans on the gender equality and women and girls rights commitments of the RECs, particularly in line with AU-level commitments in the Maputo Protocol, MPoA and forthcoming AU Gender Strategy
- Strengthen **monitoring and accountability** frameworks and mechanisms on these existing commitments on gender equality and women and girls' rights
- Increase **financial and human resources for gender infrastructure** in RECs to an adequate level that allows them to fulfil their mandates
- For ECCAS, CEN-SAD and UMA in particular, strengthen the development and adoption of gender equality and women rights and girls' rights normative and institutional frameworks
- Strengthen the engagement of the RECs with **civil society**, in particular women's rights feminist and SRHR organisations in the regions
- Put in place or strengthen formal **consultative frameworks** that promote civil society access and enable genuine civil society participation
- Advance the use of **regional courts** for to protect women and girls' rights and to enable civil society to use the judicial organs of the RECs
- Strengthen **learning and collaboration** across and between the RECs on the formulation, implementation and monitoring of gender equality and women and girls' rights commitments

Table 2. Overview of women and girls' rights and gender equality commitments and infrastructure in RECs

	ECOWAS	EAC	IGAD	SADC	COMESA
Reference to women and girls' rights or gender equality in REC treaty	Enhancement of the economic, social and cultural conditions of women; full participation of women	Good governance, gender equality, human rights; mainstreaming of gender; participation; addressing discrimination	<ul style="list-style-type: none"> No reference in Agreement Establishing IGAD Currently drafted IGAD Treaty refers to role of women in development 	Mainstreaming gender; prohibits discrimination, including on sex or gender	Full participation of women; eliminate discrimination against women
Normative framework of REC on gender equality/women and girls' rights	Supplementary Act on Equality of Rights between Women and Men (2015): 53 rights articles, including on family rights, marginalised groups, education and training, GVAW, health and HIV and AIDS, peace and security	EAC Gender Equality and Development Bill (2016) awaiting assent from EAC Heads of State: <ul style="list-style-type: none"> Non-discrimination Harmonisation of gender equality commitments across the sub-region Women's rights, including GVAW, health, peace and security, marginalised groups 	IGAD Gender Policy Framework (2012–20): <ul style="list-style-type: none"> Including Gender & Health: SRHR, HIV and AIDS, GVAW, harmful practices including gender, peace and security 	SADC Protocol on Gender and Development (2008; amended and updated in 2016): 14 thematic areas, including GVAW, health (SRH and reproductive rights), HIV and AIDS, education and training, peace-building and conflict resolution	Revised Gender Policy (2016): <ul style="list-style-type: none"> Human rights as one of the 7 guiding principles 17 priority areas, including SRHR, HIV and AIDS, adolescent SRH, child marriage, human trafficking
Monitoring mechanisms	-	-	-	<ul style="list-style-type: none"> MERF (2017) SADC Gender and Development Monitor 	<ul style="list-style-type: none"> Annual progress reports Gender Policy implementation plan and monitoring tracking matrix forthcoming
Other commitments on women and girls' rights areas central in Right By Her report	<ul style="list-style-type: none"> Dakar Declaration on the Implementation of UNSCR 1325 ECOWAS Gender Policy ECOWAS Regional Action Plan for combatting obstetric fistula in West Africa Vision 2020 	HIV and AIDS Prevention and Management Act	Regional Action Plan for Implementation of UNSCRs 1325 and 1820		<ul style="list-style-type: none"> Social Charter Framework for the Multi-Sectoral Programme on HIV & AIDS (2012–15); HIV AIDS Policy and tracking plan

Gender infrastructure in REC	Gender Development Centre	Gender Department	Gender Affairs Programme	Gender Unit	COMESA Technical Committee on Gender • Directorate on Gender and Social Affairs
Regional advocacy networks at REC level	<ul style="list-style-type: none"> • ECOWAS Gender Development Centre • Gender Commission • ECOWAS Secretariat Gender Management Team • NOPSWECO • ROAJELF • ECOFEPA • MARWOPNET 	<ul style="list-style-type: none"> • EASSI • EALS • EACSO • EAHF • EANNASO 	Underdeveloped networks with CSOs	SADC Gender Protocol Alliance	Limited involvement of CSOs <ul style="list-style-type: none"> • FEMCOM
Other aspects	<ul style="list-style-type: none"> • ECOWAS Court of Justice • 50 Million African Women Speak campaign 	<ul style="list-style-type: none"> • EAC Consultative Dialogue Framework (on participation of civil society) • EAC Court of Justice • 50 Million African Women Speak campaign • EAC Gender Equality and Development Barometer 	IGAD Women and Peace Forum (government and civil society members)	<ul style="list-style-type: none"> • SADC Gender Protocol Barometer • SADC Court suspended 	50 Million African Women Speak campaign

6 GENDER-BASED VIOLENCE AGAINST WOMEN



The Maputo Protocol defines violence against women in a **comprehensive** way, to include acts or threat of violence in both public and private spheres, in peacetime as well as during war and armed conflict. It also includes in its definition exploitation, intimidation, coercion, arbitrary restrictions and deprivations of fundamental liberties.

GVAW is directed at and experienced by women and girls because of their sex and gender. It is both a manifestation and a perpetuation of **gender inequalities and unequal power relations** and is closely linked to the subordination of women and girls, in families, communities and states. GVAW is a widespread human rights violation.

GVAW includes multiple **types** of violence: physical violence, sexual violence, psychological abuse and violence, and economic abuse and exploitation. It occurs in different public and private **settings**, including in the family, in the community, in the workplace and in educational institutions, in formal and state institutions, and in situations of armed conflict and insecurity.¹⁴

Violence against women means ‘all acts perpetrated against women which cause or could cause them physical, sexual, psychological, and economic harm, including the threat to take such acts; or to undertake the imposition of arbitrary restrictions on or deprivation of fundamental freedoms in private or public life in peace time and during situations of armed conflicts or of war’ (Art. 1).

6.1 PREVALENCE OF GVAW

There is a strong need for **reliable data** on the many ways in which women and girls are exposed to and experience GVAW, and how it affects their lives. The collection of data on GVAW is difficult and its reliability is uncertain, owing to underreporting and the sensitivity of the issue. The comparability of data is weakened because different organisations use different ways of measuring GVAW. Also, most data is on intimate partner violence (IPV) or non-partner violence, with less available on other forms of violence (in particular trafficking of women and girls and GVAW in contexts of armed conflict and war).

- One in three African women experience GVAW in their life.^{xiv} Lifetime prevalence of some form of physical and/or sexual violence by an **intimate partner** is estimated to be 36.6% for African women. IPV varies between countries from 5% to 57%.^{xv}
- **Non-partner** violence is estimated at 11.9% among African women.^{xvi} It is higher in Central and Southern Africa (21% and 17.4%, respectively) than it is in Eastern and Western Africa (11.5% and 9.2% respectively), and lowest in Northern Africa (4.5%).^{xvii}
- Not all women and girls are exposed to or experience GVAW in the same way. Young and adolescent women, elderly women, women with disabilities, female sex workers and lesbian, bisexual or transgender women can face specific and multiple challenges and be more exposed and vulnerable to certain types of violence.
- **Human trafficking** is a particular form of violence, and girls and young women make up more than a quarter of the detected cases on the continent, and adult women another quarter. This can entail forced marriage, domestic servitude, sexual slavery, sexual exploitation and trafficking into prostitution. In Africa, most trafficking takes place within countries (83%); it occurs to a much lesser extent across borders (15%).^{xviii}

¹⁴ Men and boys also experience gender-based violence. Reports that document sexual violence against men and boys are available for Burundi, CAR, DRC, Kenya, Libya, Rwanda, Sierra Leone, Somalia, South Africa, South Sudan and Sudan: <https://allsurvivorsproject.org/countries/>

- Many forms of GVAW continue to be accepted among both women and men in African countries, owing to persisting gender norms, beliefs and practices that tolerate or justify GVAW. **Attitudes** that deem that wife-beating is acceptable are present in all countries, but with considerable variations between countries and regions. In some countries, more than three quarters of adult women think this type of violence is justified in certain circumstances.^{xix}
- Women and girls continue to be disproportionately affected by **conflict and war**, among others as refugees or internally displaced persons. Women and girls face specific threats and types of violence in different phases of conflict: during conflict, during the state of flight, when residing in the country of asylum, during repatriation and during integration.^{xx}
- Sexual violence as a **weapon of war** is a pervasive problem linked to war and conflict; this affects women and girls, and also has been targeted at men and boys.^{xxi}

6.2 COMMITMENTS AND REQUIRED RESPONSE ON GVAW

The Maputo Protocol provides extensive provisions on the eradication of all forms of GVAW, reaffirming women and girls' right to life, liberty and security of the person. This eradication of GVAW is articulated in relation to women and girls' right to dignity, and is also strongly grounded in the elimination of discrimination against women and girls, including practices based on ideas of inferiority or stereotypes regarding one of the sexes. The Maputo Plan of Action (MPoA) (2016–30) calls for the elimination of all forms and discrimination against women and girls, under its key strategy on gender equality, women and girls' empowerment and the respect of human rights.

- The Maputo Protocol provisions call for the **prohibition and eradication of all forms of violence against women**.
- This explicitly includes unwanted or forced sex in either the private or the public sphere, and hence articulates a prohibition of **marital rape** and violence.
- The Maputo Protocol requires states to protect women and especially girls from all forms of abuse, including sexual harassment, **in schools or other educational institutions**.¹⁵
- It also requires states to combat and punish sexual harassment in the **workplace**, and to protect women and girls from exploitation by employers.
- The Maputo Protocol explicitly refers to marginalised groups, and provides for the rights of **elderly** women, **widows** and women with **disabilities** to be free from violence, including sexual abuse, and discrimination.
- It also explicitly addresses GVAW in **armed conflict** situations, and provides for the protection of asylum-seeking women, refugees, returnees and internally displaced persons against all forms of violence, rape or other sexual exploitation.

The Maputo Protocol sets a high bar for **state responsibility** regarding GVAW, to ensure the prevention, punishment and eradication of all forms of GVAW. This requires states to enact and enforce laws that prohibit all forms of GVAW; identify causes and consequences of GVAW; punish perpetrators; support, rehabilitate and offer reparation of victims and survivors of GVAW; and prevent and condemn trafficking in women and girls. It also requires the provision and operationalisation of adequate budgets and other resources to implement and monitor these actions aimed at the eradication and prevention of GVAW.

¹⁵ The African Convention on the Rights and Welfare of Children (1990) also calls for the protection of children from all forms of sexual exploitation and abuse, and for the prevention of abduction, sale or trafficking of children. The African Youth Charter (2006) calls for the enactment and enforcement of legislation that protects girls and young women from all forms of violence (including FGM, incest, rape, sexual abuse, sexual exploitation, trafficking prostitution and pornography)

The principles and obligations of states are articulated in more detail in the ACHPR *Guidelines on Combating Sexual Violence and Its Consequences in Africa* (2017). These articulate:

- Three **principles** for state responses to GVAW: (1) the non-discrimination principle, (2) the do-no-harm principle and (3) the due diligence principle
- The fourfold obligations of states in combating sexual violence: (1) to **prevent** sexual violence, (2) to provide **protection and support** to victims of sexual violence, (3) to guarantee **access to justice** and investigate and prosecute perpetrators of sexual violence and (4) to provide **effective remedy and reparation** for victims of sexual violence.

The Guidelines include a reference to Resolution 275 of the ACHPR (adopted in 2014). This Resolution notes and condemns violence and human rights violations, by both state and non-state actors, against persons on the basis of their imputed or real **sexual orientation or gender identity**. It strongly urges states to end all such acts of violence and abuse; this requires legal reform, punishment of such violence and violations and the ensuring of proper investigation and prosecution, in a way that is responsive to the needs of victims.

Trafficking is addressed explicitly in the Maputo Protocol article on GVAW. Art. 4 requires that states prevent and condemn the trafficking of women, prosecute perpetrators and protect women and girls most at risk. In 2006, the AU also adopted the *Ouagadougou Action Plan to combat trafficking in human beings, especially women and children*; to further its implementation by the RECs, the AU launched the *AU Commission Initiative against Trafficking Campaign* (AU.COMMIT). The AU.COMMIT campaign focuses on prevention, prosecution of offenders and protection of victims.

The Maputo Protocol explicitly addresses GVAW in settings of **insecurity, conflict and war**, and calls for the protection of women and girls in armed conflict from all forms of violence, and the prosecution of perpetrators. It also calls for the full protection of women and girl refugees, and for their right to access procedures to determine refugee status. Very importantly, the Protocol provides that states respect international humanitarian law. This implies that sexual violence and other forms of GVAW and violence experienced by women and girls during armed conflict constitutes a war crime, genocide and/or a crime against humanity. International humanitarian law applies to all states, including those that are not under a treaty, in these respects. The Maputo Protocol also endorses the international *Women, Peace and Security* agenda, and in particular *UNSCRs 1325 and 1820* and later resolutions. These call for the participation of women in the prevention and resolution of conflict, and for an end to the use of sexual violence against women and girls as a tactic of war.

6.3 NATIONAL-LEVEL DOMESTICATION ON GVAW

With respect to legal and policy reform on GVAW, the report looks at five legal and policy indicators traced at the national level:

1. Legislation on domestic violence
2. Criminalisation of marital rape
3. Legislation on sexual harassment
4. Law on human trafficking
5. National Action Plan on UNSCR 1325 (NAP 1325)

There are large variations between countries across the continent and sub-regions in terms of the strengths of their **national legal and policy frameworks** with respect to GVAW. Eight countries have only one of these legal or policy frameworks captured in the five indicators above in place: Congo Republic, Eritrea, Equatorial Guinea, Libya, Somalia, South Sudan, Sudan and Swaziland. All countries, except for South Sudan, have at least one statutory law that prohibits a form of GVAW.

On the positive end of the spectrum, six countries have legislation or policies in place on all five indicators: Burkina Faso, The Gambia, Ghana, Kenya, Rwanda and Sierra Leone. Another 10 countries have 4 out of the 5 legal or policy indicators in place: Benin, Burundi, Cape Verde, CAR, Guinea, Namibia, São Tomé and Príncipe, Senegal, South Africa and Zimbabwe. About half of the countries thus sit somewhere in the middle on these legal and policy indicators, and score positively on two or three of them only.

The key challenges vary by region. In the Western African region, the major concern for the legal framework relates to gaps in legal provisions on domestic violence, marital rape and/or sexual harassment.¹⁶ In Eastern Africa, the countries in the Horn of Africa, as well as to a slightly lesser extent Tanzania, stand out for their weak legal frameworks on all dimensions of GVAW.¹⁷ The most prominent weakness in the Central region is the lack of criminalisation of marital rape,¹⁸ and Angola, Congo Republic and DRC have the weakest legal and policy frameworks. In Southern Africa, the key gap is the lack of legislation prohibiting marital rape,¹⁹ and Comoros, Swaziland and Tanzania stand out for have the weakest national frameworks. In the Northern region, none of the countries has criminalised marital rape, and only three have legislation on domestic violence. Libya has the weakest legal and policy framework on GVAW, and Mauritius and Morocco follow.

When combining the findings on the legal frameworks on domestic violence, marital rape and sexual harassment (see also Map 1), we can observe that all countries that prohibit marital rape (except for Lesotho) also have legislation on domestic violence and on sexual harassment. Five countries can be found on other side of the spectrum, and lack legal provisions on any of these three types of GVAW. Eighteen countries have legislation on domestic violence as well as sexual harassment, but do not criminalise marital rape (marked in light green in the map). Six countries have legislation on domestic violence only (marked in yellow in the map), and eleven have legislation only on sexual harassment (marked in orange in the map).

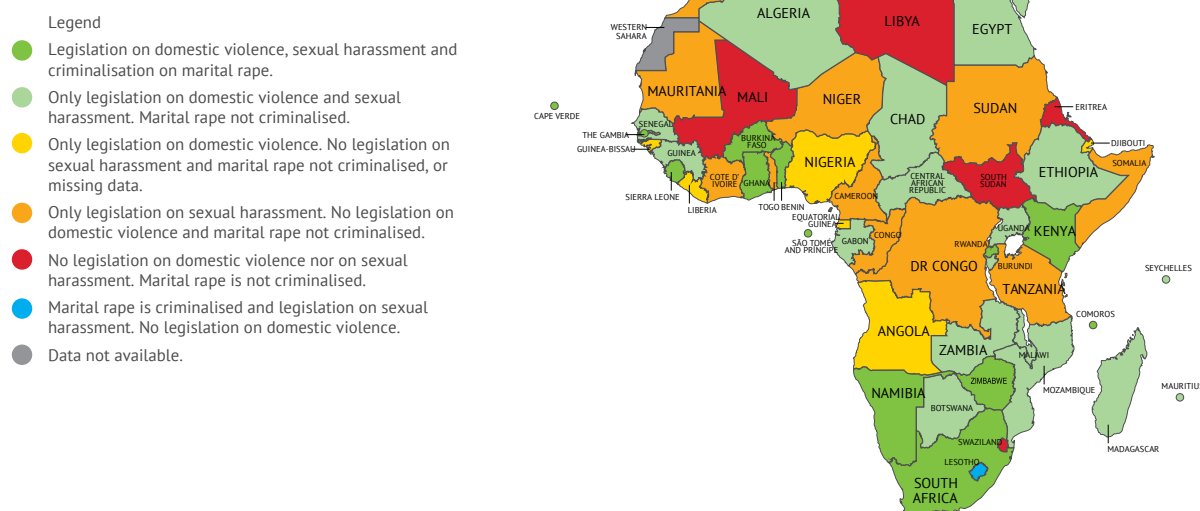
¹⁶ In particular in Côte d'Ivoire, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Nigeria, Senegal and Togo.

¹⁷ In particular in Djibouti, Eritrea, Somalia, South Sudan and Sudan. Tanzania only has a legal provision on sexual harassment and on human trafficking.

¹⁸ In particular in Angola, Burundi, Cameroon, CAR, Chad, Gabon and Equatorial Guinea.

¹⁹ In particular in Angola, Botswana, DRC, Madagascar, Malawi, Mauritius, Mozambique, Seychelles, Swaziland, Tanzania and Zambia.

Map 1 Gender Based Violence against Women (3 indicators)



Lesotho stands out as it is the only country that criminalises marital rape and has legislation on sexual harassment but not on domestic violence.

When looking at the specific legal and policy changes, the following trends can be observed:

- Two thirds of African countries have legal provisions regarding **domestic violence**, mostly in specific laws (27 countries) and in a few cases in the Penal Code (10 countries). This means much progress has been made, but still three out of ten African countries lack a legal framework regarding domestic violence.¹⁶
- Three quarters of African countries have legal provisions on **sexual harassment**. Thirty-one of these countries have specific legislation on this, and twelve address sexual harassment in workplace- or education-related legislation (the Labour Code or the like).
- Three out of five African countries do not criminalise **marital rape**. Legislation that does prohibit marital rape has been found in the following 14 countries: Benin, Burkina Faso, Cape Verde, Comoros, The Gambia, Ghana, Kenya, Lesotho, Namibia, Rwanda, São Tomé and Príncipe, Sierra Leone, South Africa and Zimbabwe. In the remaining 40 countries, marital rape is not prohibited. In addition to the many African countries that do not outlaw marital rape, there are also a few countries that explicitly exclude marital rape from the definition of rape.²⁰ These then effectively allow unconsensual sexual acts within wedlock, which goes against the Maputo Protocol provision to prohibit unwanted or unconsensual sex in the private sphere.
- The majority of the countries have a law on **human trafficking** in place. Only six lack such a legal framework: Comoros, Congo Republic, Equatorial Guinea, Somalia, South Sudan and Sudan. In terms of implementation, none of the African countries is meeting the minimum standards on the elimination of trafficking in persons, and they hence fall short in terms of the prohibition and prosecution of severe forms of trafficking in persons and/or their efforts to eliminate these forms of trafficking.²¹

²⁰ Countries that explicitly exclude marital rape from the definition of rape are Ethiopia, Nigeria and South Sudan.

²¹ For a definition of minimum standards for the elimination of trafficking in person, see US Department of State. 2017. 'Trafficking in Persons Report'. This report was also consulted for country-level data.

- Roughly half of the countries have a **NAP 1325** in place; the other half of the countries do not. Such plans are more prominent in the Western region (13 out of 15 countries), and weakly present in the Southern region (1 out of 16 countries). In the Eastern and Central regions, about half of the countries have a NAP 1325 in place. None of the Northern countries has a NAP 1325. The notable exceptions of countries that are experiencing or emerging from conflict and insecurity but that do not have a NAP 1325 are Libya, Somalia and South Sudan.

In addition to legal reform, the majority of the countries have taken on policy and/or institutional reform. This includes support services to survivors of GVAW (legal aid, medical and social welfare support, counselling services, shelters), as well as improvements in access to justice (such as gender desk/units in police stations or departments, special prosecution units, specialised courts). An important trend has been the establishment of one-stop centres for survivors of GVAW, as these combine the different services for such survivors. There are also many initiatives to train judiciary and police officers as well as medical service providers to strengthen their capacity to respond to GVAW cases in a gender-friendly and responsive manner. In many countries, awareness-raising campaigns and initiatives address GVAW in educational curricula and institutions.

In addition to the weaknesses identified in the legal and policy indicators above, domestication of the Maputo Protocol provisions and the realisation of women and girls' rights with respect to GVAW is hampered by the following **gaps and contestations**:

- A critical gap is that, even though most countries have one or more laws addressing a form of GVAW, the majority of the countries **lack a comprehensive legal framework**. In many countries, the legal framework does not address all forms of GVAW. In addition, some countries actually have retrogressive legal provisions that go against the provisions of the Maputo Protocol.
- Whereas most countries have a policy or strategy on GVAW in place, and also have undertaken institutional reforms, most **lack a holistic approach** to GVAW in the spirit of the required state response as articulated in the Maputo Protocol (which would include legal prohibition, prevention of GVAW, protection and support to survivors, prosecution of perpetrators and provision of remedies). Moreover, the emphasis is often on protection and support to survivors, and less on prevention of GVAW and prosecution of perpetrators.
- In cases where the legal, police and institutional frameworks have been put in place, actual **implementation** can be weak. Barriers for survivors of GVAW in terms of access to justice continue to exist, throughout the support and justice delivery chain, from reporting at the police, to prosecution, to actual court trials. These barriers contribute to low levels of reporting and of prosecuted and convicted cases, which in turn can undermine reporting. The gender-unfriendly response in the police, judicial and medical services also leads to secondary traumatising and further victimisation of GVAW survivors.
- Weak law enforcement is the result of both **financial and human resource constraints**. Capacity issues among the police, the judiciary and medical officers and staff continue to affect access to justice and the provision of support services to survivors of GVAW. Coordination of these different actors in the justice and support chain can also be weak. In response to some of these gaps, governments frequently reach out to and work with NGOs and CSOs.

- **Patriarchal and gender norms** also continue to constitute barriers to access to justice and support for GVAW survivors. Patriarchal norms that sustain unequal relations between women and men normalise GVAW and make it 'acceptable' in the family and community, as well as in formal state institutions. Such norms and attitudes mean that rape, domestic violence, marital rape and other forms of GVAW are often not considered a matter for police intervention. This leads to GVAW cases being settled within and between families, and outside court, without guarantees of the respect of the human rights of women and girls. A commonly observed problematic practice is that victims of GVAW are pressured to marry the man who raped them. In some countries, this is supported by existing retrogressive legal frameworks. Patriarchal gender norms also lead to stigma and taboo around GVAW, which either denounce cases or blame the victim; such stigmatisation prevents survivors from accessing support services and justice. In some countries, for instance in Northern Africa, patriarchal gender norms frame sexual violence against women and girls as attacks on honour, rather than as a human rights violation.

Recommendations

- Develop a **comprehensive legal framework** to address GVAW. This should cover legal prohibition of all forms of GVAW, the prevention of GVAW, protection of and support to survivors of GVAW, prosecution of perpetrators and remedies
- Enact legislation on **domestic violence** specifically, and in particular to **criminalise marital rape**
- Reform laws that implicitly or explicitly promote or condone GVAW, such as laws that allow perpetrators to marry the rape survivor to avoid prosecution and laws that explicitly exclude marital rape from the definition of rape
- **Enhance coordination of responses** in both the legal and the service delivery chains from a multi-sectoral perspective, to avoid secondary traumatisation of GVAW survivors, and ensure they access the legal and medical support and justice they are entitled to
- **Train and strengthen** the capacity of all officials in referral pathways, including medical officers, the police, prosecutors, the judiciary, judges and magistrates, on gendered approaches that can enhance survivors' access to and experience of justice, protection and support
- Strengthen efforts to **prevent** all forms of GVAW. This includes challenging patriarchal gender norms and promoting and strengthening gender equal norms and institutions
- Strengthen legislation on **human trafficking** to include the most severe forms and include their gendered manifestations, as well as strengthening the implementation of these laws to meet the minimum standards on the elimination of trafficking in persons
- Allocate sufficient **financial resources** to fulfil the comprehensive response of governments to GVAW

7 HARMFUL PRACTICES



The Maputo Protocol has a clear definition of harmful practices as ‘all behaviour, attitudes and/or practices which negatively affect the fundamental rights of women and girls, such as their right to life, health, dignity, education and physical integrity’ (Art. 1). Harmful practices include a wide range of practices that constitute a form of discrimination that disproportionately affects women and girls, and often amounts to GVAW. They are often based on cultural or socio-conventional norms and deeply rooted in gender inequalities and discriminatory values. Harmful practices are those conducted for non-therapeutic purposes. This report focuses on child marriage and FGM, given among others their high prevalence in African countries and their strong inter-linkages in certain contexts.

Child marriage refers to ‘a marriage in which either one of the parties, or both, is or was under the age of 18 at the time of union’ (Joint General Comment ACHPR and ACERWC on Ending Child Marriage, Point 6). Child marriages are often deeply entrenched in cultural, religious and social norms of unequal gendered power relations, and are an expression of societal control and regulation of women’s sexuality and reproductive functions. Weak legal and administrative systems, as well as legal pluralism, contribute to the continued practice of child marriage. Lack of education contributes to child marriage; in turn, child marriage leads to low education of girls. Child marriage affects the health of girls, and especially their SRHR.

Female genital mutilation concerns ‘the practice of partially or wholly removing the external female genitalia or otherwise injuring the female genital organs for non-medical and non-health related reasons’. This includes all interventions of partial or total cutting or injury of a woman’s external genitalia or sexual organs for non-therapeutic reasons. FGM is a human rights violation and involves specific violence against women’s physical integrity, and her right to life, dignity, equality and freedom from torture. FGM can be of Type I, II, III or IV. The first three types differ as to whether the clitoris and/or the inner labia have been cut off, and whether the wound has been sewn or not (infibulation). Type IV refers to all other harmful practices, which include pricking, piercing, pulling, cutting, scraping and burning of female genitalia. FGM has long-lasting effects on the reproductive organs of girls and women, and all four types of FGM represent a direct risk to their health and life. FGM is strongly affected by cultural and social norms of female subordination and control over women and girls’ sexuality and reproduction. Child marriage and FGM are also highly interrelated, and child marriage is prevalent in countries where FGM is practised.

7.1 PREVALENCE OF HARMFUL PRACTICES

Africa knows the highest rates of child marriage in the world: one in four women and girls in Sub-Saharan Africa is married before the age of 18.

- Prevalence of child marriage is highest in Western and Central Africa, and only slightly lower in Eastern and Southern regions.^{xxii}
- **Child marriage prevalence** rates in the continent vary between 2% (Tunisia) and 3% (Algeria), and 55% (Mali), 68% (CAR and Chad) and up to 76% (Niger). In seven countries, more than half of women and girls are married when they turn 18: Burkina Faso, CAR, Chad, Guinea, Mali, Niger and South Sudan. In as many as 20 countries, child marriage prevalence lies between 30% and 50% of women and girls (at age 18).^{xxiii}
- Child marriage is **slowly declining**, particularly in Northern Africa. In Western and Central Africa also, where child marriage is commonly practised, some countries have shown great declines. In other countries, prevalence has been 50–52% for the past 30 years.^{xxiv} If the current trend continues, **by 2050 Africa will become the region with the largest number of child marriages in the world.**^{xxv}
- Countries with high levels of child marriage also have high rates of maternal deaths and high adolescent birth rates.^{xxvi}

FGM is concentrated in 27 African countries from the Horn of Africa to the Atlantic coast.

- **Prevalence rates of FGM** higher than 80% are found in the following eight countries: Djibouti, Egypt, Eritrea, Mali, Sierra Leone and Sudan, with Guinea and Somalia at the highest rates, of 97% and 98%, respectively.^{xxvii}
- In a few countries—Cameroon, Ghana, Niger, Togo and Uganda—rates are under 5%. Although FGM is not commonly practised in Southern Africa, it may be present there now among migrant communities.^{xxviii}
- FGM prevalence can **vary strongly** between ethnic groups and regions within countries. This variation is observed in countries with low, moderate or high levels of FGM prevalence.^{xxix} For this reason, subnational data is important.
- There are also strong variations in **the age at which girls are cut**. In some countries and subnational regions, girls are cut before their fifth birthday (e.g. in Eritrea, Ghana, Mali, Mauritania, Nigeria and Senegal), in others between five and nine years of age (e.g. in CAR, Chad, Egypt and Somalia) and in others again between ten and fourteen years (also in CAR, as well as Guinea-Bissau, Kenya and Sierra Leone).^{xxx}
- In two thirds of the countries where FGM is concentrated, the majority of girls and women **think it should end**. In most countries, girls aged 15–19 years are less supportive of the continuation of the practice than women aged 45–49 years.^{xxxi}
- In almost all countries, even in those where FGM is almost universal, more girls are cut than the percentage of girls who support the practice.^{xxxii}

7.2 COMMITMENTS AND REQUIRED RESPONSE ON HARMFUL PRACTICES

Art. 2 of the Maputo Protocol requires state parties to ‘combat all forms of discrimination against women’. Child marriage and FGM are specific forms of discrimination against women and girls. Art. 2 requires that state parties ‘shall enact and effectively implement appropriate legislative or regulatory measures, including those prohibiting and curbing all forms of discrimination particularly those **harmful practices** which endanger the health and general well-being of women’ (Sub 1.b).

- The Maputo Protocol **prohibits and condemns ‘all forms of harmful practices** which negatively affect the human rights of women and which are contrary to international standards’ (Art. 5).
- Child marriage and FGM are identified as two of the four harmful practices in the *Joint General Recommendation/Comment on harmful practices* adopted by the CEDAW Committee and the Committee on the Rights of the Child in 2014.
- Under the Maputo Protocol, the obligations of states to eliminate harmful practices encompass four strategies: (1) **prohibition** of harmful practices and FGM, through legislative measures backed by sanctions, (2) going beyond prohibition and prevention by calling for **support and rehabilitation** services to victims of harmful practices, (3) **protecting** women who are at risk of being subjected to such practices, abuse and violence and (4) further **prevention** through public **awareness-raising**.
- The Maputo Protocol **prohibits ‘all forms of female genital mutilation**, scarification, medicalisation and para-medicalisation of female genital cutting and all other practices in order to eradicate them’ (Art. 5.a). This means that the medicalisation of FGM is not permitted under the Maputo Protocol provisions, nor are types of FGM falling under Type IV (pricking).
- FGM is included in the definition of sexual violence in the ACHPR *Guidelines on Combating Sexual Violence and its Consequences*.

Child marriage is prohibited under the Maputo Protocol, which also states that women and men shall enjoy equal rights and are regarded as equal partners in marriage. The Joint General Comment from the ACHPR and ACERWC on ending child marriage (2017) elaborates on the obligations of states with respect to ending child marriage that arise from the Maputo Protocol and the African Children's Charter. They both prohibit child marriage. The guidance provided by this Joint General Comment is grounded in four general principles: (1) the best interest of the child, (2) freedom from discrimination, (3) rights to survival, development and protection and (4) participation. The Joint General Comment provides that:

- Child marriage and the betrothal of girls and boys are **prohibited**.
- The legal age of marriage is **18 years** and effective action, including legislation, shall be taken to specify this.
- **Registration** of all marriages in an official registry is mandatory.
- **No exceptions** can be made to the legal age of marriage at 18 for betrothal and marriage, as the Africa Children's Charter defines a child as every human being below the age of 18 years.
- The prohibition of marriage under the age of 18 **applies to all marriages**, under all forms of law, including customary or religious law.
- No marriage shall take place without the **full and free consent** of both parties.
- Women and men enjoy equal rights in marriage, and are regarded as equal partners.

The obligations of states to ending child marriage include legislative measures, institutional measures (including those related to verification procedures, law enforcement, training and capacity-building, resource allocation, education, access to SRH services and information and to justice, redress and support for women and girls) and other measures (including awareness-raising, national action plans and involving men and boys, among others).

In addition to the prohibition and elimination of all harmful practices, the Maputo Protocol also provides that 'women shall have the right to live in a **positive cultural context**' (Art. 17.1). This is qualified in its Preamble that refers to 'the preservation of African values based on the principles of equality, peace, freedom, dignity justice, solidarity and democracy'. Art. 17 also articulates women's right 'to **participate in all levels** in the determination of cultural policies'. Recognising that it is not just gender-discriminatory cultural values that are impeding women and girls' enjoyment of their rights, the Protocol provisions on socio-economic rights and on the right to participate in political decision-making are of at least equal value in ending harmful practices.

7.3 NATIONAL-LEVEL DOMESTICATION ON HARMFUL PRACTICES

With respect to legal and policy reform regarding harmful practices, the report looks at seven legal and policy indicators traced at the national level. Regarding child marriage, these are:

1. Minimum age of marriage set at 18
2. Full and free consent is guaranteed (this means third-party consent is not allowed for marriage before the legal age of marriage)
3. Legal age of marriage applies to all marriages (formal civil, customary, religious and all other)

²² Ghana, Ethiopia, Malawi, Somalia, South Sudan, Sudan, Swaziland and Uganda.

²³ Botswana, Lesotho, Malawi, Mauritius, Namibia, Swaziland and Zimbabwe.

4. Action plan or strategy in place to end child marriage With respect to FGM, the three legal and policy indicators are:

With respect to FGM, the three legal and policy indicators are:

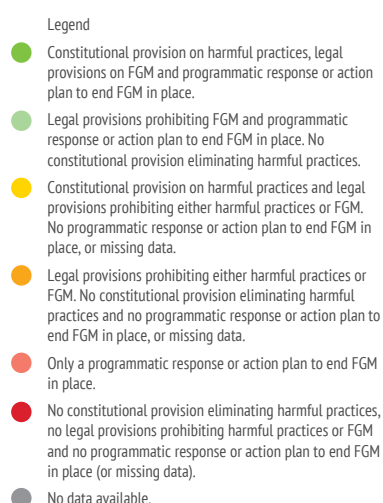
5. Constitutional provision to eliminate harmful practices

6. Statutory law that prohibits FGM (or, if not in place, that prohibits harmful practices)

7. Programmatic response or action plan to end FGM

The continental overview of constitutional or legal provisions to eliminate **harmful practices** presents a rather bleak picture. The *constitutions* of many countries across the continent lack a provision on the elimination of harmful practices; only eight countries have such a provision, five of them in the Eastern region.²² Seven countries have provisions in statutory law regarding harmful practices, all of them in the Southern region.²³ In total, 13 countries have either a constitutional and/or a legal provision on harmful practices. Among the many countries that lack a constitutional provision on the elimination of harmful practices, several have provisions that recognise customary law and indicate it cannot contradict the Constitution (e.g. Angola, Namibia, South Africa).

Map 2 FGM



Map 2 presents the strength of the legal and policy frameworks with respect to FGM. Five countries stand out as having a strong legal and policy framework, because they have a constitutional provision to eliminate harmful practices, a legal provision to prohibit FGM and a programmatic response to end FGM; these are Ghana, Ethiopia, Somalia, Sudan and Uganda. On the other side of the spectrum, 12 countries have the weakest frameworks in this regard, lacking these.²⁴ These are Algeria, Angola, Burundi, Cape Verde, Comoros, Libya, Morocco, Mozambique, Rwanda, São Tomé and Príncipe, Seychelles and Tunisia. Three Western African countries just have a programmatic response to end the practice: Liberia, Mali and Sierra Leone. Nineteen countries have a legal provision and a programmatic response to end FGM but do not have a constitutional provision to eliminate harmful practices; these are marked light green on the map.

A closer look at the trends in legal and policy frameworks on FGM reveals that the following:

- About three out of five countries have a statutory law prohibiting FGM specifically; another seven countries (in the Southern region) have statutory law that prohibits harmful practices, without explicitly addressing FGM.

²⁴ These 12 countries either score no on these indicators or have missing data.

- Fifteen countries do not have a legal provision prohibiting FGM, or otherwise harmful practices; these countries also lack a constitutional provision on the latter.²⁵
- On the positive side, eight countries have both a constitutional provision and a statutory law provision; five of them also have a programmatic response to end the practice.²⁶
- About half—that is, 27 countries—have a programmatic response or action to end FGM. This includes almost all countries in the Western region and two thirds in Eastern region countries. There is only one Southern country with a programmatic response, although this may be a reflection of the low prevalence of FGM in that region. Three countries have a programmatic response but no legal or constitutional provisions regarding harmful practices or FGM.²⁷

Map 3 Child Marriage

Legend

Legal age of marriage set at 18, with full and free consent, applying to all marriages. Action/strategic plan or campaign to end child marriage in place.

Legal age of marriage set at 18, with full and free consent, applying to all marriages. No action/strategic plan or campaign to end child marriage in place (or missing data).

Legal age of marriage set at 18 but presence of legal loopholes (either or both: no full and free consent and/or not applying to all marriages, or missing data).

Legal age of marriage not set at 18 or missing data. Action/strategic plan or campaign to end child marriage in place.

Legal age of marriage not set at 18 and no action/strategic plan or campaign to end child marriage in place.

No data available.



Map 3 captures the national legal and policy frameworks on child marriage. The strongest frameworks are found in Chad, Eritrea, Kenya, Liberia, Malawi and Zimbabwe; these six countries have all three legal provisions in place and also an action plan or strategy to end child marriage. Another five countries also have legal provisions setting the age of marriage at 18, guaranteeing full and free consent without exceptions, and applying these to civil, customary as well as religious marriages: Burundi, Cape Verde, Comoros, Rwanda and South Sudan. They do not, however, have an action plan or strategy to end child marriage. The weakest legal and policy frameworks are found in nine countries that have set the age of marriage at lower than 18, five of them in Western Africa (Burkina Faso, Guinea-Bissau, Mali, Niger and Senegal) and others in Central (Angola, Gabon) and Eastern Africa (Sudan, Tanzania). The map shows that most countries have the legal age of marriage set at 18 but then allow third parties to consent to marriages at earlier ages and/or do not apply this age of all marriages and/or lack an action plan or strategy to end child marriages.

A closer look at the legal and policy frameworks regarding **child marriage** shows the following:

- Eight in ten countries set the legal age of marriage at 18. But there are **legal loopholes** in 34 of the 45 countries that have a legal age of marriage at 18, in the sense of not having guaranteed full and free consent and/or that the legal age of marriage applies to customary and religious marriages as well.
- Full and free consent of the marrying parties is not guaranteed in a total of 36 African countries.

²⁵ Algeria, Angola, Burundi, Cape Verde, Comoros, Liberia, Libya, Mali, Morocco, Mozambique, Rwanda, São Tomé and Príncipe, Seychelles, Sierra Leone and Tunisia (missing data on legal prohibiting of FGM for Angola and Tunisia).

²⁶ Ghana, Ethiopia, Somalia, Sudan and Uganda score positively on all three indicators; Malawi, South Sudan and Swaziland have both a constitutional and a statutory law provision.

²⁷ Liberia, Mali and Sierra Leone.

- The legal age of marriage does not apply to customary and religious marriages in 12 countries, and in another 17 countries this is not clear as a result of missing data.
- The nine countries where the legal age at marriage is lower than 18²⁸ also do not explicitly guarantee full and free consent.
- A total of 33 countries have launched national plans to end child marriage, most prominently in Western Africa (in only half of the countries in Southern, Central and Northern Africa).
- Seven of the nine countries that do not have 18 as the legal age of marriage, however, do have a campaign to end child marriage.
- About three out of five of the countries that have launched such a campaign, have progressed into establishing a coordination mechanism and/or developing a national plan and/or started implementing activities. Two out of five have not (yet) progressed beyond the launch itself.

In addition to the gaps in legal and policy frameworks identified above, the domestication and implementation of the Maputo Protocol and the realisation of women and girls' rights regarding harmful practices are hampered by the following gaps and contestations:

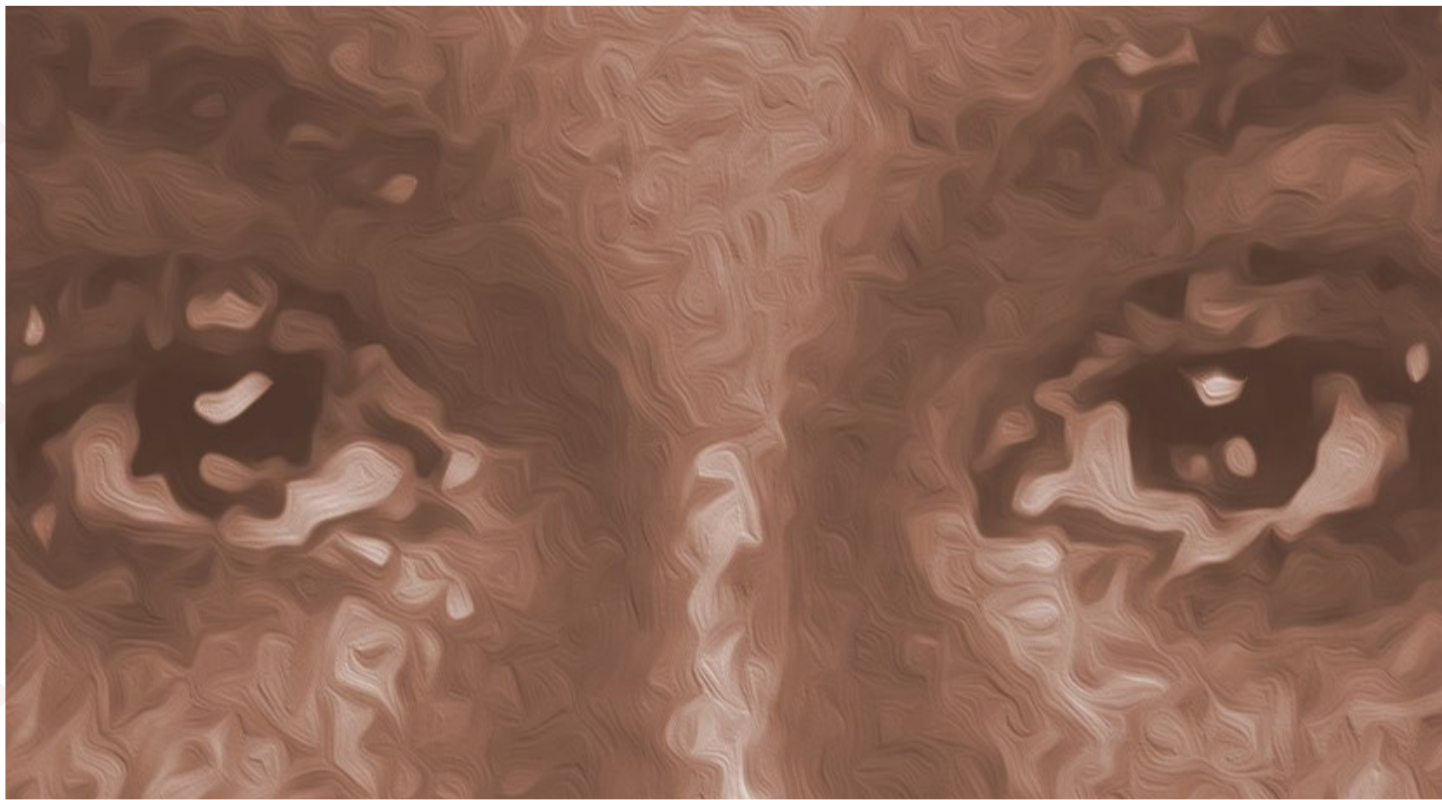
- Plural legal systems and continued contestations exist across the regions to **contradictions between codified and customary law**. These are linked to strong gender norms and attitudes that constrain women and girls' control over their bodies, sexuality and reproductive functions, and tolerate child marriage and/or FGM.
- Challenges exist in **implementation** owing to limited translation of the legal framework into action plans to actually end child marriage and FGM. This is further challenged by weak legal and administrative systems, including registration of marriages and births.
- With respect to FGM, lack of law enforcement is a challenge, not only but especially in remote areas. **Weak law enforcement** owes to low legal awareness, lack of resources or political will, inadequate capacity-building efforts and lack of community outreach programmes. It results in limited levels of prosecution of perpetrators, and in some cases has led to convictions of survivors or victims of FGM, who are intended to be protected by the law.
- With respect to FGM, the **medicalisation** of FGM is a worrisome trend observed in Western, Eastern and Central African countries. This entails FGM being carried out by medical personnel, claimed to minimise the health risks of the practice. Medicalisation of FGM is not, however, aligned with full prohibition and elimination of harmful practices and FGM in particular, and fails to take into account the non-medical harms of the practice and the assaults on women and girls' bodily integrity, dignity and equality.
- Another worrisome trend that is undermining implementation of the Maputo Protocol prohibition of all forms of FGM relates to arguments to allow for FGM when women give consent (e.g. in Kenya and Sierra Leone). Such arguments are also counter to the Maputo Protocol provisions.

²⁸ Angola, Burkina Faso, Gabon, Guinea-Bissau, Mali, Niger, Senegal, Sudan and Tanzania.

Recommendations

- Enact legislation, in constitutions or statutory law, that explicitly **prohibits harmful practices**. This applies to all 42 countries that lack such a provision, and especially to those that have ratified the Maputo Protocol and should hence align their legal frameworks accordingly
- Include a provision in the national Constitution that **customary law cannot contradict fundamental rights** guaranteed in the Constitution, and in particular cannot infringe on women and girls' human rights
- Enact legislation that **prohibits all forms of FGM**, including medicalised and other forms of FGM, and including all types of FGM and for all women and girls
- **Reform legislation regarding marriage and child marriage**, to ensure 18 is the minimum age of marriage, and to guarantee the full and free consent of marrying parties and that the legal age of marriage applies to all marriages, including customary and religious ones. In those countries that have the age of marriage set at 18, remove legal loopholes regarding full and free consent and other issues that allow for exceptions
- Legislation should be accompanied by **policies and action** to actually end these practices, and in particular to end all forms of FGM and child marriage, for all women and girls. These policies and action plans must be accompanied by adequate measures of prevention, awareness-raising, support and rehabilitation of victims of child marriage and FGM, prosecution of perpetrators and protecting of women and girls who are at risk
- Allocate **financial resources**, and put in place **institutional** bodies and mechanisms for implementation, including the **monitoring** of progress
- Ensure access of girls and young women to **education**, comprehensive **SRH services** and comprehensive **information and education** on SRH, harmful practices, sexuality and rights
- Strengthen youth and especially **girls and young women's leadership** and participation on human rights and in ending of child marriage and FGM

8 REPRODUCTIVE RIGHTS AND SEXUAL AND REPRODUCTIVE HEALTH



The Maputo Protocol guarantees the respect and promotion of women and girls' rights to health, including SRH, in Art. 14. This encompasses the rights to control one's fertility, to decide on the number, timing and spacing of pregnancies and to choose a method of contraception. In addition, the Maputo Protocol provides for the rights of women and girls to information and education on family planning and contraception, to non-discriminatory access to SRH services and to access safe abortion on specific grounds.

8.1 CRITICAL ISSUES: UNMET NEED, MATERNAL MORTALITY AND MORBIDITY, AND UNSAFE ABORTION

A first issue relates to the levels of contraceptive use and unmet need:

- The total fertility rate for the African continent is the highest in the world, at an estimated 4.6 children per women. A total of 32 Sub-Saharan African countries have a fertility rate between 4 and 5.5, and for 9 countries the fertility rate is above 5.5.^{xxxiii}
- One in three African women use a modern method of contraception. Contraception use is higher in Southern (64%), Northern (53%) and Eastern Africa (40%), and lowest in the Central (23%) and Western regions (17%).^{xxxiv}
- About one in five African women who are married have an **unmet need for contraception**. This is about 25% of the women in Eastern, Western and Central Africa, and 15% in Northern and Southern Africa.^{xxxv}
- The total unmet need for contraception is likely to be higher, as these figures do not include unmarried women and women from sexual minorities. In a total of 14 countries, more than 30% of young women aged 15–19 years (married and unmarried) have an unmet need for contraception.
- **Adolescent pregnancy** rates are highest in Sub-Saharan Africa, and its incidence is strongly related to child marriage (e.g. in Chad, Guinea, Mali and Niger).^{xxxvi} More than one in four girls in West and Central Africa are pregnant before the age of 18 and one in twenty before turning fifteen years.^{xxxvii}

A second critical concern relates to maternal mortality and morbidity. Most maternal deaths are preventable, in the presence of the necessary ante and postnatal care and skilled birth attendance. Underreporting and misclassification can affect the quality of data on maternal mortality.

- More than half of maternal deaths worldwide occur in Sub-Saharan Africa. Globally as well as in Africa, **maternal mortality** ratios have fallen over the past 25 years. Maternal mortality ratios vary strongly across countries and regions. There are 70 maternal deaths per 100,000 live births for North Africa and 546 for Sub-Saharan Africa. Within the latter category, 19 countries have high maternal mortality ratios (above 500 deaths per 100,000 live births).^{xxxviii}
- Maternal mortality is higher among women living in rural areas and in poorer communities. Moreover, the highest maternal mortality ratios are observed in countries facing conflict or insecurity, or with large refugee populations.^{xxxix}
- **Adolescent** girls face a higher risk of maternal mortality. Complications in pregnancy and childbirth are the leading cause of death among adolescent girls under 15 years.^{xl}
- **Obstetric fistula** is estimated to develop between 50,000 and 100,000 women worldwide, most of them in Sub-Saharan Africa and South Asia, in geographically remote areas. An estimated 2–3 million women lives with and is affected by obstetric fistula, mainly in these two world regions, and these women are often socially isolated and ostracised. Fistula can be prevented with proper antenatal and delivery care, as well as through delaying age of first pregnancy, ending of FGM and timely access to quality obstetric care, especially caesarean sections. Fistula can also be repaired.^{xli}

The third key issue concerns unsafe abortion—that is, terminations of pregnancy by a person who lacks the necessary skills or in an environment that lacks minimal standards. The reliability of data on induced as well as unsafe abortion is affected by the sensitivity of the issue and the criminalisation of abortion in many countries.

- During 2010–14, an estimated 8.2 million induced abortions occurred each year in Africa. Whereas the abortion rate remained constant in comparison with in the period 1990–94, the absolute number of abortion almost doubled in those two decades. This suggests a sharp increase in **unwanted pregnancies**. Abortion rates vary only slightly between sub-regions on the African continent.^{xlii}
- Unlike many other regions in the world, in Africa the abortion rates are higher among unmarried women than among married women (aged 15–44).^{xliii}
- Three out of four abortions in Africa are **unsafe abortions**.²⁹ This is also the case in Eastern Africa (76%) and Northern Africa (71%). The share of unsafe abortion is highest in Western Africa (85%) and Central Africa (88%). Southern Africa has an opposite picture, with a much lower share of unsafe abortions (27%).^{xliii}
- Unsafe abortions can lead to death and disability. Each year, 36,000 women in Sub-Saharan Africa die from unsafe abortions. Women in Africa are disproportionately affected by **mortality from unsafe abortions**: whereas 29% of the world's unsafe abortions occur in Africa, the continent accounts for 62% of deaths related to unsafe abortion.^{xlv}
- Every year, an estimated 1.4 million unsafe abortions take place among girls aged 15–19 in Africa. Both married and unmarried adolescent girls are more at risk of being exposed to unsafe abortions.^{xlvi}

Finally, access to quality SRH services and information is critical for all three concerns highlighted. Generally, women and girls face social, financial, legal and informational barriers to accessing SRH services and information, as well as discriminatory attitudes and practices in health facilities. Barriers can be more challenging for different groups of women and girls. Poor women living in rural areas face more challenges in accessing SRH services and realising their sexual and reproductive rights. Unmarried poor women, migrant or refugee women, women in indigenous communities and female sex workers also face barriers in accessing SRH services and information. Adolescents face particular challenges, owing to stigma around pre-marital sexuality and negative and judgemental attitudes from service providers. Adolescents also lack information about SRHR, even though girls aged 12–14 years in different countries recognise the importance of accessing such information and services.

8.2 COMMITMENTS AND REQUIRED RESPONSE ON REPRODUCTIVE RIGHTS AND SRH

Art. 14 of the Maputo Protocol offers a progressive and innovative framework for women and girls' reproductive rights and SRH. It covers women's reproductive freedoms, including their rights to information and education, SRH services and safe abortion. It also pays specific attention to women and girls' human rights in relation to HIV, which are addressed in the next rights area section. The provisions on reproductive rights and SRH are further articulated in General Comment No. 2 (2014). The Maputo Protocol's provisions for women and girls' right to health, including SRH, is highly linked to their rights to life, to dignity, to not be discriminated against, to integrity and security, to access to justice and to education. The right to SRH encompasses the following:

- Women and girls have the right to **control their fertility, and to decide** on maternity and the number and spacing of children.
- Women and girls' sexual and reproductive **freedom** is integral to the right of human beings to control their own health and body, and to be free from torture and from being subjected to medical treatment or experiment without their consent.

²⁹ This is much higher than for the world as a whole, and for all developing countries (where respectively 45% and 50% of abortions are unsafe).

- Women and girls' rights to control their fertility, and to decide on maternity and the number and spacing of children, are inextricably linked to women and girls' right to dignity, which implies their freedom to make such personal decisions **without interference from state or non-state actors**.
- Women and girls have the right to choose any method of **contraception**.
- General Comment No. 2 provides that women, and especially adolescent girls and young women, have the right to comprehensive **information and education** on sexuality, reproduction and SRHR, including family planning, contraception and safe abortion. This information and education should be comprehensive, based in clinical findings, and complete; it should be age-appropriate and take into account the level of maturity of adolescent girls and youth; and it should rights-based and without judgement.
- The *Joint General Comment of the ACHPR and ACEWRC on ending child marriage* explicitly refers to **CSE and information programmes** as a key institutional obligation of states, to be implemented in school curricula and out-of-school programmes. This should entail passing on age-appropriate information about sex, sexuality, SRHR and sexually transmitted diseases, including HIV and AIDS, as well as about consent to sex as distinct from consent to marriage. Information should also cover social norms and stereotypes of gender and sexuality that perpetuate gender inequality, including child marriage.
- Girls who are pregnant have the right to continue their education and **complete their schooling**.
- Women and girls have the right to **non-discriminatory access to SRH services** that are inclusive and sensitive to their diverse realities. Access to SRH services must be guaranteed to *all* women.³⁰
- Women and girls' own **full, free and informed consent** is key to their use of SRH services, including contraception and safe abortion. No woman or girl can be forced to use contraception or undergo sterilisation or abortion; this also applies to women and girls who are HIV positive, living with a disability or in any other situation.
- Women and girls **cannot be denied access** to SRH services, including safe abortion, as a result of third-party consent or conscientious objection.
- The right to access safe abortion is guaranteed on four grounds: (1) in case of sexual assault, rape or incest, (2) to save the mother's life, (3) when the physical or mental health of the mother is threatened and (4) in case of foetal impairment.
- Women and girls have the right to access to safe abortion services, free from discrimination, and ensuring privacy and confidentiality. This also calls for the decriminalisation of abortion and post-abortion care (PAC).

With respect to women and girls' reproductive rights and SRH, including safe abortion care (SAC), General Comment No. 2 articulates both general and specific **obligations** of states. The general obligations are (1) to **respect** (to refrain from hindering women's rights, directly or indirectly), (2) to **protect** (to prevent third parties from interfering with the enjoyment of women and girls' sexual and reproductive rights), (3) to **promote** (to create the conditions that enable women and girls to exercise these rights) and (4) to **fulfil** (to ensure the fulfilment, de jure and de facto, of women and girls' sexual and reproductive rights).

The specific obligations of states are (1) to put in place an enabling **legal and political framework**, (2) to ensure access to information and education on contraception and safe abortion, (3) to ensure access to contraception and safe abortion services, (4) to provide procedures, technologies and services for SRH, (5) to remove obstacles to the right to contraception and safe abortion services, (6) to allocate financial resources and (7) to ensure compliance.

³⁰ General Comment No. 2 notes that multiple forms of discrimination prevent women and girls from exercising and enjoying their SRHR, including but not limited to those related to ethnicity, race, sex, gender, age marital status, HIV status, sexual orientation, socio-economic status, disability, geographic residence, legal residence and/or traditional, religious and cultural beliefs.

8.3 NATIONAL-LEVEL DOMESTICATION ON REPRODUCTIVE RIGHTS AND SRH

A first and overall observation with respect to the legal and policy frameworks guaranteeing women and girls' reproductive rights and access to SRH services is that the domestication of these rights is not easily assessed across the countries in a systematic way. National-level legislation often does not articulate women and girls' reproductive freedoms and their rights to control fertility, to decide on the number, timing and spacing of pregnancies and to choose a method of contraception; instead, these issues are reflected in policy or strategic frameworks. Taking this into consideration, the legal and policy indicators on reproductive rights and SRH that are used in this report are as follows:

1. Constitutional provision on the right to health
2. Joined and launched a CARMMA campaign
3. Government funding for health higher than 5% of GDP (based on AU Scorecard on Domestic Financing for Health)³¹
4. Government funding for health higher than 15% of general government expenditure (also based on AU Scorecard on Domestic Financing for Health)
5. Legal guarantees for access to safe abortion: this indicator consists of five sub-indicators specifying the grounds for accessing safe abortion, as articulated in the Maputo Protocol and General Comment No. 2:
 - a) When the life of the mother is threatened
 - b) When the pregnancy poses a threat to the mental and/or physical health of the mother
 - c) In cases of foetal impairment
 - d) In case of sexual assault, rape or incest
 - e) Allowed on other grounds (not specified in the Maputo Protocol and General Comment No. 2)

With respect to the first four legal and policy indicators, the following trends can be observed:

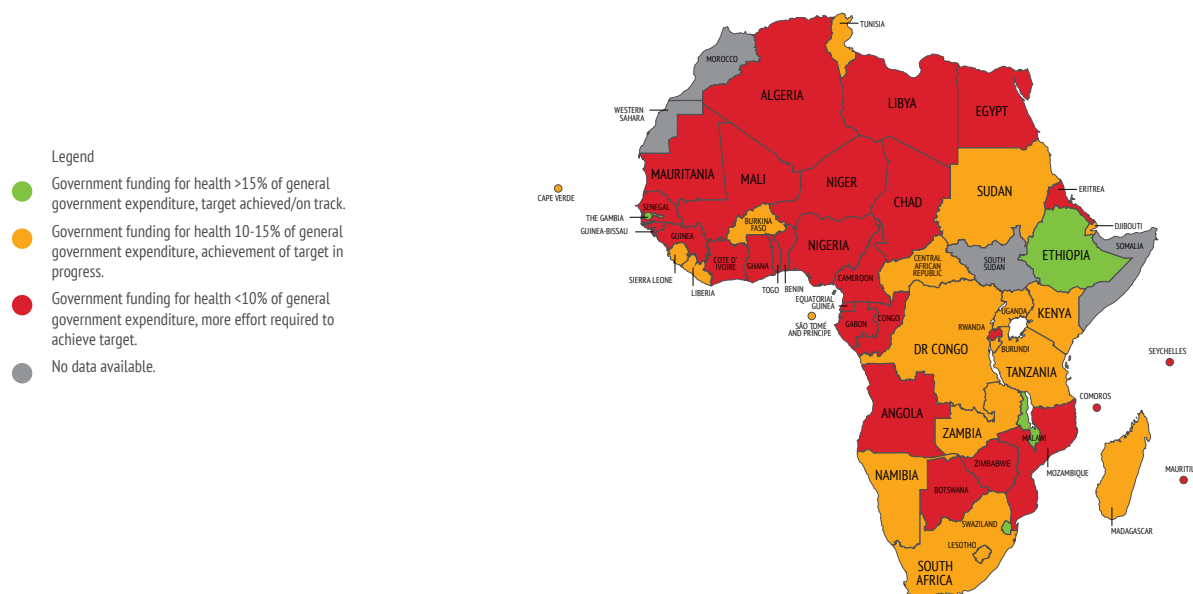
- Eight out of ten countries have **constitutional provisions** that articulate women and girls' **right to health**.³² These include the right to health as well as to health care or health services. Kenya is the only country that has a constitutional provision specific to the right to reproductive health.
- A minority of countries have **specific legislation on reproductive health**. These include, in the Western region, Benin, Burkina Faso, Guinea, Mali and Togo; in the Eastern region, Kenya and Rwanda; in the Central region, Cameroon, CAR, Chad, Equatorial Guinea and Rwanda; in the Southern region, Madagascar, Malawi and Mauritius; and in the Northern region, Mauritania.
- In most countries, SRH is addressed in a policy or strategic framework. These tend to place less emphasis on rights-based approaches to women and girls' reproductive rights and rights to non-discriminatory access to SRH services. Some countries also lack a policy or strategic framework on sexual and/or reproductive health.³³ The majority of countries have launched a chapter of the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA).³⁴

³¹ Score card published by Africa AIDS Watch: www.aidswatchafrica.net/index.php/africa-scorecard-on-domestic-financing-for-health

³³ The study could not establish an SRH or family planning policy in Comoros, Djibouti and Libya.

³⁴ The countries that have not launched a CARMMA campaign are Algeria, Cape Verde, Egypt, Libya, Mauritius, São Tomé and Príncipe, South Sudan, Sudan and Zambia. Data for Morocco and Western Sahara is missing.

Map 4 Government funding for health as percentage of general government expenditure



- A minority of countries realise the commitments expressed in the Abuja Declaration (2001) on health expenditures. The **health expenditures** of nine of the fifty-five countries are higher than 5% of GDP.³⁵ Moreover, when looking at funding for health as part of government expenditures (see Map 4), four countries reach the target of at least 15% and twenty are making progress towards this target: Ethiopia, The Gambia, Malawi and Swaziland (marked in green on the map). The 19 countries marked in orange are making progress towards the Abuja target, and spend between 10% and 15%. Of these, Djibouti, Lesotho and Sierra Leone also spend over 5% of GDP on health. Thirty-one countries (marked in red) spend less than 5% of their annual budget on health, or data regarding their health expenditures is not available.³⁶
- Adolescent access to SRH services is limited when countries lack youth-friendly services. Countries that have special **frameworks on adolescent SRH** include Djibouti, DRC, Ethiopia, Gabon, Ghana, Kenya, Malawi, Mauritania, Niger, Nigeria, Sierra Leone, South Africa, South Sudan and Tanzania.
- In the twenty countries that have agreed to work collaboratively on the ESA Commitment which includes implementation of good quality **comprehensive sexuality education (CSE)** as one of its targets, progress has been observed. Fifteen out of twenty-one countries report providing CSE and life skills in at least 40% of primary schools, and 12 countries in at least 40% of secondary schools. Fifteen countries have developed a strategic plan or national policy on sexuality education for out-of-school youth. The twenty-one countries vary in the extent to which teachers and health workers are trained in CSE and life skills, in either pre-service and in-service programmes.³⁷
- In terms of ensuring women and girls' access to SRH services, initiatives have been taken in the different regions to enhance such access. These include the allocation of budgets and formulation of costed implementation plans, the integration of SRH services into primary health care and the provision of free SRH services and contraceptive methods. Some countries have also introduced mobile clinics to enhance access to SRH services for rural women.

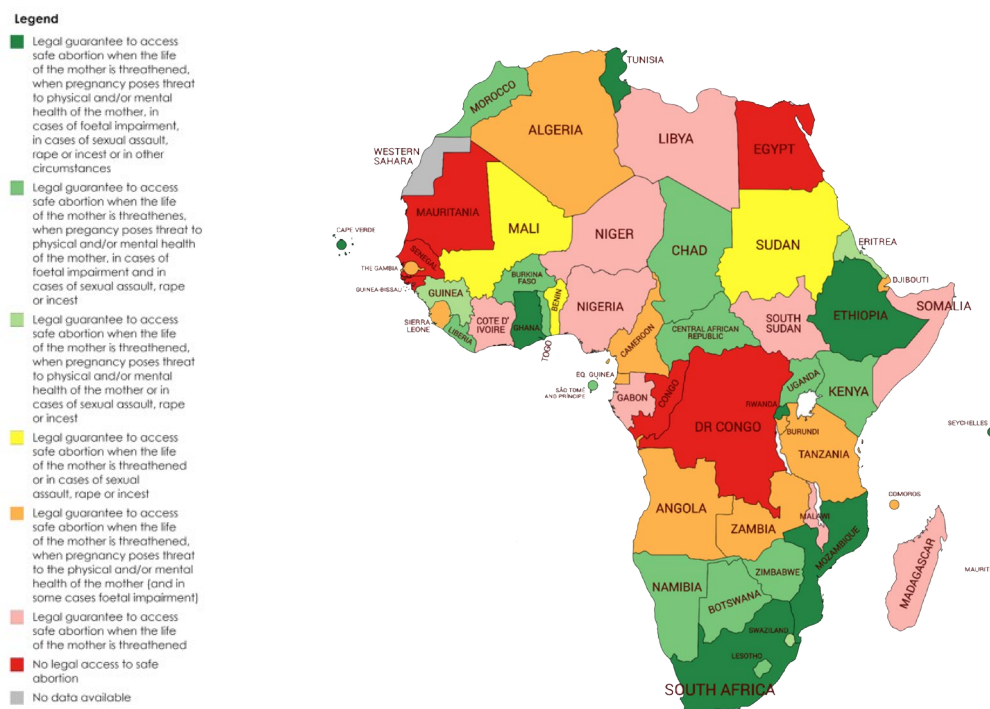
³⁵ Countries spending more than 5% of GDP on health are Algeria, Angola, Congo Republic, Djibouti, The Gambia, Lesotho, Malawi, Sierra Leone and Swaziland.

³⁶ Four countries have missing data on this indicator.

³⁷ Based on: 'Fulfilling our promise to young people today: 2013-2015 review' (UNESCO, UNFPA and UNAIDS 2017), progress review on ESA Commitment.

The countries and regions of the African continent show a large variation in the extent to which they have domesticated the provisions on **access to safe abortion** in their national legal and policy frameworks (see Map 5).

Map 5: Legal guarantee to access safe abortion



- **Twenty-two countries have legal guarantees to access safe abortion** on the four grounds specified in the Maputo Protocol (marked in green on the map). Eight of these have provisions that are broader than the Maputo Protocol; in four countries the woman's age or capacity to take care of a child can be taken into consideration (Ethiopia, Ghana, Rwanda and Seychelles), and in three countries abortion is available on demand (South Africa) or without restrictions as to reason (Cape Verde, Mozambique and Tunisia).
- **Three countries provide for access to safe abortion on three grounds** articulated in the Maputo Protocol: when the life or the health of the woman is in danger and in case of sexual assault, rape or incest: Eritrea, Guinea and Swaziland. Of these, Eritrea also allows for safe abortion taking into account the woman's age or capacity to take care of a child.
- On the other end of the spectrum, **a quarter of the African countries have highly restrictive** abortion laws. Six countries (marked in dark red on the map) prohibit abortion under any condition, which means it can only occur on grounds of necessity (Congo Republic, DRC, Egypt, Guinea-Bissau, Mauritania and Senegal). Another nine countries allow for access to safe abortion only when the life of the mother is in danger (Côte d'Ivoire, Gabon, Libya, Madagascar, Malawi, Niger, Nigeria, Somalia and South Sudan). Benin, Mali and Sudan have slightly less restrictive abortion laws, and allow abortion to save the life of the mother and in cases of sexual assault, rape or incest (marked in yellow on the map). The group of countries marked orange on the map consists of seven countries that allow for access to abortion when the life and the health of the woman is in danger (Algeria, Burundi, Comoros, Djibouti, Equatorial Guinea, Sierra Leone, Tanzania and Zambia). Angola, Cameroon and Zambia are also in this orange group, and allow for abortion on the basis of both life and health, and an additional ground. Angola also allows for abortion in case of foetal impairment. Cameroon also allows guarantees access to safe abortion in case of rape or sexual assault. Zambia stands out here as it also allows for access to safe abortion on the basis of life and the health of the mother, in cases of foetal impairment and then on other grounds (e.g. for economic reasons).

³⁸ Based on: 'Sexual rights, young people and the law' (IPPF 2017), study conducted in seven African countries (Chad, Ethiopia, Kenya, Mali, Mauritania, Niger and Zambia).

The **key gaps and contestations** on women and girls' reproductive rights and SRH services include:

- The limited availability of accurate and comprehensive data on sensitive issues around reproductive rights and SRH services and the need for institutional strengthening of harmonised **data collection, registration and information systems**, at the level of health facilities as well as at national level and in multi-country monitoring systems
- The lack of comprehensive legal frameworks on reproductive rights and SRH, which also are uneven and vary in what they cover and their rights-based orientation. This results in weak or absent legal provisions and guarantees for women and girls on their reproductive rights and non-discriminatory access to SRH services
- The fact that the majority of countries do not explicitly prohibit non-discrimination in relation to SRH services. By contrast, a critical concern relates to the **explicit restrictions** on access to contraception or SRH services (e.g. in Cameroon, Congo Republic, DRC and Gabon).
- Access to SRH services is constrained when adolescents need **parental consent**. Countries that require parental consent to access SRH services include Ethiopia, Kenya, Mali and Zambia (all parental consent for HIV testing)³⁸, and São Tomé and Príncipe (to access safe abortion). In other countries, such as Morocco and Mali, young people's access is constrained because SRH services are provided to married couples only. Legal or practical requirements for third-party consent of a husband severely restricts the free and voluntary consent of women and girls in terms of access to SRH services. Malawi stands out with a law on the age of consent to SRH services set at 12 years; in South Africa a child may consent to his or her medical treatment without parental consent.
- The contested nature of the issue of **adolescent pregnancies and access to education** in many countries and regions: in a few countries, pregnant girls or adolescent mothers are denied access to school and face barriers to continuing and completing their education (Equatorial Guinea and Tanzania)
- Provision of good quality, integrated and fully compulsory **comprehensive sexuality education** is not yet realised, and continues to be contested, despite progress made. In countries making progress in the implementation of the ESA Commitment, not all schools are being reached, neither are all out-of-school youth, and the quality and comprehensive of the CSE varies.
- Many countries lack clear legislation on age of consent to sexual activity. When in place, **sexual consent of youth** is often constructed in reference to sexual defilement or rape. This framing protects girls and young women from forced sex, sexual abuse and exploitation, but can also restrict her right to express her sexuality. In addition, most countries lack a clear legal or policy framework on the appropriate age for young people to seek SRH services.
- **Criminalisation and stigmatisation of same-sex sexual acts** limits access to SRH services of individuals marginalised and discriminated on the basis of real or imputed SOGIE identities. Same-sex sexual acts are outlawed in three out of ten African countries criminalise and outlaw same-sex sexual acts (more details in key findings on HIV and AIDS below).

With respect to **access to safe abortion**, the key gaps and contestations are as follows:

- In three out of five African countries, women cannot access safe abortion under the conditions specified in the Maputo Protocol. There is an **urgent need to decriminalise** abortion on the grounds articulated in the Maputo Protocol, and to ensure women and girls are guaranteed access to safe abortion.
- In 24 countries, women cannot access safe abortion in cases of sexual assault, rape or incest.

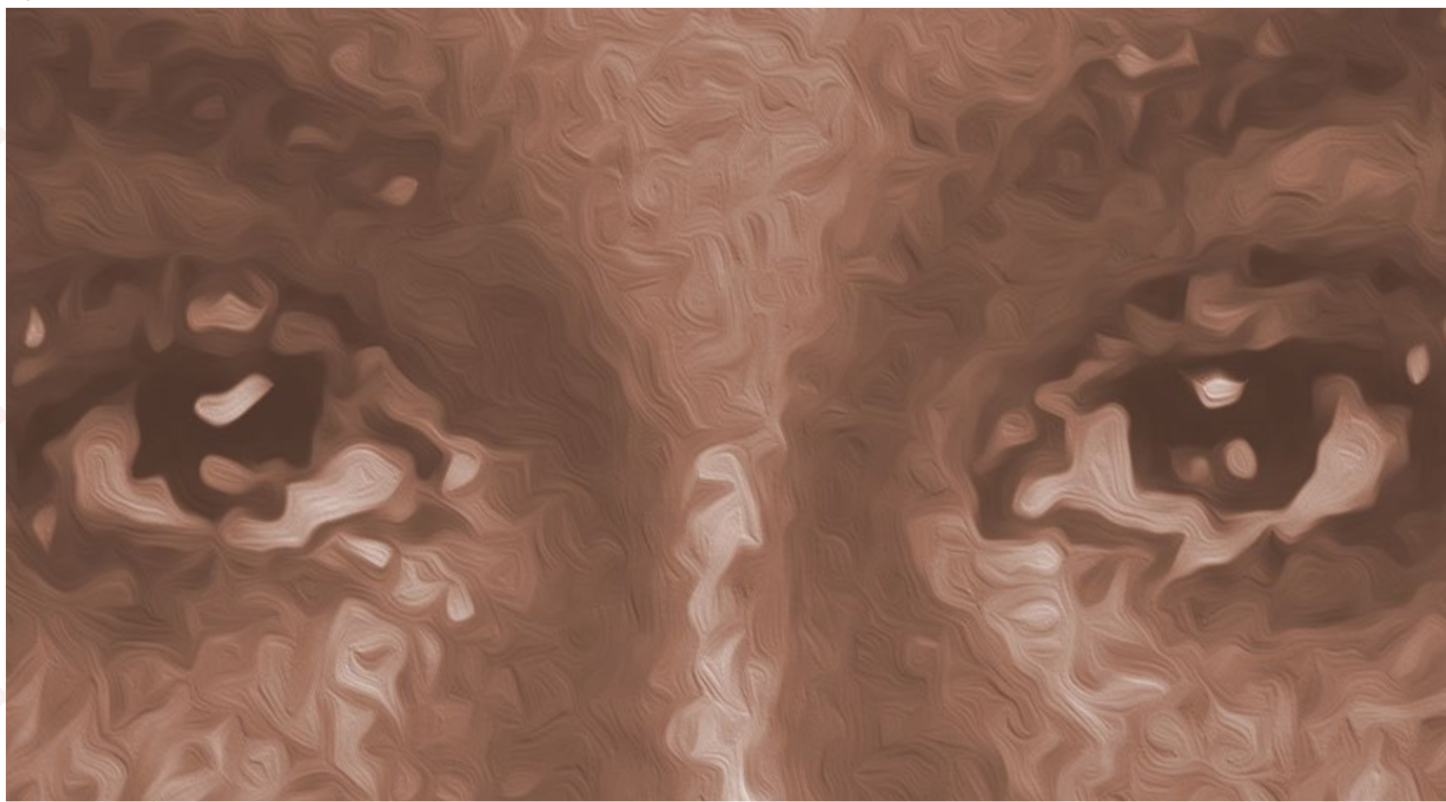
- Access to safe abortion is further restricted in countries that **require authorisation from a third party** (including one or more health professionals, courts, police, the ministry or a husband/spouse or parent). In some cases, such authorisations are sought even when not required by law (e.g. Sudan).
- In the vast majority of African countries, provisions regarding access to abortion are found in the **Penal or Criminal Code**. Instead of framing guarantees to access to safe abortion from a human rights perspective, these provisions place abortion in the realm of criminality, and contribute to increased stigma and a sense of illegality.
- Such Penal or Criminal Code provisions also contribute to the criminalisation of abortion and PAC. This affects both women and girls seeking safe abortion, and health providers who offer abortion and PAC. Criminal sanctions are an impediment to the provision of SAC and PAC services.
- In most countries, **guidelines** regarding SAC or PAC are missing. These are of critical importance to ensuring the quality of accessible safe abortion services.
- Revisions of abortion laws as well as the formulation and adoption of SAC or PAC guidelines have been obstructed by opposition actors, and this has in several cases led to these laws or guidelines being withdrawn or stalled, or to unclear language and provisions (e.g. Kenya, Sierra Leone, Uganda).
- In some countries, inconsistencies between different laws speaking to legal grounds for abortion point to the need to harmonise laws (e.g. CAR, Chad, Senegal).

Recommendations

- **Develop comprehensive legal frameworks** on women and girls' SRHR, that function to enable women and girls to exercise and enjoy their reproductive rights and freedoms. These legal frameworks should recognise the autonomy and freedom of all women and girls to make decisions on their fertility, number, timing and spacing of pregnancies, and choice of contraception, without interference of state or non-state actors.
- These legal and policy frameworks should ensure full, free and informed **consent** of women and girls, and **remove barriers**, such as third-party consent, conscientious objection or other restrictions, that limits women and girls' exercise of reproductive rights and access to SRH services. Also remove barriers to access to SRH such as marital status, age, disability, HIV status, or socio-economic and geographical ones.
- In policy and implementation frameworks, ensure **high quality, inclusive and gender-sensitive SRH services**, guaranteed to **all** women and girls. These SRH services should be delivered in an integrated way, integrating SRH, contraception, safe abortion, HIV and STIs, and primary health care.
- Develop and implement youth-friendly and gender-sensitive SRH services and programmes specifically aimed at meeting and promoting the **rights and needs of adolescent girls and young women in SRHR**.
- Provide clarity in national legal frameworks on the **appropriate age** for young people to access SRH, in a way that protects and promote their rights in SRHR.

- For countries to live up to the Abuja commitments, and increase their **health expenditures** in line with the 15% target of their national governmental budgets.
- **Train health workers** on non-discriminatory and gender-sensitive service provisions and access, including in particular ethical principles, and respect for dignity, privacy, confidentiality, and autonomy of the person, and to ensure free and informed consent of women and girls. This also includes guidance on conscientious objection.
- Provide and ensure comprehensive, complete and age-appropriate **information and education** on sexuality, reproduction and SRHR that is based on clinical findings and complete. This should be provided to women as well as adolescent girls and young women, in schools and out-of-school. It should cover family planning, contraception and safe abortion, as well as sex, sexuality, SRHR and sexually transmitted diseases, and address consent to sex as distinct from consent to marriage, and information about social norms and stereotypes of gender and sexuality that perpetuate gender inequality, including child marriage
- Ensure girls who are pregnant can continue their education and **complete their schooling**
- For countries that do not provide **access to safe abortion** on the grounds articulated in the Maputo Protocol, to align their legal parameters with the provided grounds.
- Resolve inconsistencies between different legal provisions on access to safe abortion.
- **Decriminalise abortion**, both for women and girls seeking safe abortion, and for providers of safe abortion care and post abortion care.
- Develop statutory law on access to safe abortion, that takes it out of the criminal context of the Penal or Criminal Code, and rather emphasises a human rights perspective.
- Translate abortion laws, in line with the grounds in the Maputo Protocol, to operational guidelines to ensure access to safe abortion care and post-abortion care
- Involve men and boys as change agents to promote and realise women and girls' reproductive rights and rights to SRH services

9 HIV AND AIDS



HIV has been a global concern for several decades, and since the early 2000s more than half of the people living with HIV have been women. The realisation of human rights and fundamental freedoms is essential to halt and end the HIV pandemic. HIV and AIDS have a disproportionate effect on women and girls, owing to their higher biological susceptibility to infection, as well as unequal gender relations between intimate partners and spouses. This is further affected by women and girls' limited access to SRH services and information, especially on HIV and AIDS. This implies that the human rights of women and girls are at the heart of the fight against HIV and AIDS.

9.1 PREVALENCE OF HIV AND AIDS

- Seven of the ten people living with HIV in 2016 lived in the Sub-Saharan African region—25.6 million people. A total of 80% of them lived in **Eastern or Southern Africa**, and the other 20% in Western and Central Africa. HIV prevalence in the MENA region is much lower.^{xlvi}
- Whereas **Western and Central Africa** contain 7% of the world's people, the regions are home to 17% of the global population living with HIV and account for 30% of the world's AIDS-related deaths.^{xlvi}
- More than half of the people living with HIV in Sub-Saharan Africa are **women and girls**—59% in Eastern and Southern Africa and 56% in the Western and Central region.^{xlvi}
- Between 2000 and 2014, **new HIV infections** in Sub-Saharan Africa declined by 41%, but this trend does not manifest itself in all countries.^l Whereas new HIV infections are declining in numerous countries,⁴⁰ they are in the rise in others.⁴¹ New infections tend to concentrate in specific countries.⁴²
- HIV and AIDS **affect women and girls disproportionately**. More than half of the new infections in the region occur in women; for **young women** aged 15–22 years, the rate is as high as 66%.^{li} Young women aged 15–24 in Sub-Saharan Africa are 2.5 times more likely to be infected with HIV than men.^{lii} For the African continent, AIDS-related illnesses are the second leading cause of death for young women aged 15–24.^{liii}
- **Female sex workers** are particularly vulnerable to HIV, and 13.5 times more likely to be living with HIV than other women.^{liv} Nine of the ten countries with the highest HIV prevalence among sex workers in 2016 were on the African continent: Burkina Faso, Ghana, Guinea, Madagascar, Niger, Rwanda, Senegal, South Sudan and Zimbabwe.^{lv}
- Gender unequal power relations constrain women and girls' to protect themselves from HIV infection. **GVAW and harmful practices** further increase women and girls' exposure to and risk of acquiring HIV and AIDS.^{lvi,lvii,lviii}
- Women and girls are also disproportionately affected by the **stigma and discrimination** associated with HIV infection. They face discrimination in their families and communities, as well as in schools or in the workplace.^{lix} This especially affects vulnerable groups and key population (including women refugees, migrants, women from ethnic minorities, women living with disabilities, SOGIE people and sex workers).^{lx}
- Stigma and discrimination can limit women and girls' access to HIV prevention, treatment and care, as well as to SRH and other services. It can also lead to increased GVAW, and limit women and girls' educational attainment or make them lose their jobs, income or property rights. When women are more likely to be tested on HIV than their male partners, such as during pregnancies and in maternal health care, they are also more vulnerable to stigma, and especially to being accused of bringing HIV to the family.

⁴⁰ For example Burundi, Guinea-Bissau, Mozambique, Nigeria, Senegal, Uganda, Zimbabwe.

⁴¹ For example Congo Republic, Ethiopia, Ghana, Liberia, Madagascar.

⁴² Including Kenya, Malawi, Mozambique, Nigeria, South Africa, Tanzania, Uganda, Zimbabwe.

Testing and knowing one's status is essential to HIV prevention as well as treatment, care and support services. The 2014 International AIDS Conference established the **90-90-90 target**: that 90% of all people living with HIV know their status, that 90% of the people who know their status are on treatment and that 90% of the people on treatment are virally suppressed.⁴³

WHO and UNAIDS strongly emphasise the critical importance of **voluntary HIV testing**, which should respect personal choice and ethical principles. The 'five Cs' of voluntary testing are (1) consent, (2) confidentiality, (3) counselling, (4) correct results and (5) connections.

- In Eastern and Southern Africa, three out of four people living with HIV **know their status** (2012–16); this is almost twice as high as in the previous period (2007–11). Nearly 80% of these are on treatment, and 83% are virally suppressed.^{lxii} In Western and Central Africa, these rates have increased fourfold, but the targets are still lower. Four out of ten know their status, of whom 83% are on treatment, of whom 73% are virally suppressed.^{lxiii}
- For the African region as a whole, the gap between reaching the 90-90-90 targets remains large. Men, young people and key populations often face more challenges in accessing HIV testing as well as treatment. Stigma and discrimination also affect women's access to testing and treatment; these may particularly affect girls and young women.
- Forced sterilisation of women living with HIV has been reported in various African countries, including but not restricted to Kenya, Namibia, South Africa and Uganda. Forced and coerced sterilisation undermines women and girls' human rights, and in turn generates fear and undermines access to testing and HIV treatment and care.^{lxiii}

HIV can be **transmitted from mother to child** during pregnancy, labour, delivery and breast-feeding.

- **Effective interventions can reduce the risk** of mother-to-child transmission (MTCT) to under 5%; without treatment, rates are between 15% and 45%. These interventions entail ART for the pregnant mother, a short course to the baby and appropriate breast-feeding practices.^{lxv}
- Without treatment, about a third of children living with HIV die by their first birthday, and half by their second.
- HIV-positive pregnant women are exposed to discrimination in accessing information, care and treatment. Women who have faced HIV-related stigma are **less likely to access ante and postnatal treatment and care**.^{lxvi}
- The 21 countries in Africa where more than 4 out of 5 women living with HIV reside are progressing in coverage of ART and **reduction of MTCT**. Six countries have achieved over 95% ART coverage (Botswana, Namibia, South Africa, Swaziland, Uganda and Zimbabwe). In Angola and Nigeria, coverage is under 50%. In the remaining 13 coverage ranges between 50% and 95%.^{lxvii}

⁴³ Virally suppressed means someone's viral load is reduced to an undetectable level.

9.2 COMMITMENTS AND REQUIRED RESPONSE ON HIV AND AIDS

The Maputo Protocol is ground-breaking as the first human rights instrument that refers to women and girls' rights in relation to HIV and AIDS, and STIs more generally. These provisions are in Art. 14, and have been further articulated in General Comment No. 1 (2012). Women and girls are unable to enjoy their human rights to the highest attainable standard of health, including SRHR, when they are at high risk of HIV exposure and transmission.

Under women and girls' right to health, including SRH, Art. 14 provides for (1) the right of women and girls to **self-protection and to be protected** against STIs, including HIV and AIDS and (2) the right of women and girls **to be informed on their HIV status and on the health status of their partner**, particularly with STIs and HIV and AIDS, in accordance with internationally recognised standards.

With respect to the first, the right to self-protection and to be protected against STIs and HIV and AIDS includes:

- Women and girls have the **right to access information and education** on sex, sexuality, HIV and sexual and reproductive rights. This should be evidence-based, facts-based, rights-based, non-judgemental and understandable in content and language, and should also address and deconstruct taboos, misconceptions and gender stereotypes.
- They have the right to access **SRH services** that should be available **to all women and girls**, and not be based on a discriminatory assessment of risk.
- Women and girls' right to access SRH services **cannot be denied** based on conscientious objection.
- Women and girls' right to equality and **non-discrimination based on HIV status**⁴⁴ also implies that their HIV status is not used as a condition to access SRH services, contraception and safe abortion services.

The **obligations** of states in relation to the right to self-protection and to be protected are (1) to ensure access to **information and education**, in particular for youth and adolescents (including through the training of health providers and educators on health and human rights), (2) to ensure **access to SRH services to all women** and (3) to create an **enabling legal and policy framework** allowing women and girls to control their sexual and reproductive choices and HIV prevention and protection (including enactment of non-discrimination legislation).

Regarding the second provision, the right to be informed on their HIV status and on the HIV status of their partner entails the following:

- Women and girls have the right to **access information about their health** that is adequate, reliable, non-discriminatory and comprehensive. This includes procedures, methods and technologies for HIV testing, CD4 count, viral load, TB and cervical cancer, as well as counselling services (both pre- and post-test).
- **All women, irrespective** of their marital status, and including young and adolescent women, women living with HIV, migrant and refugee women, indigenous women, detained women and women with disabilities, have access to such information about their health.
- Women and girls have the right to **be informed of the health status of their partner**.
- There is an emphasis on informed consent in revealing one's health status to a partner. Information about a partner's health status can be obtained through **disclosure** by that person, or through **notification** by a third party (usually a health worker).

⁴⁴ Discrimination has been noted to be based on various grounds, including race, sex, sexuality, sexual orientation, age, pregnancy, marital status, HIV status, social and economic status, disability, harmful customary practices and/or religion (General Comment No. 1, para. 4).

- Health workers are authorised, but not obliged, to decide whether to inform a patient's sexual partners. A set of **principles** guides health workers in revealing a person's health status; these include thorough counselling of the HIV-positive person; assessment of the risk of HIV transmission; efforts to not reveal a person's identity; ensuring the HIV-positive person is not at risk of physical violence after the notification; and the provision of follow-up services and support.

The **obligations** of states in relation to the right to be informed on one's health status and on the health status of one's partner are to ensure (1) **access to information and education** (including pre- and post-test counselling, and guaranteeing privacy and confidentiality) and (2) **non-discriminatory access to SRH procedures, technologies and services for all women** (including through training of health workers on non-discrimination, confidentiality, respect for dignity, autonomy and informed consent).

With respect to both rights provisions on HIV and AIDS, state obligations also include (1) the **removal and elimination of all barriers** to women and girls' enjoyment of their SRH (including gender disparities, harmful practices, patriarchal attitudes and discriminatory laws and policies, as well as geographical and economic barriers), (2) the provisions of **financial resources** and (3) to allow for **redress** for SRH violations.

9.3 NATIONAL-LEVEL DOMESTICATION ON HIV AND AIDS

There has been a great deal of progress in reform in relation to the legal and policy indicators for HIV and AIDS in most of the regions on the continent, with some notable gaps. To trace this, five legal and policy indicators have been used:

1. Non-discrimination legislation based on HIV
2. Policy and/or legal regulations that ensure voluntary testing
3. Criminalisation of wilful transmission of HIV⁴⁵
4. Programmatic response to access ART
5. Programmatic responses on MTCT

When looking at the trends on the specific legal and policy indicators, the following emerges:

- Legislation ensuring **non-discrimination on the basis of HIV status** is in place in the majority of the countries, but could not be confirmed in three out of ten countries. Sixteen countries lack such legislation, and for four it could not be established (missing data). Countries lacking non-discrimination legislation are six in Eastern Africa (mostly in the Horn)⁴⁶, five in Northern Africa⁴⁷, five in Central Africa⁴⁸, three in Western Africa⁴⁹, and only one in Southern Africa⁵⁰.
- Most countries have provisions regarding HIV testing, and the majority (39) have legal regulations ensuring **voluntary testing**. For 10 countries, it could not be established whether they have policy or legal regulations that ensure voluntary testing (missing data).⁵¹ In a notable minority of countries, HIV testing is mandatory for specific groups (Togo, for sex workers; Burundi and Uganda, for pregnant women; Angola, Chad, Angola for medical procedures). In Eritrea, regulations ensuring voluntary HIV testing are absent.

⁴⁵ The colour coding of this indicator is different from all other legal and policy indicators in the report; the reason for this is that the presence of such laws is currently contested in terms of its effect on the realisation of women and girls' rights.

⁴⁶ Eritrea, Ethiopia, Rwanda, Somalia, South Sudan and Sudan.

⁴⁷ Algeria, Egypt, Libya, Morocco and Tunisia.

⁴⁸ Cameroon, Gabon, and Rwanda; and missing data for Equatorial Guinea and São Tomé and Príncipe.

⁴⁹ Cape Verde and Guinea, and missing data for The Gambia.

⁵⁰ Swaziland.

⁵¹ Algeria, Cape Verde, Equatorial Guinea, Gabon, Guinea, Guinea-Bissau, Mali, Mauritania, Niger and Western Sahara.

- The vast majority of countries have a programmatic response to access ART in place, and also have a programmatic response on prevention of mother-to-child transmission of HIV. The only exceptions to this are Comoros (missing data regarding MTCT response), The Gambia (missing data on an ART programmatic response), Equatorial Guinea (missing data on both an ART and a MTCT programmatic response) and Tunisia (lacking a programmatic response on MTCT).

A key trend on the continent has been the **criminalisation of the wilful transmission of HIV**. More than six out of ten countries in Africa have adopted such legislation (see Map 7 below), and some others are considering doing so. This trend has raised controversy in the different regions, as these laws tend to further stigmatise people living with HIV and AIDS and certain sexual conducts, and also violate their rights to dignity and privacy. Women and girls can suffer harm from being wilfully exposed to transmission of HIV but can also be disproportionately affected by unjust accusations of wilfully transmitting HIV. Criminalisation of non-disclosure, exposure and transmission of HIV as well as of sexual and HIV-related conduct poses a threat to voluntary testing and counselling and access to information, education and SRH services for people living with or at risk of HIV. As such, this type of legislation can be counterproductive to a public health perspective.

Maps 6 and 7 allow for comparing the trends in legal reform on non-discrimination and voluntary testing on the one hand, and criminalisation of wilful transmission of HIV on the other. In Map 6, the indicators on non-discrimination on the basis of HIV and on voluntary testing are combined.

- Twenty-six countries (marked in darker green in Map 6) have legislation both ensuring non-discrimination on the basis of HIV and ensuring voluntary testing. Of these 26, 8 are marked blue in Map 7, as they do not criminalise wilful transmission of HIV.⁵² Another 18 countries of these 26 do criminalise wilful HIV transmission (marked yellow on Map 7).
- Nine countries have legislation on non-discrimination on the basis of HIV but lack guarantees for voluntary testing. Half of them are in Western Africa. These nine all criminalise wilful HIV transmission.⁵³ Their legal frameworks thus seem unbalanced, as this combination of legal provisions does not support women, or men, to protect themselves and know their status, but does make them vulnerable to criminal charges.
- Thirteen countries lack legislation on non-discrimination on the basis of HIV but do ensure voluntary testing; many of them are in Northern Africa and the Horn. Three of them criminalise wilful transmission of HIV⁵⁴ and eight lack such legislation.^{55,56} All these 13 thus have unbalanced legal frameworks regarding (self-)protection and knowing one's health status.
- Six countries (marked in red in Map 6) lack legislation that ensures non-discrimination on the basis of HIV and also lack guarantees on voluntary testing; five of these six, however, criminalise wilful transmission of HIV.⁵⁷ These five countries thus have legal frameworks on HIV that are biased towards criminalisation, rather than an enabling framework that supports women and men to exercise their right to (self-)protect and to know their status.

⁵² These eight are Comoros, Côte d'Ivoire, Ghana, Namibia, Nigeria, Seychelles, South Africa and Zambia.

⁵³ These nine countries are Angola, Burundi, Chad, Guinea-Bissau, Mali, Mauritania, Niger, Togo and Uganda.

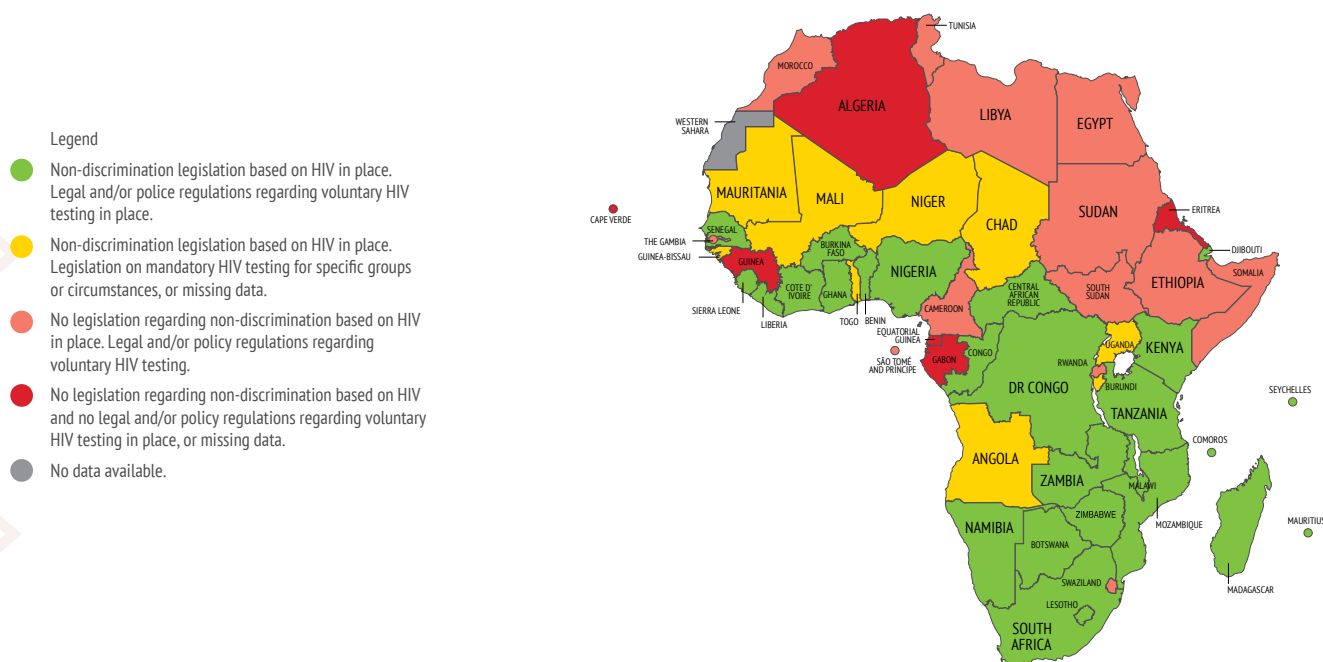
⁵⁴ Cameroon, Rwanda and South Sudan.

⁵⁵ Egypt, Ethiopia, The Gambia, São Tomé and Príncipe, Somalia, Sudan, Swaziland and Tunisia.

⁵⁶ For two countries, data on criminalisation of wilful transmission of HIV is missing: Libya and Morocco.

⁵⁷ Algeria, Cape Verde, Eritrea, Equatorial Guinea, Gabon and Guinea. For Algeria, data is missing regarding criminalisation of wilful HIV transmission.

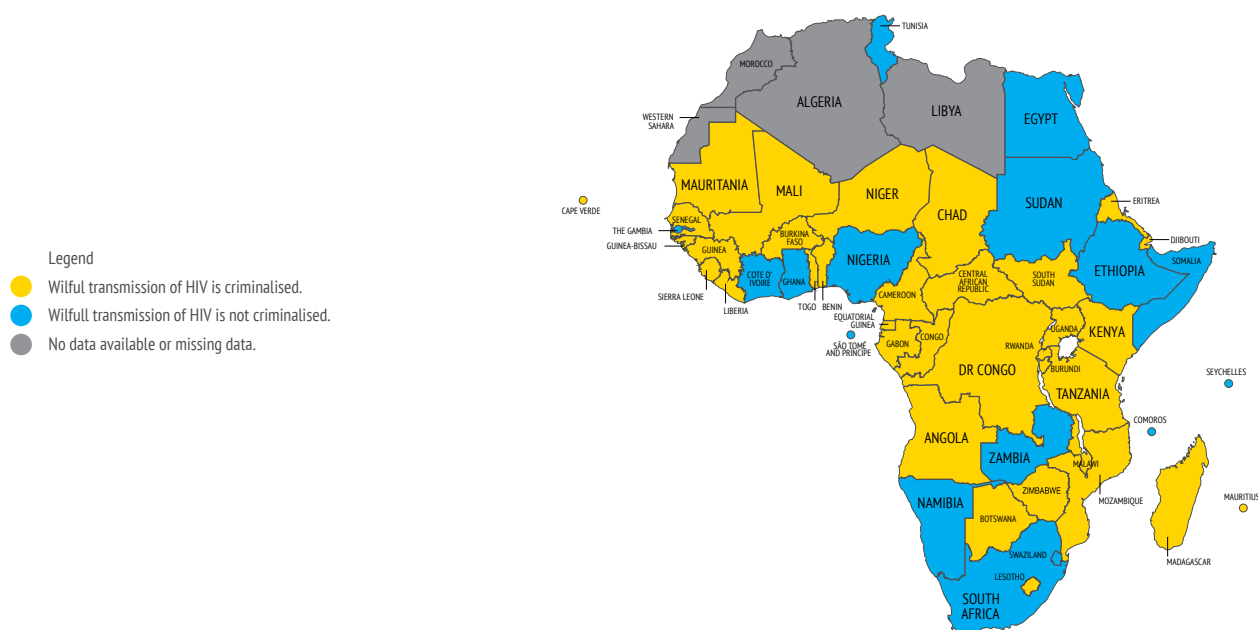
Map 6 Non-discrimination based on HIV and legislation/policy on voluntary testing



Other critical gaps and contestations in relation to women and girls' rights and HIV and AIDS are as follows:

- An overall concern is the **weak translation of the human rights approach** to legal, policy and institutional frameworks. Whereas many policies and strategic plans make a more or less elaborate reference to HIV prevalence among women and girls, they do not always offer a specific analysis of and approaches to **addressing gender differences or the underlying gender relations** that contribute to the disproportional effect of HIV among women and girls. Congo Republic, Rwanda

Map 7 Criminalisation of willful transmission of HIV



and several countries in the Southern region are positive exceptions to this, and do offer gender-disaggregated data and targeted actions in their policies or strategic plans. Gender-aware strategies are of particular importance given how stigmatisation affects women and girls' access to HIV testing, treatment and support.

- A minority of countries have **specific laws** on the rights of people living with HIV and AIDS.
- A critical concern relates to the **age restrictions for HIV testing** that are present in some countries (e.g. CAR, Congo Republic, Côte d'Ivoire, DRC, Senegal). In these cases, parental consent is required to access HIV testing. A number of countries also allow for the **disclosure** of HIV results of minors to their parents or guardians (e.g. DRC).
- Even when regulations for voluntary testing, consent and counselling are present, these do not always translate into **resources and staff competencies to respect these rights**.
- There is a bias in HIV testing towards pregnant women, and in some cases sex workers; this is often the case in practice, and sometimes also in legal regulations. This can result in **inadequate access** to HIV testing and counselling for women and girls who are not pregnant or not sex workers, as well as a neglect of both married and unmarried men.
- Another trend is that many HIV policies and strategies **focus on mother-to-child transmission**, in HIV testing as well as treatment. While this is important and laudable, and much progress has been achieved here, a critical concern is the limited attention to addressing **gender concerns and women's rights beyond this**.
- A related concern is that attention to **key populations** tends to be underdeveloped in many policies and strategies, including in the Southern region.
- The focus on pregnant women also calls for further recognition of the **stigma and risks women face in disclosing HIV-positive test results**, and the challenges they may confront in taking and following treatment. Few programmes and strategic plans take these gender-related risks and challenges into account. This also calls policies and strategic plans to further prioritise the strengthening of providers' capacities to identify such risks and avoid coercive testing and disclosure in prevention of mother-to-child transmission programmes.
- Three out of then African countries criminalise and **outlaw same-sex sexual acts**⁵⁸; in three countries same-sex sexual acts are punishable by death (Nigeria, Sudan and Mauritania). Twenty-one countries do not criminalise same-sex sexual acts;⁵⁹ these includes both countries that do not have a legal provision on the topic, and countries that once had but have now removed a provision that criminalised same-sex acts. South Africa is the only country that has legalised same-sex partnership and marriage. Mauritius' criminalisation of same-sex sexual acts is contradicted by the recognition of the right to non-discrimination based on sexual orientation.^{60,61} Stigmatisation and discriminatory attitudes and practices towards sexual orientation and gender diversity exist in virtually all African countries.
- Another critical concern relates to the disrupting effects of situations of **conflict** (e.g. CAR, DRC and Libya) on HIV prevention and treatment services in those countries.

⁵⁸ In Western Africa: The Gambia, Ghana, Guinea, Liberia, Nigeria, Senegal, Sierra Leone and Togo. In Eastern Africa: Burundi, Eritrea, Ethiopia, Kenya, Somalia, South Sudan, Sudan, Tanzania and Uganda. In Central Africa: Angola, Burundi and Cameroon. In Southern Africa: Angola, Botswana, Malawi, Mauritius, Namibia, Swaziland, Tanzania, Zambia and Zimbabwe. In Northern Africa: Algeria, Libya, Mauritania, Morocco and Tunisia.

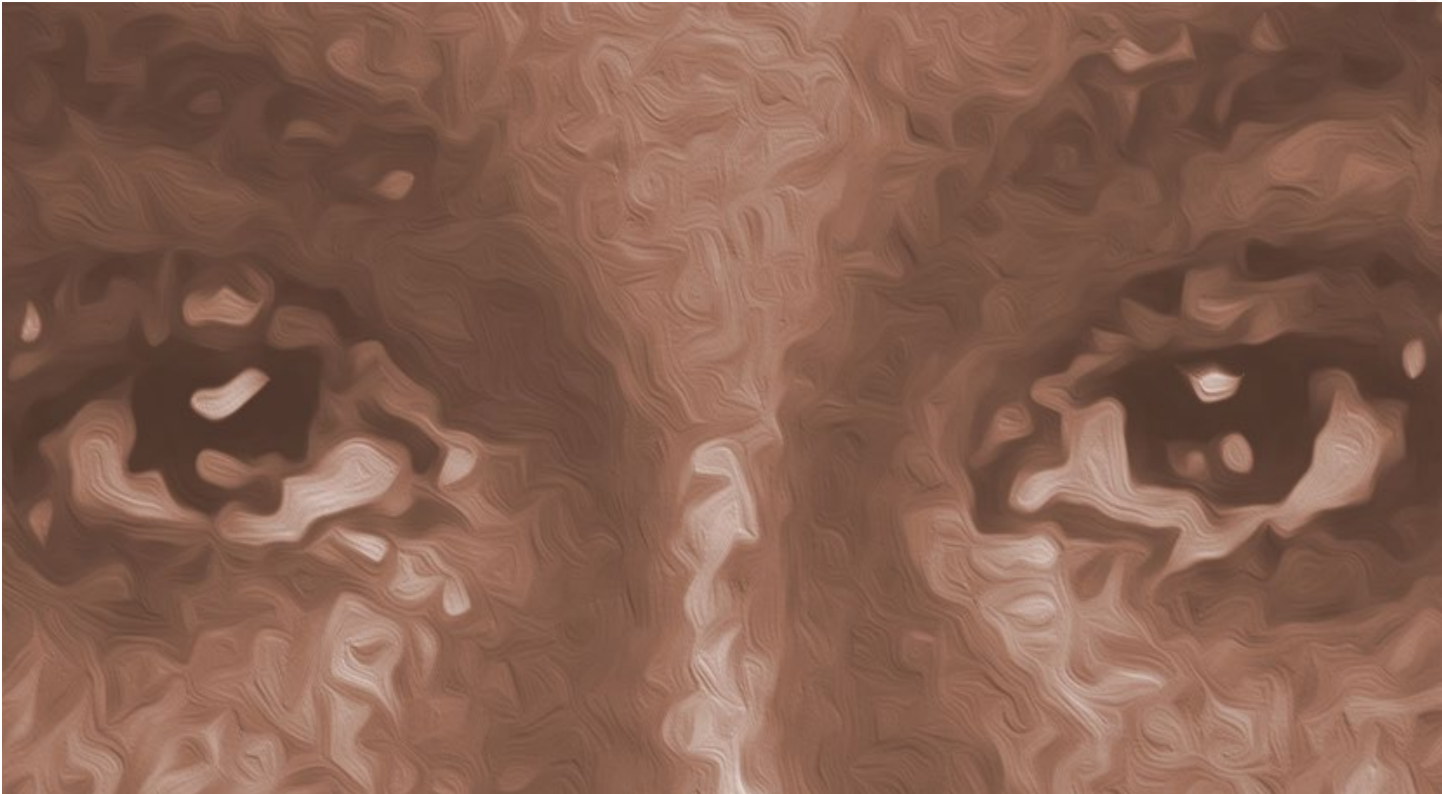
⁵⁹ These twenty-one countries are all countries not listed in the previous footnote, minus South Africa which has legalised same-sex partnership and marriage.

⁶⁰ Which is recognised in Mauritius' Equal Opportunities Act of 2008 and the Code of Ethics for Public Officers.

⁶¹ Based on: Carroll, A. and Mendos, L.R. (2017). State Sponsored Homophobia: A world survey of sexual orientation laws: criminalisation, protection and recognition. Geneva: ILGA. Based on: Carroll, A. and Mendos, L.R. (2017). State Sponsored Homophobia: A world survey of sexual orientation laws: criminalisation, protection and recognition. Geneva: ILGA.

Recommendations

- Adopt and implement specific **laws** on HIV that respect and promote, amongst others, the right to non-discrimination on the basis of HIV as well as guarantee and ensure voluntary testing and counselling on HIV.
- Ensure that national HIV laws, as well as policy frameworks, address particular concerns and human **rights of marginalised and vulnerable groups** of women and girls, including key populations.
- Put in place gender-sensitive national **commissions** or institutional mechanisms on HIV and AIDS
- Enhance access to information and SRH services that include HIV testing, treatment and care, including MTCT and ART, through **tailored messages for women and girls**
- **Reform laws that criminalise exposure, non-disclosure and/or wilful transmission of HIV**, in recognition of the rights of people living with HIV to non-discrimination.
- Ensure **full, free and informed consent** in access to SRH services and information, so that women and girls cannot be denied SRH services nor forced to take a specific treatment, based on either mandatory HIV testing or HIV positive results.
- **Remove restrictions**, such those related to age and marital status, on HIV testing and counselling, including the removal of third party consent requirements.
- **Train health service providers and counsellors** on non-discrimination, confidentiality, respect for dignity, autonomy and informed consent in the provision of integrated SRH services, including HIV. Strengthen their skills to provide guidance and support safe disclosure for both men and different groups of women, in a gender-responsive way.
- In MTCT programmes and services, **embed a gender-responsive approach** that respects and promotes women and girls' rights and their HIV prevention and protection choices.
- Reform laws that criminalise HIV related (sexual) conduct, in particular reform laws that criminalise same-sex sexual acts.
- Allocate sufficient and adequate **resources** to provide comprehensive and quality HIV and AIDS services in an integrated way with SRH services and primary health care.



ENDNOTES

- ⁱ UNECA, AUC and UNFPA. (2013). Addis Ababa Declaration on Population and Development beyond 2014. African Regional Conference on Population and Development, Addis Ababa, 3–4 October (ECA/ICPD/MIN/2013/4, 4 October), p.6 and p.7, respectively. www.unfpa.org/sites/default/files/resource-pdf/addis_declaration_english_final_e1351225_1.pdf
- ⁱⁱ Preamble to the Constitution of WHO as adopted by the International Health Conference, New York, 19 June–22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of WHO, no. 2, p. 100) and entered into force on 7 April 1948. The definition has not been amended since 1948. See www.who.int/suggestions/faq/en/
- ⁱⁱⁱ OHCHR and WHO. (2008). 'The Right to Health'. Factsheet 31. Geneva: OHCHR and WHO. <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf>
- ^{iv} ACHPR. (2014). General Comment No. 2 on Article 14.1(a), (b) and (c) and Article 14.2(a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para. 6. See also Starrs, A., Ezech, A., Barker, G. et al. (2018). 'Accelerate Progress: Sexual and Reproductive Health and Rights for All'. Report of the Guttmacher-Lancet Commission', p.9.
- ^v UN Women. (1995). Beijing Platform for Action. United Nations Fourth World Conference on Women, September, Section C. Women and Health, Para. 96. <http://www.un.org/womenwatch/daw/beijing/platform/health.htm>
- ^{vi} See also IPPF. (1997). Charter on Sexual and Reproductive Rights Guidelines. London: IPPF. https://www.ippf.org/sites/default/files/ippf_charter_on_sexual_and_reproductive_rights_guidelines.pdf
- ^{vii} ACHPR General Comments Nos 1 and No. 2 also refer to SRHR.
- ^{viii} See also Addis Ababa Declaration, para. 44 (under 'Health') and also Starrs, A., Ezech, A., Barker, G. et al. (2018). 'Accelerate Progress: Sexual and Reproductive Health and Rights for All'. Report of the Guttmacher-Lancet Commission'.
- ^{ix} This has also been clearly articulated in the Beijing Platform for Action (of the Fourth World Conference on Women, United Nations 1994), in particular under 'Women and Health', and paras 93–97 and in the recently published report of the Guttmacher-Lancet commission: Starrs, A., Ezech, A., Barker, G. et al. (2018). 'Accelerate Progress: Sexual and Reproductive Health and Rights for All'. Report of the Guttmacher-Lancet Commission', p.9.
- ^x WHO (2006). Defining Sexual health: report from a technical consultation on sexual health 28-31 January 2002 Geneva. Geneva: World Health organisation, p. 5.
- ^{xi} WHO (2006). Defining Sexual health: report from a technical consultation on sexual health 28-31 January 2002 Geneva. Geneva: World Health organisation, p. 5.
- WHO (2010). Developing sexual health programmes: a framework for action. Geneva, p. 3.
- WHO (2015). Sexual health, human rights and the law. Geneva, p. 5.
- ^{xii} Ibid.
- ^{xiii} Ibid.

- ^{xiv} WHO. (2013). Global and Regional Estimates of Violence against Women: Prevalence and Health Effects of Intimate ^{xiv} Partner Violence and Non-Partner Sexual Violence. Geneva: WHO.
- ^{xv} UN Women. (n.d.) Global Database on Violence against Women. <http://evaw-global-database.unwomen.org/en>
- ^{xvi} WHO. (2013). Global and Regional Estimates of Violence against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence. Geneva: WHO.
- ^{xvii} WHO. (2013). 'Global Health Data Repository. Non-Partner Sexual Violence Prevalence'. Retrieved 19 January 2017 from <http://apps.who.int/gho/data/view.main.NPSVGBDREGION>
- ^{xviii} United Nations Office on Drugs and Crime UNODC. (2016). Global report Report on Trafficking in Persons 2016. Vienna: UNODC. https://www.unodc.org/documents/data-and-analysis/glotip/2016_Global_Report_on_Trafficking_in_Persons.pdf
- ^{xix} UNICEF. (2014). A Statistical Snapshot of Violence against Adolescent Girls. New York: UNICEF.
- ^{xx} UN Women. (2013). Violence against Women in Conflict, Post-Conflict and Emergency Settings. New York: UN Women.
- ^{xxi} UN. (2017). 'Report of the Secretary-General on Conflict-related Sexual Violence'. S/2017/249. <http://www.un.org/en/events/elimination-of-sexual-violence-in-conflict/pdf/1494280398.pdf>
- ^{xxii} UNICEF Global Databases. (2018). 'Child Marriage Is a Violation of Human Rights, But Is All Too Common'. <https://data.unicef.org/topic/child-protection/child-marriage/#>
- ^{xxiii} *ibid*
- ^{xxiv} Girls Not Brides. (n.d.). 'Ending Child Marriage in Africa'. Brief. <http://girlsnotbrides.theideabureau.netdna-cdn.com/wp-content/uploads/2015/02/Child-marriage-in-Africa-A-brief-by-Girls-Not-Brides.pdf>
- ^{xxv} UNICEF. (2017). Achieving a Future without Child Marriage. Focus on West and Central Africa. New York: UNICEF.
- ^{xxvi} Centre for Child Rights. (2018). 'A Report on Child Marriage in Africa'. Pretoria: University of Pretoria, in collaboration with ACHPR and SRRWA
- ^{xxvii} UNICEF global databases (2018). 'At Least 200 Million Girls and Women Alive Today Living in 30 Countries Have Undergone FGM/C'. <https://data.unicef.org/topic/child-protection/female-genital-mutilation/>
- ^{xxviii} *ibid*
- ^{xxix} UNICEF. (2013). Female Genital Mutilation and Cutting. A Statistical Overview and Exploration of the Dynamics of Change. New York: UNICEF
- ^{xxx} *ibid*

- ^{xxxii} UNICEF. (2013). Female Genital Mutilation and Cutting. A Statistical Overview and Exploration of the Dynamics of Change. New York: UNICEF.
- ^{xxxiii} *ibid*
- ^{xxxiv} PRB. (2017). ‘2017 World Population Data Sheet. With a Special Focus on Youth’. http://www.prb.org/pdf17/2017_World_Population.pdf
- ^{xxxv} UNDESA. (2015). ‘Trends in Contraceptive Use Worldwide’. Population Division, Fertility and Family Planning Section. [www.un.org/en/development/desa/population/publications/pdf/family/trendsContraceptiveUse\(2015Report.pdf](http://www.un.org/en/development/desa/population/publications/pdf/family/trendsContraceptiveUse(2015Report.pdf)
- ^{xxxvi} *Ibid*.
- ^{xxxvii} WHO. (2014). ‘Adolescent Pregnancy’. Fact Sheet. www.who.int/mediacentre/factsheets/fs364/en/
- ^{xxxviii} *ibid*
- ^{xxxix} WHO, UNICEF, UNFPA, World Bank Group and the UNPD (2015). Trends in maternal mortality: 1990 to 2015. https://data.unicef.org/wp-content/uploads/2015/12/Trends-in-MMR-1990-2015_Full-report_243.pdf
- ^{xli} WHO. (2017). Maternal Health. <http://www.afro.who.int/health-topics/maternal-health>
- ^{xlii} WHO. (2016). ‘Maternal Mortality’. Fact Sheet. <http://www.who.int/mediacentre/factsheets/fs348/en/>; also Patton, G.C., Coffey, C., Sawyer, S.M. et al. (2009). ‘Global Patterns of Mortality in Young People: A Systematic Analysis of Population Health Data’. The Lancet 374: 881–92.
- ^{xliii} UNFPA. (2013). State of the World Population: Motherhood in Childhood. Facing the Challenge of Adolescent Pregnancy. New York: UNFPA.
- ^{xliv} Sedgh, G., Singh, S., Henshaw, S. and Bankole, A., (2012). ‘Induced Abortion: Incidence and Trends Worldwide from 1995 to 2008’. The Lancet 379(9816): 625–32; Guttmacher Institute. (2017). ‘Abortion in Africa. Incidence and Trends’. <https://www.guttmacher.org/fact-sheet/facts-abortion-africa>
- ^{xlv} Sedgh, G., Bearak, J., Singh, S. et al. (2016). ‘Abortion Incidence between 1990 and 2014: Global, Regional, and Subregional Levels and Trends’. Lancet 388(10041): 258–67; Guttmacher Institute. (2017). ‘Abortion Worldwide: Uneven Progress and Unequal Access’. https://www.guttmacher.org/sites/default/files/report_pdf/abortion-worldwide-2017.pdf
- ^{xlvi} Guttmacher Institute. (2017). ‘Abortion Worldwide: Uneven Progress and Unequal Access’. https://www.guttmacher.org/sites/default/files/report_pdf/abortion-worldwide-2017.pdf; Ganatra, B., Gerdtts, C., Rossier, C. et al. (2017). ‘Global, Regional, and Subregional Classification of Abortions by Safety: Estimates from a Bayesian Hierarchical Model’. The Lancet 390: 2373–81.
- ^{xlvii} WHO. (2017). ‘Preventing Unsafe Abortion’. Fact Sheet. www.who.int/mediacentre/factsheets/fs388/en/
- ^{xlviii} UNFPA. (2015). For People, Planet and Prosperity. 2015 Annual Report. New York: UNFPA.
- ^{xlix} UNAIDS. (2017). Number of people living with HIV in 2016. <http://aidsinfo.unaids.org/>
- ^l UNAIDS. (2017). ‘Ending AIDS: Progress towards the 90-90-90 Targets’ (p. 112). http://www.unaids.org/sites/default/files/media_asset/Global_AIDS_update_2017_en.pdf
- ^{li} UNAIDS. (2017). Number of people living with HIV in 2016. <http://aidsinfo.unaids.org/>

- ⁱ OHCHR. (2016). 'Joint Statement by UN Human Rights Experts on the Occasion of the High-Level Meeting on Ending AIDS by 2030'. <http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20053&LangID=E>
- ⁱⁱ UN Women. (2017). 'Facts and Figures: HIV and AIDS'. <http://www.unwomen.org/en/what-we-do/hiv-and-aids/facts-and-figures>
- ⁱⁱⁱ WHO. (2017). 'Global AIDS Epidemic Shows No Sign of Abating; Highest Number of HIV Infections and Deaths Ever'. Media Center. <http://www.who.int/mediacentre/news/releases/2003/prunaids/en/>
- ^{liii} UNAIDS. (2017). 'Ending AIDS: Progress towards the 90-90-90 Targets' (p. 22). http://www.unaids.org/sites/default/files/media_asset/Global_AIDS_update_2017_en.pdf
- ^{liv} WHO. (2017). 'HIV/AIDS. Sex Work'. http://www.who.int/hiv/topics/sex_work/about/en/
- ^{lv} UNAIDS. (2017). 'Ending AIDS: Progress towards the 90-90-90 Targets'. http://www.unaids.org/sites/default/files/media_asset/Global_AIDS_update_2017_en.pdf
- ^{lvi} ARASA. (2014). 'HIV and AIDS in Southern and Eastern Africa. AIDS Rights for Southern Africa. 2014 Annual Report'. (p. 13).
- ^{lvii} Jewkes, R. (2010). 'HIV/AIDS. Gender Inequities Must Be Addressed in HIV Prevention'. *Science* 329(5988): 145–7; Vyas, S. and Watts, C. (2009). 'How Does Economic Empowerment Affect Women's Risk of Intimate Partner Violence in Low and Middle Income Countries? A Systematic Review of Published Evidence'. *Journal of International Development*.
- ^{lviii} Maleche, A. and Day, E. (2011). 'Traditional Cultural Practices & HIV: Reconciling Culture and Human Rights'. Working Paper for the Third Meeting of the Technical Advisory Group of the Global Commission on HIV and the Law.
- ^{lix} UNDP. (2011). 'Regional Issue Briefs and Video of the Africa Regional Dialogue'. Global Commission on HIV and the Law. New York: UNDP, HIV/AIDS Practice.
- ^{lx} WHO and UNAIDS. (2017). 'WHO, UNAIDS Statement on HIV Testing Services: New Opportunities and Ongoing Challenges'. http://www.hst.org.za/publications/NonHST%20Publications/2017_WHO-UNAIDS_statement_HIV-testing-services_en.pdf
- ^{lxi} UNAIDS. (2017). Special Analysis. See annex on methods for more details.
- ^{lxii} Ibid.
- ^{lxiii} Agiresaasi, A. (2016) 'Lawsuits Spotlight Forced Sterilization of Women with HIV in East African Countries'. Global Press Journal. <https://globalpressjournal.com/africa/kenya/lawsuits-spotlight-forced-sterilization-of-women-with-hiv-in-east-african-countries/>; Kakande, Y. (2016). 'HIV-Positive Ugandan Women Complain of Forced Sterilization in Government Hospitals'. <https://www.reuters.com/article/us-uganda-hiv-sterilisation/hiv-positive-ugandan-women-complain-of-forced-sterilization-in-government-hospitals-idUSKCN11A0D9>
- ^{lxiv} WHO. (2017). 'Mother-to-Child Transmission of HIV'. <http://www.who.int/hiv/topics/mtct/en/>
- ^{lxv} Ibid
- ^{lxvi} OHCHR. (2016). 'Joint Statement by UN Human Rights Experts on the Occasion of the High-Level Meeting on Ending AIDS by 2030'. <http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20053&LangID=EOHCHR>. (2016). Joint Statement by the UN human rights experts on the occasion of the High Level Meeting on ending AIDS by 2030. <http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20053&LangID=E#ftn3>
- ^{lxvii} UNAIDS 2017 estimates.

Annex 1

Selected data sources on national legal and policy frameworks

Convention on the Elimination of All Forms of Discrimination Against Women, Country Reports: <http://www.un.org/womenwatch/daw/cedaw/reports.htm>

UN Women Global Database on Violence against Women: <http://evaw-global-database.unwomen.org/en/countries>

United Nations Population Fund data and reports

UNAIDS data and reports

Guttmacher Institute fact sheets

Center for Reproductive Rights: <http://worldabortionlaws.com/>

Global Network of People Living with HIV, Global Criminalisation Scan: <http://criminalisation.gnpplus.net/>

Girls Not Brides: <https://www.girlsnotbrides.org/>

World Health Organization Global Abortion Policies Database: <http://srhr.org/abortion-policies/>

Eba, P. (2015). 'HIV-Specific Legislation in Sub-Saharan Africa: A Comprehensive Human Rights Analysis'. African Human Rights Law Journal, 224–62: <http://www.ahrlj.up.ac.za/eba-p-m#pgfId-1129339>

UN Data, Legal Age of Marriage: <http://data.un.org/DocumentData.aspx?id=336>

African Human Rights Case Law Database: <http://www.chr.up.ac.za/index.php/documents/african-human-rights-case-law-database.html>

Annex 2

Legal and policy indicators per rights area

This Annex provides the descriptions of the legal and policy indicators developed for and used in the State of African Women report. They are presented for each rights area: GVAW, Harmful practices, Reproductive rights and SRH, and HIV and AIDS.

GVAW: legal and policy indicators		
Name/description of indicator	Codes	Explanation of the indicator codes
Indicator 1 – Legislation on domestic violence	Yes	There is specific legislation on domestic violence (footnote added in case this is legislation on GVAW)
	PC	Legal provisions that criminalise domestic violence are in the penal/criminal code
	No	There are no legal provisions that criminalise domestic violence
	M	Missing data; legislation not found
Indicator 2 – Criminalisation of marital rape	Yes	Marital rape is criminalised in the law
	No	a. the law does not address or criminalise marital rape b. footnote added, in case the law explicitly excludes marital rape from the definition of rape
Indicator 3 – Law on sexual harassment	Yes	Either a broad law dedicated to sexual harassment, or a specific law on sexual harassment, or sexual harassment is addressed in a stand-alone law on GVAW (footnote added in case the legislation is specific to sexual harassment in schools or educational institutions)
	WP	In case the provisions on sexual harassment are specific to legislation on the workplace (i.e. in the labour code)
	No	There is no law or legal provision on sexual harassment
	M	Missing data; legislation not found
Indicator 4 – Law or legal provision on human trafficking	Yes	Law or legislation on human trafficking in place
	No	No law or legislation on human trafficking
Indicator 5 – National Action Plan (NAP) 1325	Yes	NAP 1325 adopted and in place
	No	No NAP 1325

Harmful practices: legal and policy indicators		
Name/description of indicator	Codes	Explanation of the indicator codes
Indicator 1 – Legal age of marriage set at 18	Yes	Legal age of marriage is set at 18
	Yes*	Legal age of marriage is set at 18 and guaranteed in the Constitution
	No	Legal age of marriage not guaranteed at 18
	M	Missing data; information could not be found
Indicator 2 – Full and free consent is guaranteed	Yes	This means there are no exceptions (i.e. consent of parents or other third parties) to the legal age of marriage
	No	This means marriage under the legal age of marriage is allowed when parents or other third parties provide consent (footnote gives explanation on exception)
	M	Missing data; information could not be found
Indicator 3 – Legal age of marriage applies to all marriages	Yes	This means the legal age of marriage applies to formal, customary, religious and all other marriages, and that this is explicitly stated in the law
	No	This means the legal age of marriage does not apply to all marriages, and customary, religious or other marriages are exempted (footnote gives explanation on the exemption)
	M	Missing data; could not find a specific indication that the legal age of marriage applies to all marriages or not
Indicator 4 – Action/strategic plan or campaign to end child marriage	Yes	Plan or campaign in place (either national initiative, or part of AU campaign to end child marriage)
	No	Plan or campaign not in place
	M	Missing data; information could not be found
Indicator 5 – Constitutional provisions to eliminate harmful practices	Yes	When Constitution provides for elimination of harmful practices (footnote added when provisions are formulated in broader terms)
	No	Constitution does not have provisions regarding the elimination of harmful practices
Indicator 6 – Legal provisions regarding elimination of FGM	Yes	Yes, the law prohibits FGM
	HP	There is a legal provisions that prohibits harmful practices, that could be applied/does apply to FGM
	No	There are no legal provisions that prohibit harmful practices or FGM (footnotes can indicate further qualifications regarding specifications under which they allow or prohibit FGM, i.e. age)
	M	Missing data; information could not be found
Indicator 7 – Programmatic response or action plan to end FGM	Yes	Programmatic response or action plan to end FGM is in place
	No	There is no programmatic response or action plan to end FGM
	M	Missing data; information could not be found

Reproductive rights and SRH: 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 reproductive 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 ²	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	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 – Constitutional provisions to eliminate harmful practices	When life mother is endangered	Yes	Abortion is allowed when the life of the mother is in danger
		No	Abortion is not 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 physical health of the mother is threatened
		MH	Abortion is allowed when the mental health of the mother is threatened
		PH+MH	Abortion is allowed when the health of the mother is threatened (physical and mental health both mentioned explicitly)
		H	Abortion is allowed when the health 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 not 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 not 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 (footnote is provided with explanation on grounds for abortion provided for)
		No	Abortion is not allowed on other grounds than the ones listed above

HIV and AIDS: legal and policy indicators		
Name/description of indicator	Codes	Explanation of the indicator codes
Indicator 1 – Non-discriminatory legislation based on HIV	Yes	Legislation on non-discrimination on basis of HIV is in place
	No	Legislation on non-discrimination on basis of HIV does not exist
	M	Missing data: no data found on whether this legislation exists or not
Indicator 2 – Voluntary testing guaranteed	VOL	a. HIV testing and counselling is voluntary, or provider-initiated with an opt-out b. Footnote added in case voluntary testing is guaranteed, and there is an exception allowing for forced testing of people being tried for sexual offences
	MAN	There is a regulation that indicates HIV testing is mandatory for specific groups or circumstances, or that there are exceptions to voluntary testing (i.e. pregnant women, pre-marital testing)
	ABS	There is no regulation regarding HIV testing and counselling
	M	Missing data: no data found on whether regulations exist regarding HIV testing and counselling
Indicator 3 – Criminalisation of wilful transmission of HIV	Yes	There is legislation that criminalises wilful transmission of HIV
	No	There is no legislation that criminalises wilful transmission of HIV
	M	Missing data: no data found on whether this legislation exists or not
Indicator 4 – Programmatic response to access ART	Yes	A government programmatic response to access ART is in place
	No	There is no government response to access ART
	M	Missing data: no data found on presence of government programmatic responses on access to ART
Indicator 5 – Programmatic response on MTCT	Yes	A government programme is in place on MTCT
	No	There is no government programme on MTCT
		Missing data: no data found on presence of government programmatic responses on MTCT

Annex 3

Regional units of analysis

The legal and policy framework data and analysis in the full report are organised and presented by region. The Key Findings version only refers to these in the continental and regional overview tables of the legal and policy indicators. The five regions are: Western, Eastern, Central, Southern and Northern. The composition of these regions is based on a combination of REC membership and the African regions defined by the AU, of which the details are provided in the table below.

Regional unit of analysis	Countries covered (and number of countries)	REC membership	Overlap with other regions ⁷
Western region	Benin, Burkina Faso, Cape Verde, Côte d'Ivoire, The Gambia, Ghana, Guinea-Bissau, Guinea, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone and Togo (15 countries)	All ECOWAS members	No overlap
Eastern region	Burundi*, Djibouti, Eritrea, Ethiopia, Kenya*, Rwanda*, Somalia, South Sudan*, Sudan, Tanzania* and Uganda* (11 countries)	- EAC members (six, marked with *) - IGAD members (eight, marked with ~)	- Rwanda and Burundi also in Central region and ECCAS members - Tanzania also in Southern region and SADC member - Seven COMESA members ⁸
Central region	Angola, Burundi, Cameroon, CAR, Chad, Congo Republic, DRC, Equatorial Guinea, Gabon, Rwanda and São Tomé & Príncipe (11 countries)	All ECCAS members	- Rwanda and Burundi also in Eastern region (EAC member) - Angola and DRC also in Southern region and SADC member
Southern region	Angola, Botswana, Comoros, DRC, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe (16 countries)	All SADC members	- Angola and DRC also in Central region and ECCAS members - Tanzania also in Eastern region (EAC member). - Nine COMESA members ⁹
Northern region	Algeria, Egypt, Libya, Mauritania, Morocco, Tunisia and Western Sahara ¹⁰ (seven countries)	UMA members, except for Egypt and Western Sahara)	Two COMESA members ¹¹

⁸ The countries of the Eastern region that are also members of COMESA are Djibouti, Eritrea, Ethiopia, Kenya, Rwanda, Sudan and Uganda (see also Chapter 4).

⁹ The countries of the Southern region that are also members of COMESA are Comoros, DRC, Madagascar, Malawi, Mauritius, Seychelles, Swaziland, Zambia and Zimbabwe (see also Chapter 4).

¹⁰ We were not able to find reliable information on legislation and policies on women and girls' rights in SRHR for Western Sahara, for any of the rights areas. The legal and policy indicator tables indicate 'missing data' for this country in Chapters 5–8.

¹¹ The countries of the Northern region that are also COMESA members are Egypt and Libya (see also Chapter 4).

Annex 4

Reservations by country on the Maputo Protocol

Country	Codes	Explanation of the indicator codes
Cameroon	Declaration	(Regarding homosexuality, abortion (except therapeutic abortion), genital mutilation, prostitution or any other practice which is not consistent with universal or African ethical and moral values)
Kenya	Reservation	Art. 10(3) (regarding reducing military expenditures in favour of social development) Art. 14(2)(c) (regarding access to safe abortion)
Namibia	Reservation	Art. 6(d) (regarding recording and registration of customary marriages)
Rwanda	Reservation	Art. 14(2)(c) (regarding access to safe abortion) (lifted in 2012)
South Africa	Reservation	Art. 4(j) (regarding death penalty) Art. 6(d) (regarding registration and recognition of marriages) Art. 6(h) (regarding equal rights of women and men in marriage in relation to nationality of their children)
	Interpretative declaration	Art. 1(f) (regarding definition of discrimination of women) Art. 31 ('South African Bill of Rights shall not be interpreted to offer less favourable protection of human rights than the Protocol, which does not expressly provide for such limitations')
Uganda	Reservation	Art. 14(1)(a) (regarding: women entirely having the right to control their fertility regardless of their marital status) Art. 14(2)(c) (regarding access to safe abortion)
Mauritius	Reservation	Art. 6(b)(c) (regarding minimum age of marriage; and regarding polygamous marriages) Art. 9 (regarding women's equal participation in political life) Art. 4(2)(k), Art. 10(2)(d) and Art. 11(3) (regarding measures for women seeking refuge or asylum, and protection of women in armed conflict) Art. 14(2)(c) (regarding access to safe abortion)
South Sudan	Reservation	Regarding polygamous marriages, regarding women's right to control their sexuality and their reproductive rights Art. 14(2)(c) (regarding access to safe abortion)

¹ UNECA, AUC and UNFPA. (2013). Addis Ababa Declaration on Population and Development beyond 2014. African Regional Conference on Population and Development, Addis Ababa, 3–4 October (ECA/ICPD/MIN/2013/4, 4 October), p.6 and p.7, respectively. www.unfpa.org/sites/default/files/resource-pdf/addis_declaration_english_final_e1351225_1.pdf



