

# THE STATE OF AFRICAN WOMEN

August 2018

This project is funded by the European Union



A project implemented by:



**The State of African Women report**  
© August 2018

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



This publication has been produced with the financial support of the European Union. The contents of this publication are the sole responsibility of the State of the African Woman Campaign Project Consortium Partners, under the leadership of IPPF Africa Region, and can in no way be taken to reflect the views of the European Commission.

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## Preface

The 'State of African Women' 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 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 Consortium Partners 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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## 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 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, Mark Okundi, Vitalis Mukhebi, Hanna Mekonnen, Macharia Karanja, Gina Wharton, Julia Millauer, Lorena Fuehr, Rena Föhr, Alice Bridgwood, Andreia Oliveira, and their colleagues in their respective organisations, for their insightful comments, ideas and feedback along the way. Throughout the drafting of the report, Natalie Nkoume and Peter Munene stood out in providing guidance and direction which was highly appreciated. We also would like to express our sincere gratitude to the project development team that was led by Matthias Brucker in 2016 when this State of African Women project was conceptualised.

We have been lucky to work with a passionate core team of researchers that authored this report. Rainatou Sow (Guinea and United Kingdom), Laura Nyirinkindi (Uganda), Mariam Mamunyu (Kenya), Elsbet Lodenstein (Netherlands) and Marlies Visser (Netherlands), 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 Margareth 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 Kapusniak, 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 Nyakundi**

## Glossary

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**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, *Defining Sexual Health: report from a technical consultation on sexual health, 28-31 January 2002*, p. 5).

**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<sup>1</sup>). 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'. 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' (WHO 2006, updated 2010).

**SOGIE** refers to sexual orientation and gender identity and expression.

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<sup>1</sup> 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.

**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.

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**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' (ACHPR 2017, Guidelines on Combatting Sexual Violence and Its Consequences in Africa, 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<sup>2</sup>).

**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)

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<sup>2</sup> <https://emergency.unhcr.org/entry/60283/sexual-and-gender-based-violence-sgbv-prevention-and-response>

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**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 ACHPR and ACERWC on Ending Child Marriage, 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 ACHPR and ACERWC on Ending Child Marriage, 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 ACHPR and ACERWC on Ending Child Marriage, 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)

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**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 Comment No.2 refers 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)

**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; p. iv)

**Surgical abortion** refers to ‘surgical methods of abortion’. These are defined as ‘the use of transcervical procedures for terminating pregnancy, including vacuum aspiration and dilatation and evacuation (D&E)’. (WHO 2012, *Safe Abortion: Technical and Policy Guidance for health systems*, 2012; p. iv)

**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*, p. 18)

**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.<sup>3</sup>

**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.<sup>4</sup>

**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.<sup>5</sup> HIV testing can also be mandatory for pregnant women, and there are also trends of mandatory pre-marital testing (of both women and men).<sup>6</sup>

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

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3 WHO. 'Terminology', in HIV Testing and Counselling toolkit. <http://www.who.int/hiv/topics/vct/toolkit/introduction/en/index1.html>

4 WHO. 'Terminology', in HIV Testing and Counselling toolkit. <http://www.who.int/hiv/topics/vct/toolkit/introduction/en/index1.html>

5 De Cock et al. (2002). Shadow on the continent; public health and HIV/AIDS in Africa in the 21<sup>st</sup> century. *The Lancet*, vol. 360 (July 6, 2002), *AIDS in Africa*. <http://www.unhcr.org/protection/health/4073cec54/shadow-continent-public-health-hiv-aids-africa-21st-century-lancet.html>

6 Open Society Institute (2010). *Mandatory Premarital HIV Testing*. <https://www.opensocietyfoundations.org/sites/default/files/mandatory-premarital-hiv-testing-20100513.pdf>

## List of acronyms

50 MAWS	50 Million African Women Speak
ACDHRS	African Centre for Democracy and Human Rights Studies
ACERWC	African Committee of Experts on the Rights and Welfare of the Child
ACHPR	African Commission on Human and People's Rights
ACJHR	African Court of Justice and Human Rights
ACPF	Africa Child Policy Forum
ACRWC	African Charter on Rights and Welfare of the Child
AEC	African Economic Community
AEPB	Abuja Environmental Protection Board
AfDB	African Development Bank
AIC	African Independent Church
AIDS	Acquired Immune Deficiency Syndrome
AJS	Association des Juristes Sénégalaises (Association of Senegalese Jurists)
AMNET	Advocacy Movement Network (Sierra Leone)
APHRC	African Population and Health Research Center
APRM	African Peer Review Mechanism
ARCAD-Sida	Association for Research, Communication and Home Support for People Living with HIV/AIDS (Mali)
ART	Antiretroviral Therapy
ARV	Antiretroviral
ASC	Agent de Santé Communautaire (Community Health Agent)
ATBEF	Association Togolaise pour le Bien-Être Familial (Togo)
AU	African Union
AUC	African Union Commission
AU.COMMIT	AU Commission Initiative against Trafficking Campaign
AUWC	African Union Women's Committee
AWA	Aids Watch Africa
AWARE-HIV & AIDS	Action for West Africa Region-HIV & AIDS
AWD	African Women's Decade
AWEPA	Association of European Parliamentarians with Africa
AYC	African Youth Charter
BIAWE	Business Incubator for African Women Entrepreneurs
CAMNAFAW	Cameroon National Association for Family Welfare
CAPA	Council of Anglican Provinces of Africa
CAR	Central African Republic
CARMMA	Campaign on Accelerated Reduction of Maternal Mortality in Africa
CDF	Consultative Dialogue Framework (EAC)
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CEHURD	Centre for Health Human Rights and Development (Uganda)
CEN-SAD	Community of Sahel-Saharan States
COMESA	Common Market for Eastern and Southern Africa
COWLHA	Coalition of Women Living with HIV/AIDS (Malawi)
CPA	Cotonou Partnership Agreement
CPF	Continental Policy Framework on Sexual and Reproductive Health and Rights
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organisation
CSW	Commission on the Status of Women
DEVAW	Declaration on the Elimination of Violence against Women
DFID	UK Department for International Development

## List of acronyms

DHS	Demographic Health Survey
DRC	Democratic Republic of Congo
EAC	East African Community
EACJ	East African Court of Justice
EAC OHI	EAC Open Health Initiative
EACSOFF	East African Civil Society Organisations Forum
EAHRC	East African Health Research Commission
EALA	East African Legislative Assembly
EALS	East African Law Society
EANNASO	Eastern Africa National Networks of AIDS Service Organisations
EASSI	Eastern African Sub-Regional Support Initiative for the Advancement of Women
ECCAS	Economic Community of Central African States
ECOFEPA	Association of ECOWAS Female Parliamentarians
ECOWAS	Economic Community of West African States
EGDC	ECOWAS Gender Development Centre
EID	Early Infant Diagnosis
eMTCT	Elimination of Mother-to-Child Transmission
ESA	Eastern and Southern Africa
EU	European Union
EWLA	Ethiopian Women Lawyers Association
FAS	Femmes Africa Solidarité
FEMCOM	COMESA Federation of Women in Business
FEMNET	African Women's Development and Communications Network
FGM	Female Genital Mutilation
FIDH	Fédération Internationale des Ligues des Droites de l'Homme (International Federation for Human Rights)
FLAS	Family Life Association of Swaziland
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GED Barometer	Gender Equality and Development Barometer
GEM	African Gender and Media Initiative
GIMAC	Gender is My Agenda Campaign
GIPA	Greater Involvement of PLWHIV
GMT	ECOWAS Secretariat Gender Management Team
GPDD	AU Gender Policy and Development Division
GVAW	Gender-based Violence Against Women
HIV	Human Immunodeficiency Virus
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICGLR	International Conference of the Great Lakes Region
ICPD	International Conference on Population and Development
ICT	Information and Communication Technology
ICW	International Community of Women Living with HIV
ICWEA	International Community of Women living with HIV Eastern Africa
IGAD	Intergovernmental Authority on Development
IGADD	Intergovernmental Authority on Drought and Development
IHRDA	Institute for Human Rights and Development in Africa
INGO	International Non-Governmental Organisation
IPPF AR	International Planned Parenthood Federation Africa Region
IPV	Intimate Partner Violence
JAES	Joint Africa EU Strategy

JASS	Just Associates
KELIN	Kenya Legal and Ethical Issues Network on HIV & AIDS
LAC	Legal Assistance Centre (Namibia)
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
MANERELA+	Malawi Network of Religious Leaders Living with HIV/AIDS
MARWOPNET	Mano River Women's Peace Network (Sierra Leone)
MDG	Millennium Development Goal
MENA	Middle East and North Africa
MERF	SADC Monitoring, Evaluation and Reporting Framework
MESDINE	Meeting SRH Diversity Needs (Cameroon)
MEWC	Make Every Woman Count
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MoU	Memorandum of Understanding
MPoA	Maputo Plan of Action
MSM	Men Who Have Sex With Men
MTCT	Mother-to-Child Transmission
NAP	National Action Plan
NAPTIP	National Agency for Prohibition of Traffic in Persons and Other Related Matters (Nigeria)
NEPAD	New Partnership for Africa's Development
NGO	Non-Governmental Organisation
NHIS	National Health Insurance Scheme (Ghana)
NOPSWECO	Network on Peace and Security for Women in the ECOWAS Region
OAFLA	Organisation of African First Ladies against HIV/AIDS
OAIS	Organisation of African Independent Churches
OHCHR	Office of the UN High Commissioner for Human Rights
OSIWA	Open Society Initiative for West Africa
PAC	Post-Abortion Care
PEP	Post-Exposure Prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PICT	Provider-Initiated Testing and Counselling
PLWHIV	People Living with HIV and AIDS
PMNCH	Partnership for Maternal, Newborn and Child Health
PMTCT	Prevention of Mother-to-Child Transmission
PoA	Programme of Action (ICPD)
PRC	Post-Rape Care
PrEP	Pre-Exposure Prophylaxis
PTA	Preferential Trade Area
RCSF	Regional Civil Society Forum
REC	Regional Economic Community
RMNCAH	Reproductive, Maternal, Neonatal, Child and Adolescent Health
RMNCH	Reproductive, Maternal, New-Born and Child Health
ROAJELF	Réseau Ouest Africain des Jeunes Femmes Leaders (West African Network of Young Women Leaders Network)
RTF	Regional Training Facility
SAC	Safe Abortion Care
SADC	Southern African Development Community
SADC-CNGO	SADC Congress of NGOs
SADC-PF	SADC Parliamentary Forum
SAGI	SADC Gender Conditions Indicator
SDG	Sustainable Development Goal

## List of acronyms

SG's Forum	Secretary General's Forum (EAC)
SGDI	Southern Africa Gender and Development Index
SMEs	Small and Medium-Sized Enterprises
SOAWR	Solidarity for African Women's Rights
SOGIE	Sexual Orientation or Gender Identity or Expression
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SRRWA	Special Rapporteur on the Rights of Women in Africa
STC	Specialised Technical Committee
STI	Sexually Transmitted Infection
TECMN	Tanzania Ending Child Marriage Network
TIP	Trafficking in Persons
UCU	Uganda Christian University
UDHR	Universal Declaration on Human Rights
UMA	Union du Maghreb arabe (Arab Maghreb Union)
UK	United Kingdom
UN	United Nations
UN CRC	United Nations Convention on the Rights of the Child
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNECA	United Nations Economic Commission for Africa
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UN-Habitat	United Nations Human Settlements Programme
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UNSCR	United Nations Security Council Resolution
USAID	United States Agency for International Development
VAW	Violence Against Women
VCAT	Value Clarification and Attitude Transformation
VCT	Voluntary Counselling and Testing
VMMC	Voluntary Medical Male Circumcision
WACOL	Women's Aid Collective (Nigeria)
WAHO	West African Health Organisation
WCA	West and Central Africa
WEEF	Women's Economic Empowerment Forum
WGDD	Women, Gender and Development Directorate (AU)
WHO	World Health Organization
WILDAF	Women in Law and Development in Africa
WLHIV	Women and Girls Living with HIV and AIDS
WLSA	Women and Law in Southern Africa
YWCA	Young Women's Christian Association

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## Chapter 1

# Introduction

### 1.1 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 to be 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 in 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 (IPPF AR).<sup>1</sup> 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 and 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). Figure 1.1 presents the core rights areas as well as the cross-cutting issues.

Figure 1.1. The four core rights area of this report, with the cross-cutting issues

### CORE RIGHTS AREAS



### CROSS-CUTTING ISSUES



<sup>1</sup> The project is funded under the EU.

## 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.

### 1.3.1 Audience

The State of African 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 1.1. 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**

### 1.3.2 Objectives and added value

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

<sup>2</sup> 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.'

## 1.4 SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

The four core rights areas in this report (GVAW, harmful practices, reproductive rights and SRH, and HIV and AIDS) 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. 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'.<sup>i</sup>

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'.<sup>ii</sup> The right to the highest attainable standard of physical and mental health is articulated in the International Covenant on Economic, Social and Cultural Rights<sup>2</sup> (ICESCR) (Art. 12.1).<sup>iii</sup> 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.'<sup>iv</sup>

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'.<sup>v</sup> 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'<sup>vi</sup> and guarantee that everyone can enjoy sexual and reproductive freedom, free from any coercion, discrimination or violence and within a context respectful of dignity.<sup>vii</sup> 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.<sup>viii</sup> 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.<sup>ix</sup> This report is based on this understanding of SRHR and the definitions, as presented in Box 1.2.

**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).<sup>x</sup>

**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).<sup>3</sup>

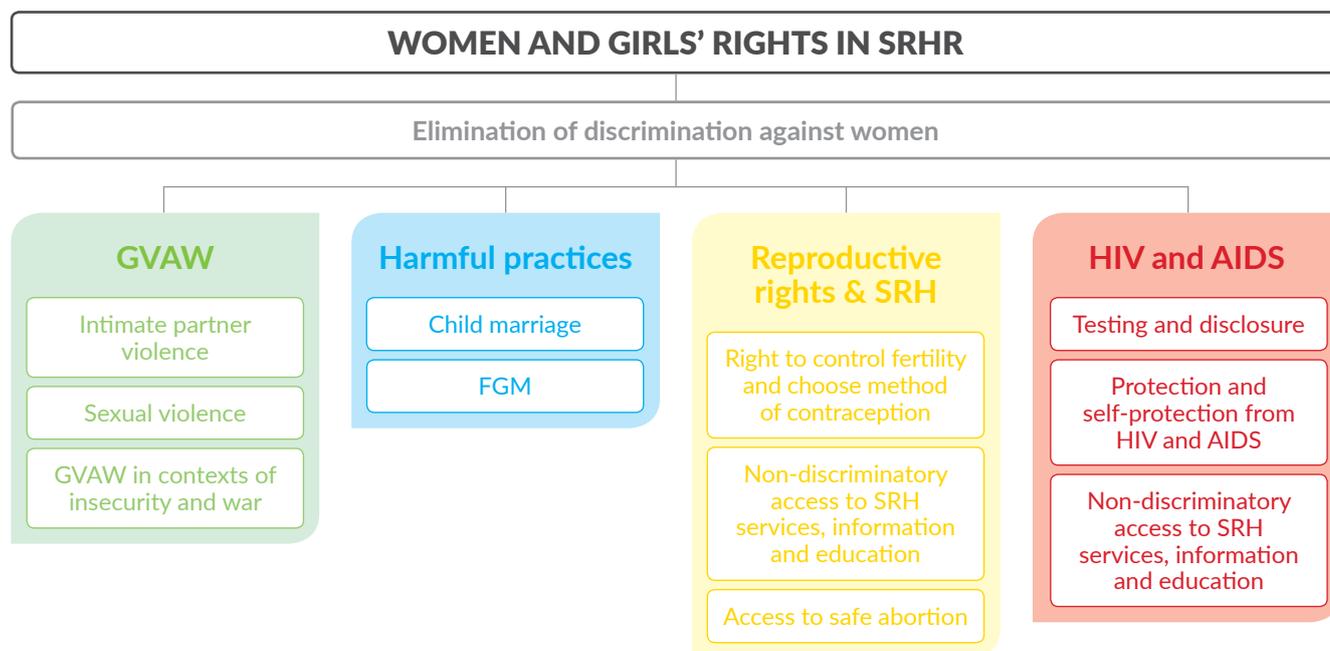
**Sexual rights**, in a similar vein, 'embrace certain human rights that are already recognized in international and regional human rights documents and other consensus documents and in national laws' (WHO, 2006, updated 2010, and WHO 2015).<sup>xi</sup> This means that 'the application of existing human 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'.<sup>xii</sup> 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'.<sup>xiii</sup>

<sup>3</sup> 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](http://www.unfpa.org/sites/default/files/event-pdf/key_actions_en.pdf)

SRHR represents the comprehensive and holistic umbrella under which this reports 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.<sup>4</sup> 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. This is illustrated in Figure 1.2 below.

Figure 1.2. Women and girls' SRHR and the four rights areas in this State of African Women report



<sup>4</sup> 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/](http://www.achpr.org/sessions/55th/resolutions/275/)

## 1.5 REPORT OUTLINE

This State of African Women report is set up in eight chapters. The introductory chapter is immediately followed by a chapter presenting the key findings and recommendations. The subsequent six chapters provide an in-depth analysis of the different dimensions of the report. Chapter 3 gives an overview of women and girls' rights in SRHR in the AU normative and institutional framework; it presents and contextualises the Maputo Protocol and the MPoA. Chapter 4 puts the spotlight on the normative and institutional commitments and frameworks of the RECs with respect to women and girls' rights in SRHR.

Each of the four following chapters focuses on one of the rights areas in particular: Chapter 5 addresses GVAW, Chapter 6 harmful practices, Chapter 7 reproductive rights and SRH, and Chapter 8 HIV and AIDS. These latter four chapters all follow the same structure: they start with a section analysing the key issues, then continue with a second section giving a detailed explanation of the provisions and obligations of the Maputo Protocol and other relevant continental commitments and instruments, as appropriate. The third section then looks at the national legal and policy frameworks of all countries on the continent to assess the extent to which the continental commitments are domesticated and implemented. The fourth section of each rights area chapter presents a set of case studies, on diverse actors, using often diverse strategies, to realise women and girls' rights in the particular rights area (see Table 1.1 for an overview of the report structure). The four rights area chapters present a total of XX\* case studies.

It is likely that few people will read this State of African Women report from the first to the last page. Its comprehensive scope and analysis have led the result to be quite a voluminous report. This comprehensive scope and analysis is of added value, because the report brings together these four different rights areas in a comprehensive frame, and because it links the different levels where change is happening and is needed (continental, regional, national and subnational). In order to help readers gain an overview of the report, in terms of both what it covers and what the main insights are, Chapter 2 presents the key findings and recommendations. This placement at the beginning of the report will help readers see where to refer for information on their specific areas of interest. The chapter provides an overview of the more detailed subsequent six chapters, and brings together the key findings and recommendations.

To further facilitate readers' use of the report, it has been built up in a modular way. This allows readers to follow their own pathway through the report, depending on their core interests. Some readers will want to focus on a specific region, and can look, for instance, at findings on the Western region in Chapter 4 on the RECs, as well as the relevant regional national legal and policy framework analysis in each of the rights area chapters (5–8). Other readers may be more interested in the background to the Maputo Protocol; they can find more general information in Chapter 3 and the provisions specific to each rights area in the second section of each rights area chapter (5–8). Readers with a primary interest in the level of domestication can look at the third section of Chapters 5–8, to gain a comprehensive overview of implementation of the Maputo Protocol and the MPoA across the four rights areas. Others may focus on the case studies in Chapters 5–8, and in this way gain more insight into the diverse strategies utilised by different actors on all four rights areas to promote and realise women and girls' rights in SRHR.

**Table 1.1. Overview of the structure of the State of African Women report**

Chapter 1 <b>Introduction</b>	<ul style="list-style-type: none"> <li>• Background and positioning</li> <li>• Aims, objectives and audience</li> <li>• Sexual and reproductive health and rights</li> <li>• Report outline and 'how to read/use this report'</li> <li>• Methodology</li> </ul>
Chapter 2 <b>Key findings and recommendations</b>	<ul style="list-style-type: none"> <li>• Insight and recommendations regarding women's and girls' rights in SRHR in the AU framework as well as the RECs</li> <li>• Prevalence, continental commitments, national level domestication and case studies per rights area</li> <li>• Strategies on legal and social norm change</li> <li>• Recommendations (thematic and overall)</li> </ul>
Chapter 3 <b>Women's and girls' rights and SRHR in the African Union framework</b>	<ul style="list-style-type: none"> <li>• Overview of AU normative framework and commitments regarding women's and girls' rights in SRHR (incl. the Maputo Plan of Action)</li> <li>• Qualities and strengths of Maputo Protocol</li> <li>• Africa Women's Decade and existing campaigns on women's and girls' rights in SRHR</li> <li>• Institutional framework for gender equality and women's rights at the AU</li> </ul>
Chapter 4 <b>The Regional Economic Communities and women's and girls' rights</b>	<ul style="list-style-type: none"> <li>• ECOWAS, EAC, IGAD, SADC, COMESA, ECCAS, UMA, CEN-SAD</li> </ul>
Chapter 5 <b>Gender-based violence against women</b>	<ul style="list-style-type: none"> <li>• Section 1: Issue analysis</li> <li>• Section 2: Continental commitments</li> <li>• Section 3: National legal and policy frameworks</li> <li>• Section 4: Case studies</li> </ul>
Chapter 6 <b>Harmful practices</b>	
Chapter 7 <b>Reproductive rights and SRH</b>	
Chapter 8 <b>HIV and AIDS</b>	

## 1.6 METHODOLOGY

### 1.6.1 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 2018 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.

## 1.6.2 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.

## 1.6.3 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 first step in this was to collect legal and policy data from each country and to document these in a *national framework table* consisting of four columns, covering (1) constitutional provisions, (2) legal provisions, (3) policy provisions and (4) institutional reforms. These tables entail relevant plausible expressed or implied provisions that promote or hinder the realisation of the specific rights area. 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 Box 1.3 below for an overview of selected data sources on national legal and policy frameworks). These extensive national-level data tables on legal, policy and institutional frameworks are available as digital annexes to the report.<sup>5</sup>

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.<sup>6</sup> 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.

### Box 1.3. 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.gnplus.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.ahrj.up.ac.za/eba-p-m#pgfld-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>

<sup>5</sup> These digital annexes are available on the campaign website: [www.rightbyher.org](http://www.rightbyher.org)

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

The report (in the third section of each of Chapters 5–8) features two elements that are based on these elaborate data tables: legal and policy indicators, which are accompanied by a narrative analysis on that rights area. The **legal and policy indicator tables** comprise selected 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 instruments (as discussed in the second section of each of these four chapters). These indicators are explained at the start of each of these sections.

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 cases, the report uses existing secondary comparative data and analysis to support and complement the primary data we collected ourselves.

The **narrative analysis** that accompanies the legal and policy indicators assesses the broader dataset and the main trends observed through legal, policy and institutional provisions. Where possible, it takes into account the implementation of legal and policy frameworks. It also highlights key contestations and gaps.

The legal and policy framework data and analysis in these third sections of Chapters 5–8 are organised and presented by **region**. Each regional sub-section presents the indicator tables and the narrative analysis, covering Western Africa, Eastern Africa, Central Africa, Southern Africa and Northern Africa. These regions are based on a combination of REC membership and the African regions defined by the AU. Their composition is presented in Table 1.2.

**Table 1.2. Regions used in the report and their composition**

Regional unit of analysis	Countries covered (and number of countries)	REC membership	Overlap with other regions <sup>7</sup>
<b>Western region</b>	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
<b>Eastern region</b>	Burundi*~, Djibouti~, Eritrea~, Ethiopia~, Kenya*~, Rwanda*, Somalia~, South Sudan*~, Sudan~, Tanzania* and Uganda*~ (11 countries)	<ul style="list-style-type: none"> <li>• EAC members (six, marked with *)</li> <li>• IGAD members (eight, marked with ~)</li> </ul>	<ul style="list-style-type: none"> <li>• Rwanda and Burundi also in Central region and ECCAS members</li> <li>• Tanzania also in Southern region and SADC member</li> <li>• Seven COMESA members<sup>8</sup></li> </ul>
<b>Central region</b>	Angola, Burundi, Cameroon, CAR, Chad, Congo Republic, DRC, Equatorial Guinea, Gabon, Rwanda and São Tomé & Príncipe (11 countries)	All ECCAS members	<ul style="list-style-type: none"> <li>• Rwanda and Burundi also in Eastern region (EAC member)</li> <li>• Angola and DRC also in Southern region and SADC member</li> </ul>
<b>Southern region</b>	Angola, Botswana, Comoros, DRC, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe (16 countries)	All SADC members	<ul style="list-style-type: none"> <li>• Angola and DRC also in Central region and ECCAS members</li> <li>• Tanzania also in Eastern region (EAC member).</li> <li>• Nine COMESA members<sup>9</sup></li> </ul>
<b>Northern region</b>	Algeria, Egypt, Libya, Mauritania, Morocco, Tunisia and Western Sahara <sup>10</sup> (seven countries)	UMA members, except for Egypt and Western Sahara)	Two COMESA members <sup>11</sup>

<sup>7</sup> See Chapter 4 on overlap membership with CEN-SAD.

<sup>8</sup> 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).

### 1.6.4 Methodology for case studies

The aim 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. The case studies 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 are of much value to the report, as they 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. By documenting these efforts and reflecting on these strategies, the case studies provide a sense of the possible.

After an initial broader scoping of potential case studies, the selection of the case studies was based on a set of criteria that included the need to present a combination of different initiatives/drivers of non-actors and state actors at national, regional or continental levels. The set of case studies was expected to capture and reflect the (potential) diversity and complementarity of groups and actors engaged in advancing women and girls' rights, and which strategies, initiatives and alliances work and what challenges and contestations may be encountered along the way. An important criterion was that the case study had to convey strategic insights and lessons of value to future action, or can inspire action in other countries or regions.

Non-state actors include a wide range of CSOs, SRHR and women's rights NGOs and activists, youth champions and leaders, faith-based organisations, and religious or traditional leaders. These actors use different channels for advocacy such as legal action and political, social, religious and traditional channels. They can seek to hold states to account on their commitments, calling for domestication and implementation of existing instruments they have signed up to; advocate at national level for the adoption and/or implementation of new policies and new legislation; or mobilise to advocate for public attitude/behaviour change and awareness-raising. State actors include policy-makers, politicians, parliamentarians and professional bodies in their efforts to domesticate and implement commitments at different stages. This can concern the signing and ratifying of existing instruments, legal reform and policy change (law, policies, actions plans and strategies) or constitutional change.

Selection of the case studies was guided by a need to ensure coverage of different levels (continental, regional, national and subnational). We also sought a geographical balance, and attempted to identify case studies from the different regions of the continent. However, although the final set of case studies chosen for this report represent many countries and regions, the geographical balance is unfortunately not optimal: there are few case studies from the Central and Northern regions and some countries feature in multiple case studies. Some promising and interesting case studies eventually did not make it to the report because of a lack of sufficient data; because time and resources to document them were too limited; or because the key actors involved could not be reached or contacted. The final set of case studies does cover countries that have and have not ratified the Maputo Protocol (in the latter case, on Madagascar and Niger in particular).

Once the potential case studies had been selected for the shortlist, key informant interviews were held to obtain more insights. These took place mostly via phone or Skype, and via e-mail, and where possible happened face-to-face, for instance during the visits to the RECs or in the context of the Regional Research Workshop. Publications and reporting on the case studies also proved valuable information. Once the write-up had been carried out, the initiators/drivers were contacted for validation and cross-checking before publication.

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<sup>9</sup> 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).

<sup>10</sup> 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.

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

## Chapter 1

# 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](http://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/](http://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., Ezeh, 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](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., Ezeh, 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., Ezeh, 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.

## Chapter 2

# Key findings and conclusions

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.

### 2.1 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.<sup>1</sup>

- 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.

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.

<sup>1</sup> 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.

## 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.<sup>2</sup>

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 the continental campaigns, and especially their implementation at national level, for example with guidelines, support and resources

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<sup>2</sup> 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'.

## 2.2 KEY FINDINGS AND CONCLUSIONS ON 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 28 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 23 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 2.1. Overview of women and girls' rights and gender equality commitments and infrastructure in RECs

	ECOWAS	EAC	IGAD	SADC	COMESA
<b>Reference to women and girls' rights or gender equality in REC treaty</b>	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"> <li>No reference in Agreement Establishing IGAD</li> <li>Currently drafted IGAD Treaty refers to role of women in development</li> </ul>	Mainstreaming gender; prohibits discrimination, including on sex or gender	Full participation of women; eliminate discrimination against women
<b>Normative framework of REC on gender equality/women and girls' rights</b>	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"> <li>Non-discrimination</li> <li>Harmonisation of gender equality commitments across the sub-region</li> <li>Women's rights, including GVAW, health, peace and security, marginalised groups</li> </ul>	IGAD Gender Policy Framework (2012–20): <ul style="list-style-type: none"> <li>Including Gender &amp; Health: SRHR, HIV and AIDS, GVAW, harmful practices</li> <li>including gender, peace and security</li> </ul>	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"> <li>Human rights as one of the 7 guiding principles</li> <li>17 priority areas, including SRHR, HIV and AIDS, adolescent SRH, child marriage, human trafficking</li> </ul>
<b>Monitoring mechanisms</b>	-	-	-	<ul style="list-style-type: none"> <li>MERF (2017)</li> <li>SADC Gender and Development Monitor</li> </ul>	<ul style="list-style-type: none"> <li>Annual progress reports</li> <li>Gender Policy implementation plan and monitoring tracking matrix forthcoming</li> </ul>
<b>Other commitments on women and girls' rights areas central in Right By Her report</b>	<ul style="list-style-type: none"> <li>Dakar Declaration on the Implementation of UNSCR 1325</li> <li>ECOWAS Gender Policy</li> <li>ECOWAS Regional Action Plan for combatting obstetric fistula in West Africa</li> <li>Vision 2020</li> </ul>	HIV and AIDS Prevention and Management Act	Regional Action Plan for Implementation of UNSCRs 1325 and 1820		<ul style="list-style-type: none"> <li>Social Charter</li> <li>Framework for the Multi-Sectoral Programme on HIV &amp; AIDS (2012–15); HIV AIDS Policy and tracking plan</li> </ul>
<b>Gender infrastructure in REC</b>	<ul style="list-style-type: none"> <li>ECOWAS Gender Development Centre</li> <li>Gender Commission</li> <li>ECOWAS Secretariat Gender Management Team</li> </ul>	Gender Department	Gender Affairs Programme	Gender Unit	<ul style="list-style-type: none"> <li>COMESA Technical Committee on Gender</li> <li>Directorate on Gender and Social Affairs</li> </ul>
<b>Regional advocacy networks at REC level</b>	<ul style="list-style-type: none"> <li>NOPSWECO</li> <li>ROAJELF</li> <li>ECOFEPA</li> <li>MARWOPNET</li> </ul>	<ul style="list-style-type: none"> <li>EASSI</li> <li>EALS</li> <li>EACSOFF</li> <li>EAHP</li> <li>EANNASO</li> </ul>	Underdeveloped networks with CSOs	SADC Gender Protocol Alliance	Limited involvement of CSOs <ul style="list-style-type: none"> <li>FEMCOM</li> </ul>
<b>Other aspects</b>	<ul style="list-style-type: none"> <li>ECOWAS Court of Justice</li> <li>50 Million African Women Speak campaign</li> </ul>	<ul style="list-style-type: none"> <li>EAC Consultative Dialogue Framework (on participation of civil society)</li> <li>EAC Court of Justice</li> <li>50 Million African Women Speak campaign</li> <li>EAC Gender Equality and Development Barometer</li> </ul>	IGAD Women and Peace Forum (government and civil society members)	<ul style="list-style-type: none"> <li>SADC Gender Protocol Barometer</li> <li>SADC Court suspended</li> </ul>	50 Million African Women Speak campaign

## 2.3 GENDER-BASED VIOLENCE AGAINST WOMEN: KEY FINDINGS AND RECOMMENDATIONS

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.<sup>3</sup>

### 2.3.1 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. 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%.
- **Non-partner** violence is estimated at 11.9% among African women. 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%).
- 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 (80%); it occurs to a much lesser extent across borders (15%).
- 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.
- 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.
- 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.

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<sup>3</sup> 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/>

### 2.3.2 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**.<sup>4</sup>
- 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.

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.

<sup>4</sup> 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).

### 2.3.3 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.<sup>5</sup> 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.<sup>6</sup> The most prominent weakness in the Central region is the lack of criminalisation of marital rape,<sup>7</sup> 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,<sup>8</sup> 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). 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.
- 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.<sup>9</sup> 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.

<sup>5</sup> In particular in Côte d'Ivoire, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Nigeria, Senegal and Togo.

<sup>6</sup> In particular in Djibouti, Eritrea, Somalia, South Sudan and Sudan. Tanzania only has a legal provision on sexual harassment and on human trafficking.

<sup>7</sup> In particular in Angola, Burundi, Cameroon, CAR, Chad, Gabon and Equatorial Guinea.

<sup>8</sup> In particular in Angola, Botswana, DRC, Madagascar, Malawi, Mauritius, Mozambique, Seychelles, Swaziland, Tanzania and Zambia.

<sup>9</sup> Countries that explicitly exclude marital rape from the definition of rape are Ethiopia, Nigeria and South Sudan.

Map 1 Gender Based Violence against Women (3 indicators)



Legend

- Legislation on domestic violence, sexual harassment and criminalisation on marital rape.
- Only legislation on domestic violence and sexual harassment. Marital rape not criminalised.
- Only legislation on domestic violence. No legislation on sexual harassment and marital rape not criminalised, or missing data.
- Only legislation on sexual harassment. No legislation on domestic violence and marital rape not criminalised.
- No legislation on domestic violence nor on sexual harassment. Marital rape is not criminalised.
- Marital rape is criminalised and legislation on sexual harassment. No legislation on domestic violence.
- Data not available.

- 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.<sup>10</sup>
- 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 traumatisation 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.

<sup>10</sup> 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.

## 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

## 2.4 HARMFUL PRACTICES: KEY FINDINGS AND RECOMMENDATIONS

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.

### 2.4.1 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.
- **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).
- 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. If the current trend continues, **by 2050 Africa will become the region with the largest number of child marriages in the world.**
- Countries with high levels of child marriage also have high rates of maternal deaths and high adolescent birth rates.

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.
- 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.
- 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. 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).
- 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.
- 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.

## 2.4.2 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.

Map 2 Harmful practices and FGM



**Legend**

- Constitutional provision on harmful practices, legal provisions on FGM and programmatic response or action plan to end FGM in place.
- Legal provisions prohibiting FGM and programmatic response or action plan to end FGM in place. No constitutional provision eliminating harmful practices.
- Constitutional provision on harmful practices and legal provisions prohibiting either harmful practices or FGM. No programmatic response or action plan to end FGM in place, or missing data.
- Legal provisions prohibiting either harmful practices or FGM. No constitutional provision eliminating harmful practices and no programmatic response or action plan to end FGM in place, or missing data.
- Only a programmatic response or action plan to end FGM in place.
- No constitutional provision eliminating harmful practices, no legal provisions prohibiting harmful practices or FGM and no programmatic response or action plan to end FGM in place (or missing data).
- No data available.

### 2.4.3 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)
4. Action plan or strategy in place to end child marriage

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.<sup>11</sup> Seven countries have provisions in statutory law regarding harmful practices, all of them in the Southern region.<sup>12</sup> 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 presents the strength of the legal and policy frameworks with respect to **FGM**. The orange line in the map demarcates those countries where FGM is concentrated. 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.<sup>13</sup> 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.
- Fifteen countries do not have a legal provision prohibiting FGM, or otherwise harmful practices; these countries also lack a constitutional provision on the latter.<sup>14</sup>
- 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.<sup>15</sup>
- 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.<sup>16</sup>

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.

<sup>11</sup> Ghana, Ethiopia, Malawi, Somalia, South Sudan, Sudan, Swaziland and Uganda.

<sup>12</sup> Botswana, Lesotho, Malawi, Mauritius, Namibia, Swaziland and Zimbabwe.

<sup>13</sup> These 12 countries either score no on these indicators or have missing data.

<sup>14</sup> 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).

<sup>15</sup> 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.

<sup>16</sup> Liberia, Mali and Sierra Leone.

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.

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.
- 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 18<sup>17</sup> 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.

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<sup>17</sup> 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

## 2.5. REPRODUCTIVE RIGHTS AND SEXUAL AND REPRODUCTIVE HEALTH: KEY FINDINGS AND RECOMMENDATIONS

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.

### 2.5.1 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.
- 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%).
- 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.
- 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). 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.

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).
- 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.
- **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.
- **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.

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.
- Unlike many other regions in the world, in Africa the abortion rates are *higher among unmarried* women than among married women (aged 15–44).
- Three out of four abortions in Africa are **unsafe abortions**.<sup>18</sup> 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%).
- 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.
- 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.

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.

## 2.5.2 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.
- 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.<sup>19</sup>

<sup>18</sup> 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).

<sup>19</sup> 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.

- 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**.

### 2.5.3 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)<sup>20</sup>
4. Government funding for health higher than 15% of general government expenditure (also based on AU Scorecard on Domestic Financing for Health)<sup>21</sup>
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**.<sup>22</sup> 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.

<sup>20</sup> Score card published by Africa AIDS Watch: [www.aidswatchafrica.net/index.php/africa-scorecard-on-domestic-financing-for-health](http://www.aidswatchafrica.net/index.php/africa-scorecard-on-domestic-financing-for-health)

<sup>21</sup> Ibid.

<sup>22</sup> The countries that lack a constitutional provision on the right to health are Algeria, Botswana, Cameroon, Chad, Djibouti, Ghana, Guinea-Bissau, Mauritius, Namibia and Tanzania.

- 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.<sup>24</sup> The majority of countries have launched a chapter of the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA).<sup>25</sup>
- 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.<sup>26</sup> 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.<sup>27</sup>
- 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.<sup>28</sup>
- 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.

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).

- **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).

<sup>24</sup> The study could not establish an SRH or family planning policy in Comoros, Djibouti and Libya.

<sup>25</sup> 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.

<sup>26</sup> Countries spending more than 5% of GDP on health are Algeria, Angola, Congo Republic, Djibouti, The Gambia, Lesotho, Malawi, Sierra Leone and Swaziland.

<sup>27</sup> Four countries have missing data on this indicator.

<sup>28</sup> Based on: 'Fulfilling our promise to young people today: 2013-2015 review' (UNESCO, UNFPA and UNAIDS 2017), progress review on ESA Commitment.

Map 4 Government funding for health as percentage of general government expenditure<sup>23</sup>



<sup>23</sup> Score card published by Africa AIDS Watch: [www.aidswatchafrica.net/index.php/africa-scorecard-on-domestic-financing-for-health](http://www.aidswatchafrica.net/index.php/africa-scorecard-on-domestic-financing-for-health)

Map 5 Legal guarantee to access safe abortion



**Legend**

- Legal guarantee to access safe abortion when the life of the mother is threatened, when pregnancy poses threat to physical and/or mental health of the mother, in cases of foetal impairment, in cases of sexual assault, rape or incest or in other circumstances.
- Legal guarantee to access safe abortion when the life of the mother is threatened, when pregnancy poses threat to physical and/or mental health of the mother, in cases of foetal impairment and in cases of sexual assault, rape or incest.
- Legal guarantee to access safe abortion when the life of the mother is threatened, when pregnancy poses threat to physical and/or mental health of the mother or in cases of sexual assault, rape or incest.
- Legal guarantee to access safe abortion when the life of the mother is threatened or in cases of sexual assault, rape or incest.
- Legal guarantee to access safe abortion when the life of the mother is threatened, when pregnancy poses threat to the physical and/or mental health of the mother (and in some cases foetal impairment).
- Legal guarantee to access safe abortion when the life of the mother is threatened.
- No legal access to safe abortion.
- No data available.

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),<sup>29</sup> 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 comprehensiveness 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.<sup>30</sup> 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 25 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).

<sup>29</sup> 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).

<sup>30</sup> Based on: 'Sexual rights, young people and the law' (IPPF 2017).

## 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

## 2.6 HIV AND AIDS: KEY FINDINGS AND RECOMMENDATIONS

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.

### 2.6.1 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.
- 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.
- 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.
- Between 2000 and 2014, **new HIV infections** in Sub-Saharan Africa declined by 41%, but this trend does not manifest itself in all countries. Whereas new HIV infections are declining in numerous countries,<sup>31</sup> they are in the rise in others.<sup>32</sup> New infections tend to concentrate in specific countries.<sup>33</sup>
- 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%. Young women aged 15–24 in Sub-Saharan Africa are 2.5 times more likely to be infected with HIV than men. For the African continent, AIDS-related illnesses are the second leading cause of death for young women aged 15–24.
- **Female sex workers** are particularly vulnerable to HIV, and 13.5 times more likely to be living with HIV than other women. 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.
- Gender unequal power relations constrain women and girls' exposure to and risk of acquiring HIV and AIDS. **GVAW and harmful practices** further increase women and girls' exposure to and risk of acquiring HIV and AIDS.
- 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. 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).
- 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.

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.<sup>34</sup>

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. 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.
- 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.

<sup>31</sup> For example Burundi, Guinea-Bissau, Mozambique, Nigeria, Senegal, Uganda, Zimbabwe.

<sup>32</sup> For example Congo Republic, Ethiopia, Ghana, Liberia, Madagascar.

<sup>33</sup> Including Kenya, Malawi, Mozambique, Nigeria, South Africa, Tanzania, Uganda, Zimbabwe.

<sup>34</sup> Virally suppressed means someone's viral load is reduced to an undetectable level.

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.
- 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**.
- 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%.

## 2.6.2 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**<sup>35</sup> 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).
- 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.

<sup>35</sup> 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).

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



**Legend**

- Non-discrimination legislation based on HIV in place. Legal and/or police regulations regarding voluntary HIV testing in place.
- Non-discrimination legislation based on HIV in place. Legislation on mandatory HIV testing for specific groups or circumstances, or missing data.
- No legislation regarding non-discrimination based on HIV in place. Legal and/or policy regulations regarding voluntary HIV testing.
- No legislation regarding non-discrimination based on HIV and no legal and/or policy regulations regarding voluntary HIV testing in place, or missing data.
- No data available.

Map 7 Criminalisation of willful transmission of HIV



Legend

- Wilful transmission of HIV is criminalised.
- Wilful transmission of HIV is not criminalised.
- No data available or missing data.

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.

### 2.6.3 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 HIV<sup>36</sup>
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),<sup>37</sup> five in Northern Africa,<sup>38</sup> five in Central Africa,<sup>39</sup> three in Western Africa,<sup>40</sup> and only one in Southern Africa.<sup>41</sup>
- 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).<sup>42</sup> 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.
- 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.<sup>43</sup> Another 18 countries of these 26 do criminalise wilful HIV transmission (marked yellow on Map 7).

<sup>36</sup> 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.

<sup>37</sup> Eritrea, Ethiopia, Rwanda, Somalia, South Sudan and Sudan.

<sup>38</sup> Algeria, Egypt, Libya, Morocco and Tunisia.

<sup>39</sup> Cameroon, Gabon, and Rwanda; and missing data for Equatorial Guinea and São Tomé and Príncipe.

<sup>40</sup> Cape Verde and Guinea, and missing data for The Gambia.

<sup>41</sup> Swaziland.

<sup>42</sup> Algeria, Cape Verde, Equatorial Guinea, Gabon, Guinea, Guinea-Bissau, Mali, Mauritania, Niger and Western Sahara.

<sup>43</sup> These eight are Comoros, Côte d'Ivoire, Ghana, Namibia, Nigeria, Seychelles, South Africa and Zambia.

- 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.<sup>44</sup> 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 HIV<sup>45</sup> and eight lack such legislation.<sup>46,47</sup> 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.<sup>48</sup> 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.

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 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**<sup>49</sup>; 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; 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.<sup>50</sup> 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.<sup>51,52</sup> 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.

<sup>44</sup> These nine countries are Angola, Burundi, Chad, Guinea-Bissau, Mali, Mauritania, Niger, Togo and Uganda.

<sup>45</sup> Cameroon, Rwanda and South Sudan.

<sup>46</sup> Egypt, Ethiopia, The Gambia, São Tomé and Príncipe, Somalia, Sudan, Swaziland and Tunisia.

<sup>47</sup> For two countries, data on criminalisation of wilful transmission of HIV is missing: Libya and Morocco.

<sup>48</sup> Algeria, Cape Verde, Eritrea, Equatorial Guinea, Gabon and Guinea. For Algeria, data is missing regarding criminalisation of wilful HIV transmission.

<sup>49</sup> 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.

<sup>50</sup> These twenty-one countries are all countries not listed in the previous footnote, minus South Africa which has legalised same-sex partnership and marriage.

<sup>51</sup> Which is recognised in Mauritius' Equal Opportunities Act of 2008 and the Code of Ethics for Public Officers.

<sup>52</sup> 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.

## 2.7 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.

## 2.8 CONCLUDING REMARKS AND OVERALL RECOMMENDATIONS

Progress can be observed across the continent of women and girls' rights in SRHR. Progress in legal, policy and institutional reform at continental, regional and national levels, as well as shifts and changes in social norms around women and girls' rights in SRHR. For women and girls' rights in SRHR to be realised, promoted and expanded, states not only need to sign and ratify the Maputo Protocol and live up to the Maputo Plan of Action and the Abuja Declaration commitments. To realise women and girls' rights in the four rights areas central in this report, states also need to take additional steps to **bring their national legal and constitutional frameworks in line with the normative provisions** on GVAW, harmful practices, reproductive rights and SRH, and HIV and AIDS. Moreover, these legal reforms need to be further translated into policy frameworks and action plans, as well as institutional reforms for implementation. All four rights areas require that sufficient and adequate financial and human resources are allocated and secured.

In addition to the recommendations already presented in this chapter, there are several overall recommendations with which this chapter will end.

### Recommendations

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.

## Chapter 3

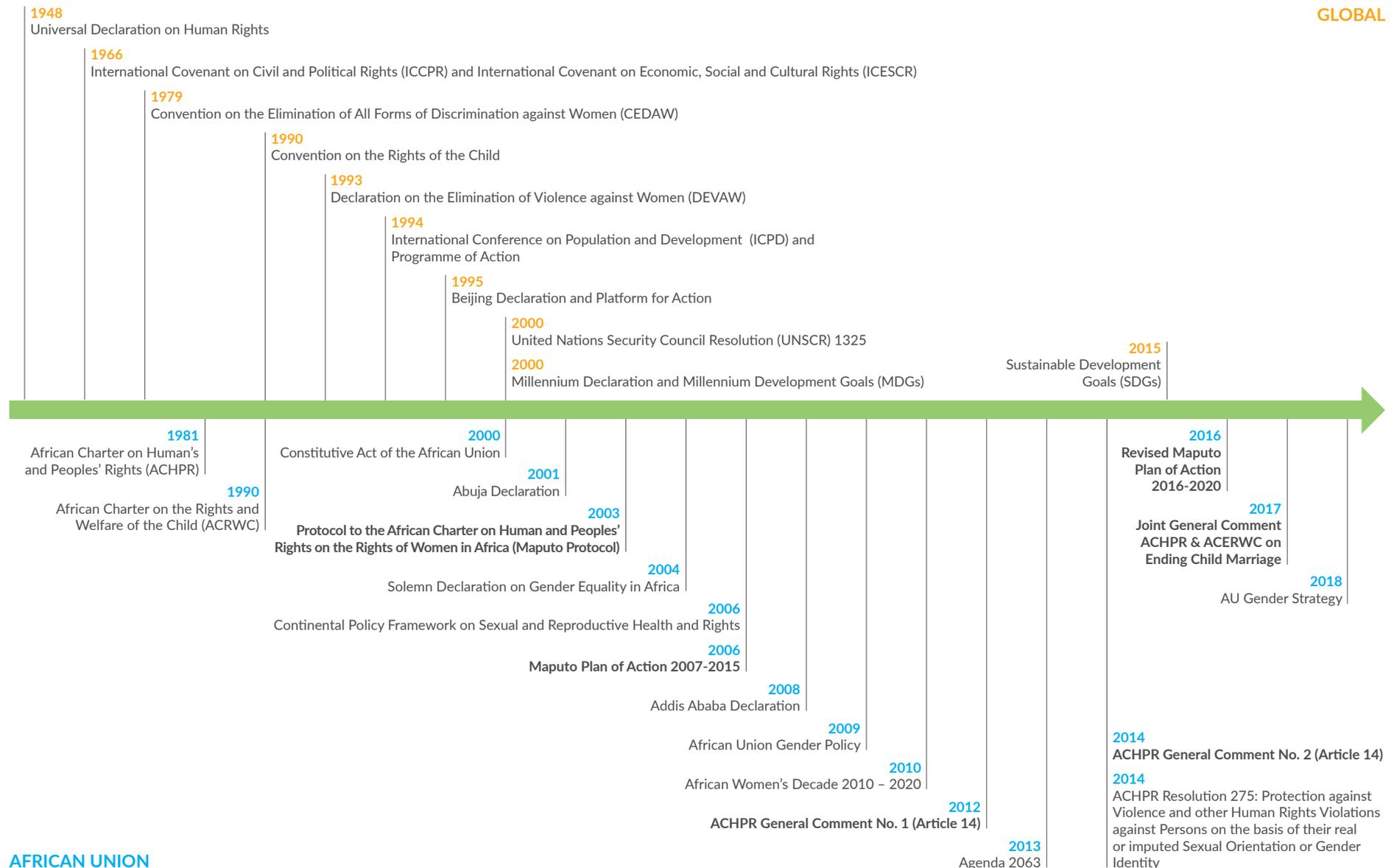
# Women and girls' rights and SRHR in the African Union framework

What normative and institutional frameworks exist at the African continental level for the promotion and realisation of women and girls' rights and SRHR? This chapter offers an overview of these, in four main sections. Section 3.1 provides an overview of the normative frameworks. It starts with the Maputo Protocol and takes a brief look at the Solemn Declaration on Gender Equality in Africa. It then introduces the Continental Policy Framework on SRHR and the Maputo Plan of Action. This is complemented by a brief introduction of the African Charter on the Rights and Welfare of the Child and the African Youth Charter. This is followed by a review of the AU Gender Strategy, which is to be adopted in 2018. Figure 3.1 offers a graphic overview of the key continental as well as global commitments on women and girls' rights and SRHR.

Section 3.2 takes a closer look at the significance of the Maputo Protocol. It discusses the comprehensiveness of the Protocol and introduces the three General Comments that have been elaborated in relation to it. This section also looks at the status of signing and ratification, at reservations made by member states and at state periodic reporting.

Section 3.3 of the chapter then turns the spotlight on Africa Women's Decade and highlights key campaigns that have been initiated to promote and realise gender equality and women and girls' rights. Section 3.4 provides an overview of the institutional framework at the AU. It introduces the gender equality and women's rights actors and bodies and also reflects on the mandate of the ACHPR to protect and promote women and girls' rights.

Figure 3.1. Timeline of key frameworks for women and girls' rights and SRHR at the global and AU level



## Key insights on women and girls' rights and SRHR in the AU Framework

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. **Africa Women's Decade** is also important to furthering gender equality and women and girls' rights, and so are the continental Campaigns on Ending Child Marriage (CECM), Maternal Mortality (CARMMA) and Gender Is My Agenda (GIMAC) and the recently launched Free to Shine.

The **Maputo Protocol** is a ground-breaking protocol on women and girls' rights, which was adopted in 2003 and came into force in 2005. It includes 32 articles and an explicit definition of discrimination against women, and pays specific attention to vulnerable and marginalised women and girls.

**Civil society and women's rights and feminist organisations** have played a key role in the formulation and adoption of the Maputo Protocol. Since its adoption, they have proven critical players in further ratification, domestication, implementation and popularisation of the Protocol.

The Continental Policy Framework on SRHR, and its translation into the **Maputo Plan of Action (MPoA)**, offer guidance to African states on the implementation of the ICPD Programme of Action (UN 1994), as well as the Abuja Declaration (AU 2001).

The Maputo Protocol is progressive in many areas, including rights areas of central concern to women and girls in terms of SRHR. The Maputo Protocol has strong provisions regarding GVAW, harmful practices, FGM, child marriage, reproductive rights and SRH, access to safe abortion, and HIV and AIDS.

The African Commission on Human and Peoples' Rights (ACHPR) has developed **General Comments** as well as **Guidelines** on specific topics, to provide interpretative guidance to member states on the Maputo Protocol provisions and the required state response on women and girls' rights.

Fifty-two countries have signed the Maputo Protocol; of these, forty countries 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.

The 12 countries that have not (yet) ratified the Maputo Protocol are Burundi, CAR, Chad, Ethiopia, Eritrea, Madagascar, Niger, Somalia, Sudan, Tunisia, Western Sahara and São Tomé and Príncipe. Three countries have not signed the Protocol: Botswana, Egypt and Morocco.

At the end of 2017, nine countries had reported on implementation of the Maputo Protocol; **state reporting** can be strengthened using the *Guidelines for State Reporting under the Maputo Protocol*.

**Implementation** of the MPoA is affected by 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.

Implementation of the Maputo Protocol has been 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.

## 3.1 OVERVIEW OF NORMATIVE FRAMEWORKS AND COMMITMENTS AND THEIR ADOPTION

### 3.1.1 The African Charter and the Maputo Protocol

On 11 July 2003, the AU member states adopted the **Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa**, widely referred to as 'the Maputo Protocol', in reference to the capital city of Mozambique where it was adopted. The Maputo Protocol came into force on 25 November 2005, after its ratification by 15 countries. It strengthens the provisions on gender equality of the **African Charter on Human and Peoples' Rights** ('the African Charter'), which lies at the foundation of the African human right system and was adopted in 1981.<sup>1</sup> The African Charter is the 'parent treaty' of the Maputo Protocol.

The African Charter introduced and enshrined the principle of non-discrimination on any grounds, including on the basis of sex (Art. 2), and calls for the elimination of discrimination against women and girls and the protection of their rights (Art. 18).

#### Box 3.1. African Charter on Human and Peoples' Rights

##### Article 2

Every individual shall be entitled to the enjoyment of the rights and freedoms recognized and guaranteed in the present Charter without distinction of any kind such as race, ethnic group, colour, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or other status

##### Article 3

- (1) Every individual shall be equal before the law.
- (2) Every individual shall be entitled to equal protection of the law.

##### Article 18

The State shall ensure the elimination of every discrimination against women and also censure the protection of the rights of the woman and the child as stipulated in international declarations and conventions.

In June 1995, the AU Assembly of Heads of State<sup>2</sup> recommended the African Commission on Human and People's Rights (ACHPR) elaborate a protocol on the rights of women in Africa. The adoption of the Maputo Protocol was a landmark decision for the AU and its member states, because of the comprehensive framework it provides on women and girls' economic, social and cultural as well as civic and political rights (this is discussed in more detail in Section 3.2).

The Maputo Protocol builds on the women and girls' rights in the African Charter, and provides an explicit definition of discrimination against women and girls, something missing in the African Charter.

The Maputo Protocol is the product of concerted collaborative efforts between the ACHPR and NGOs. In 1995, Women in Law and Development in Africa (WILDAF) and the ACHPR organised a meeting to discuss the situation of women and girls in Africa. At this, it was noted that the legal disenfranchisement of women in Africa could be alleviated through a continental commitment on the elimination of discrimination against women and girls akin to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). This initiative also found support from the then Organisation of African Unity.<sup>1</sup>

#### Box 3.2. The Maputo Protocol definition of 'discrimination against women'

'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.

At the ACHPR level, the development of this continental framework was a key determinant in the establishment of the mandate of the Special Rapporteur on the Rights of Women in Africa (SRRWA). The initial mandate-holders were preoccupied with the development, adoption and ratification of the Maputo Protocol and, to date, its continued ratification and implementation forms a key part of the SRRWA's mandate (see more on this in Section 3.4).

<sup>1</sup> The Charter was adopted on 27 June 1981 and came into force on 21 October 1986.

The role of continental NGOs, particularly women's rights organisations, in undertaking advocacy towards the development, adoption and ratification, as well as popularisation, of the Maputo Protocol has been critical. This sustained advocacy culminated in the Protocol being the fastest ratified treaty in the history of the AU. Beyond ratification, NGOs have also campaigned for the Protocol's domestication and popularisation. In this regard, two important civil society initiatives that have tracked the Protocol and that have had a continent-wide outreach are SOAWR and FEMNET. The **Solidarity for African Women's Rights (SOAWR) coalition**<sup>3</sup> was founded in 2004; FEMNET was established in 1980, and is one of the founding members of SOAWR (see Box 3.3).<sup>4</sup>

### Box 3.3. The Solidarity for African Women's Rights coalition and the African Women's Development and Communications Network

The **Solidarity for African Women's Rights (SOAWR) coalition** is a regional network comprising 50 national, regional and international CSOs based in 25 countries. SOAWR works towards the promotion and protection of women's human rights in Africa. Since its inauguration in 2004, SOAWR's main area of focus has been to compel African states to urgently sign, ratify, domesticate and implement the Maputo Protocol.

The **African Women's Development and Communications Network (FEMNET)** is a feminist, pan-African organisation for women's rights, gender equality and women's empowerment. FEMNET was established in 1980 (based in Nairobi) and comprises over 500 individual and institutional members across 43 African countries. It contributes to building the women's movement in Africa and ensuring women's voices are heard at global, regional and national levels. FEMNET is one of the founding members of SOAWR. It ran the #Follow the Protocol campaign in 2016, to track progress on the Maputo Protocol.

## 3.1.2 Solemn Declaration and the Gender is My Agenda Campaign

In July 2004, the AU member states adopted the **Solemn Declaration on Gender Equality in Africa**. In this, they reaffirmed their commitment to gender equality, gender parity and women and girls' human rights as enshrined in Art. 4(L) of the Constitutive Act of the AU as well as other international, regional and national commitments. Importantly, the Solemn Declaration expressed the commitment to sign and ratify the landmark Maputo Protocol, for it to enter into force by 2005, and to support sensitisation campaigns and to continue, to expand and to accelerate efforts to promote gender equality at all levels.

The AU Commission (AUC) is expected to submit a **yearly general report** on the progress of implementation of commitments as set out in the Solemn Declaration and on the state of gender equality. When states sign the Declaration, they are **committed to reporting** on it, under Art. 12, for which guidelines have been developed.<sup>ii 5</sup>

### Box 3.4. The Solemn Declaration on Gender Equality in Africa (2004)

The Solemn Declaration emphasises the commitments of AU states to fighting HIV and AIDS; to enabling women's full participation in peace processes; and to launching a campaign to end GBV; as well as to expanding and promoting gender parity; to ensuring the education of girls and literacy of women; and to promoting and protecting all human rights for women, especially with respect to land, property and inheritance.

### Box 3.5. Femmes Africa Solidarité

FAS is an NGO founded in Geneva by African Women Leaders in 1996. It aims to prevent and resolve conflicts in Africa and empower women to have a voice in leadership and peace-building efforts. Since 2002, FAS has annually organised the Women's AU Pre-Summit Consultative Meeting to strengthen women's voice in advancing African women's agenda.

<sup>3</sup> SOAWR members include ACDHRS, ACFODE, AEFL, AJM, Akina Mama wa Afrika, Alliances for Africa, AWDF, BAOBAB for Women's Human Rights, CAFOB, CJSI, COVAW, CPTAFE, CSV, EASSI, Equality Now – Africa Regional Office, Fahamu – Networks for Social Justice, FAMEDEV, FEMNET, FIDA Kenya, Forum Mulher, Girl Child Network, HURILAWS, IAC, IPAS Africa Alliance for Women's Reproductive Health and Rights, Legal and Human Rights Centre – Tanzania, MEWC, NAFGEM Tanzania, NGO Gender Coordination Network – Malawi, Oxfam GB, POWA, RHRA, SIHA, Sister Namibia, STEWARD, Tomorrow's Child Initiative, UNFD, University of Pretoria Centre for Human Rights, UWONET, Voix de Femmes, WANET, WILDAF, WLSA Zambia, WOLPNET, WONGOSOL and WRAPA. See [www.soawr.org](http://www.soawr.org) for more information.

<sup>4</sup> Another campaign to push for further ratification of the Maputo Protocol was Africa's Women's Rights: Ratify and Respect! This was initiated in 2009 by the International Federation for Human Rights (Fédération internationale des ligues des droites de l'homme (FIDH)), in cooperation with the African Centre for Democracy and Human Rights Studies (ACDHRS), Femmes Africa Solidarité (FAS), Women's Aid Collective (WACOL), WILDAF and Women and Law in Southern Africa (WLSA).

<sup>5</sup> An Implementation Framework for the Solemn Declaration on Gender Equality in Africa was adopted at the first AU Conference of Ministers Responsible for Women and Gender in Dakar, Senegal (2005). There was no information accessible on the level of state reporting on progress regarding implementation of the Solemn Declaration.

The Solemn Declaration is an important point of reference for civil society campaigning and advocacy. In July 2005, the **Gender is My Agenda Campaign (GIMAC)** was initiated, coordinated by Femmes Africa Solidarité (FAS) (Box 3.5). Currently, the campaign comprises around 55 international and national organisations. It aims to create a space for civil society to monitor implementation of the Solemn Declaration. The annual Pre-Summit Consultative Meeting to the AU Assembly of Heads of State and Government represents a key effort in this regard. In addition, GIMAC promotes networking of CSOs across the African continent and the compilation of reports as main strategies in promoting women and girls' rights.<sup>6</sup>

### 3.1.3 The Continental Policy Framework on Sexual and Reproductive Health and Rights

In January 2006, the AU Heads of State endorsed the **Continental Policy Framework on Sexual and Reproductive Health and Rights (CPF)**.<sup>7</sup> This was developed by the AUC, in cooperation with key development partners,<sup>8</sup> and is based on a set of sub-regional studies and meetings on SRHR challenges in the continent. The CPF offers guidance in policy formulation and in the actions of member states to further the implementation of the ICPD PoA and the Millennium Development Goals (MDGs).

Informed by its review of SRHR gaps and challenges, the CPF identifies eight core strategic areas, and calls for their mainstreaming and harmonisation in national, sub-regional and continental development initiatives.

#### Box 3.6. Strategic areas and core policy concerns in the CPF

- Maternal mortality and morbidity
- Infant and child mortality
- Contraceptive use and family planning services
- Unsafe abortion
- Sexually transmitted infections and HIV and AIDS
- Adolescent reproductive health
- Female genital mutilation
- Gender-based violence

In addition, the CPF identifies a number of challenges, including inadequate policies owing to lack of human and technical capacity, weak health infrastructure and a lack of partnerships for systematic cooperation. A key challenge concerns low budgetary allocations to health and the unrealised promises of donors at the ICPD.

The CPF aims to strengthen implementation of the recommendations of the Abuja Declaration of the 2001 Summit of Heads of State and Government in order to increase resources for the health sector.

#### Box 3.7. Abuja Declaration (2001)

After adoption of the Millennium Declaration in 2000 at the UN level, AU Heads of State met in April 2001 in Abuja, Nigeria, and pledged to allocate a minimum of 15% of their annual budget to strengthen the health sector.<sup>iii</sup> These commitments have proven hard to make good on.<sup>9 iv</sup>

The AU member states also urged donor countries to 'fulfil the yet to be met target of 0.7% of their gross national product as official development assistance to developing countries'.

<sup>6</sup> In addition, women's groups coordinated by FAS adopted 'The Civil Society's Guidelines and Mechanism for Implementation, Monitoring and Evaluation of the Solemn Declaration on Gender Equality in Africa'.

<sup>7</sup> This followed the adoption of the CPF by the Conference of Ministers of Health in Gaborone, Botswana, in October 2005.

<sup>8</sup> These include the United Nations Population Fund (UNFPA), the African Regional Office of the International Planned Parenthood Federation and other development partners.

<sup>9</sup> Progress on realisation of the Abuja targets is monitored by AIDS Watch Africa; see [www.aidswatchafrica.net/index.php/africa-scorecard-on-domestic-financing-for-health](http://www.aidswatchafrica.net/index.php/africa-scorecard-on-domestic-financing-for-health). Chapter 7 of this report includes more details on progress on realisation of the Abuja targets, drawing on the Scorecard of AIDS Watch Africa. Earlier observations noted that, after 10 years, the World Health Organization (WHO) found that only Tanzania had reached this target; 26 states had increased health expenditures and 11 states had reduced them. The remaining nine countries did not show a trend either up or down (WHO, 2011. *The Abuja Declaration: Ten Years On*).

### 3.1.4 The Maputo Plan of Action

The **Maputo Plan of Action (MPoA)** is the further operationalised and costed plan of action to implement the CPF. The first MPoA ran from 2007 to 2010; it was then extended to 2015. After a comprehensive review of this first period,<sup>v</sup> a revised MPoA was formulated for the period 2016–30. The **MPoA 2016–30** aims for African governments, civil society, the private sector and multi-sectoral development partners to join forces and redouble their efforts towards the effective implementation of the CPF.

#### Box 3.8. Maputo Plan of Action 2016–30: ultimate goal

The ultimate goal of the MPoA 2016–30 is to end preventable maternal, newborn, child and adolescent deaths by expanding contraceptive use, reducing levels of unsafe abortion, ending child marriage, eradicating harmful traditional practices including FGM, eliminating all forms of violence and discrimination against women and girls and ensuring access of adolescents and youth to SRH by 2030 in all countries in Africa (p. 11).

In order to achieve its aims, the MPoA defines strategic interventions and indicators that reflect reproductive, maternal, neonatal, child and adolescent health (RMNCAH) issues on the African continent. These are consistent with the framework set out in the Agenda 2063 Ten Year Implementation Plan and other continental and international commitments.<sup>10</sup> In order to achieve the ultimate goal, the following 10 key strategies are formulated:

1. Improving political commitment, leadership and good governance
2. Instituting health legislation and policies for improved access to RMNCAH services
3. Ensuring gender equality, women and girls' empowerment and respect of human rights
4. Improving strategic communication for SRH and reproductive rights
5. Investing in the SRH needs of adolescents, youth and other vulnerable marginalised populations
6. Optimising the functioning health system for RMNCAH
7. Investing in human resources by strengthening training, recruitment and retention
8. Improving partnerships and multi-sectoral collaborations for RMNCAH
9. Ensuring accountability and strengthening monitoring and evaluation, research and innovation
10. Increasing investments in health

Implementation of MPoA has been hampered by various factors, with many states experiencing challenges meeting the targets set out in the Plan and in the Abuja Declaration. Whereas there are as yet no reports on implementation of the revised MPoA, the progress review of the first MPoA, carried out in 2015, points to several main barriers to meeting its objectives.<sup>vi</sup> These include limited political commitment and leadership, inadequate financing for health and high donor dependency. In addition, implementation has been hampered by inadequate health legislation and weak health systems (i.e. lack of SRH services, resources and capacity, data monitoring and male involvement). Lastly, limited women and girls' empowerment and presence of harmful practices present challenges to achieving the objectives. Earlier civil society reports noted similar barriers to implementation.<sup>11 vii</sup>

<sup>10</sup> Including the SDGs, Rio+20, ICPD+20, the Global Strategy for Women's, Children's and Adolescent's Health, the Gaborone Declaration on the Roadmap towards Universal Access to Prevention, Treatment and Care, the Brazzaville Commitment on Scaling up towards Universal Access and the Abuja commitments.

<sup>11</sup> The African Population and Health Research Center (APHRC), commissioned by IPPFAR, undertook an evaluation of status of implementation of the Maputo Protocol in 2009. It found that, first, the translation of policies, relevant to the MPoA, into implementation had been hampered as a result of various factors, including financial and human resourcing problems, lack of political will in some countries, lack of organisation in government structures and inefficient use of financial resources. Second, fragmentation of government structures for SRH limits progress on achieving the MPoA objectives, given competing government priorities and lack of clear responsibilities. Furthermore, tracking of government budgets in order to identify how much is allocated to health and SRH has proven a complex endeavour. Lastly, awareness levels of the MPoA vary widely among CSOs and the MPoA does not necessarily inspire the work of CSOs on SRH.

### 3.1.5 The African Charter on the Rights and Welfare of Children and the African Youth Charter

The MPoA focuses specifically on youth and adolescents as a vulnerable population group (Key Strategy 5). There are two important normative frameworks regarding children and youth at the African level. First is the **African Charter on Rights and Welfare of the Child (ACRWC)**, also called the African Children's Charter, which was adopted in 1990 and came into force in 1999. At the international level, the United Nations Convention on the Rights of the Child (UNCRC) has been adopted, also in 1990. The African continent is the only one with a region-specific instrument on child rights. The ACRWC builds on the same principles as the UNCRC and highlights issues that are of specific importance to the African context. As of January 2017, all member states have signed the ACRWC; a remaining seven states have to ratify the document.<sup>12</sup>

The **African Youth Charter** was adopted in 2006, and it responds to the need to prioritise youth development and empowerment.<sup>13</sup> It underscores youth participation in debates and decision-making on development in the continent and seeks to ensure their effective involvement in the development agenda. The African Youth Charter consists of 31 articles, including one specifically on health (Art. 16) and one on girls and young women (Art. 23).

Table 3.1 presents the relevant articles regarding the four rights areas central to this report, plus general discrimination against women and girls, of the African Children's Charter and African Youth Charter.

**Table 3.1. Articles in the African Children's Charter and the African Youth Charter relevant to this report**

	African Children's Charter (1990)	African Youth Charter (2006)
<b>Discrimination against women and girls</b>	Art 3 – Non-Discrimination Art. 26 – Protection against Apartheid and Discrimination	Art. 4 – Non-Discrimination Art. 23 – Girls and Young Women
<b>GVAW</b>	Art. 5 – Survival and Development Art. 15 – Child Labour Art. 16 – Protection against Child Abuse and Torture Art. 22 – Armed Conflict Art. 27 – Sexual Exploitation Art. 29 – Sale, Trafficking and Abduction	Art. 17 – Peace and Security Art. 23 – Girls and Young Women Art. 26 – Responsibilities of Youth
<b>Harmful practices</b>	Art. 19 – Parental Care and Protection Art. 21 – Protection against Harmful Social and Cultural Practices	Art. 20 – Youth and Culture Art. 25 – Elimination of Harmful Social and Cultural Practices
<b>Reproductive rights and SRH</b>	Art. 14 – Health and Health Services	Art. 16 – Health Art. 23 – Girls and Young Women
<b>HIV and AIDS</b>	Art. 14 – Health and Health Services	Art. 13 – Education and Skills Development Art. 16 – Health Art. 26 – Responsibilities of Youth

<sup>12</sup> DRC, Morocco, Sahrawi Arabic Democratic Republic, Somalia, São Tomé and Príncipe, South Sudan and Tunisia.

<sup>13</sup> The African Youth Charter defines youth or young people as 'every person between the ages of 15 and 35 years'.

### 3.1.6 Agenda 2063 and the AU Gender Equality and Women's Empowerment Strategy

In 2018, the AU will adopt its first Gender Equality and Women's Empowerment Strategy (2018–27), which will reaffirm its commitment to advancing gender equality. The Gender Strategy will be instrumental in aligning gender mainstreaming in the AU to Agenda 2063, the Maputo Protocol and the Sustainable Development Goals (SDGs). More specifically, the Gender Strategy is expected to contribute to attaining Agenda 2063 visions for gender equality, as expressed in Aspiration 6.<sup>viii</sup> Goal 17 of Aspiration 6 is to achieve 'full gender equality in all spheres of life', and requires, among others, the domestication and full implementation of the Maputo Protocol.<sup>14</sup>

In relation to Agenda 2063, the African Union Commission (AUC) published the African Gender Score Card in 2015. This aims to measure national progress towards gender equality in seven sectors: health, education, access to land, business, employment, parliament and decision-making, and access to credit. Within this there is a special call for a gender-responsive data revolution. The first Gender Score Card underlined the need to invest in gender-responsive statistics, in order to be able to realise commitments on gender equality and women's empowerment.<sup>ix</sup>

#### Box 3.9. Agenda 2063: The Africa We Want – Aspiration 6, Goal 17<sup>15</sup>

**Aspiration 6** An Africa whose development is people driven, relying on the potential offered by people, especially its women and youth and caring for children

**Goal 17.** Full gender equality in all spheres of life    Priority area 1: Women empowerment  
Priority area 2: Violence and discrimination against women and girls

The AU Gender Strategy is being developed by the Women, Gender and Development Directorate (WGDD) of the AUC in an elaborate process<sup>16</sup> involving AU departments, divisions and organs, gender structures of the RECs, national gender machineries and UN, local, national, regional and international CSOs and faith-based organisations. In the consultative process, child marriage, FGM, GVAW and other harmful practices featured as prominent priorities, as did the eradication of preventable maternal mortality and HIV and AIDS. Attention was also drawn to ensuring affordable and accessible SRH services, with specific emphasis placed on SRHR for youth (especially in terms of adolescent pregnancies, commercial sexual exploitation, lack of youth-friendly SRH services and sexual violence/harassment in schools). The importance of grounding the Gender Strategy in a gender equality, women's empowerment and women's rights framework was also emphasised.

<sup>14</sup> The First Ten Year Implementation Plan of Agenda 2063 formulates targets (national and continental) to be reached by 2023, and indicates the key process actions and milestones on AU frameworks, as well as indicative strategies to reach the set targets.

<sup>15</sup> The Seven Aspirations of Agenda 2063 are 1) a prosperous Africa, based on inclusive growth and sustainable development, 2) an integrated continent, politically united, based on the ideals of pan-Africanism and the vision of Africa's renaissance, 3) an Africa of good governance, democracy, respect for human rights, justice and the role of law, 4) a peaceful and secure Africa, 5) an Africa with a strong cultural identity, common heritage, values and ethics, 6) an Africa whose development is people driven, relying on the potential offered by people, especially its women and youth and caring for children and 7) an Africa as a strong, united, resilient and influential global player and partner.

<sup>16</sup> The process encompassed 10 consultative workshops and an online discussion.

## 3.2 THE QUALITIES AND STRENGTHS OF MAPUTO PROTOCOL

### 3.2.1 The innovative character of the Maputo Protocol

The Maputo Protocol is based on existing international instruments, including CEDAW (1979), adopted by the UN in 1981, translating and advancing these human rights of women and girls into the African context. It defines the term 'women' as referring to 'persons of female gender, including girls' (Art. 1).

The Maputo Protocol is a major step forward in the promotion and protection of women and girls' rights in Africa. The comprehensive framework of women and girls' human rights includes the right to equal pay and to maternity leave, as well as affirmative action and equal participation at all levels of decision-making. The Protocol recognises the right of women to participate in the promotion and maintenance of peace and to equal participation in law enforcement and the judiciary.

The Maputo Protocol is progressive in a range of areas. It is the first human rights instrument to make an explicit reference to HIV and AIDS, and is also innovative in its legal prohibition of FGM. It provides legal protection against violence against women, in both the public and the private spheres, and in times of peace and war. The Protocol is the first treaty to recognise abortion, under specific conditions, as a human right for women and girls.

Adolescent girls as well as several other groups of women facing specific vulnerabilities are addressed in particular provisions; these include widows, elderly women, disabled women, poor women and women from marginalised population groups and pregnant or nursing women in detention. For instance, the Protocol defines the equal rights of widows. It provides protection to adolescent girls to be free from abuse and sexual harassment in schools. It prohibits forced marriage and marriage for girls under the age of 18.<sup>x</sup>

#### Articles in the Maputo Protocol

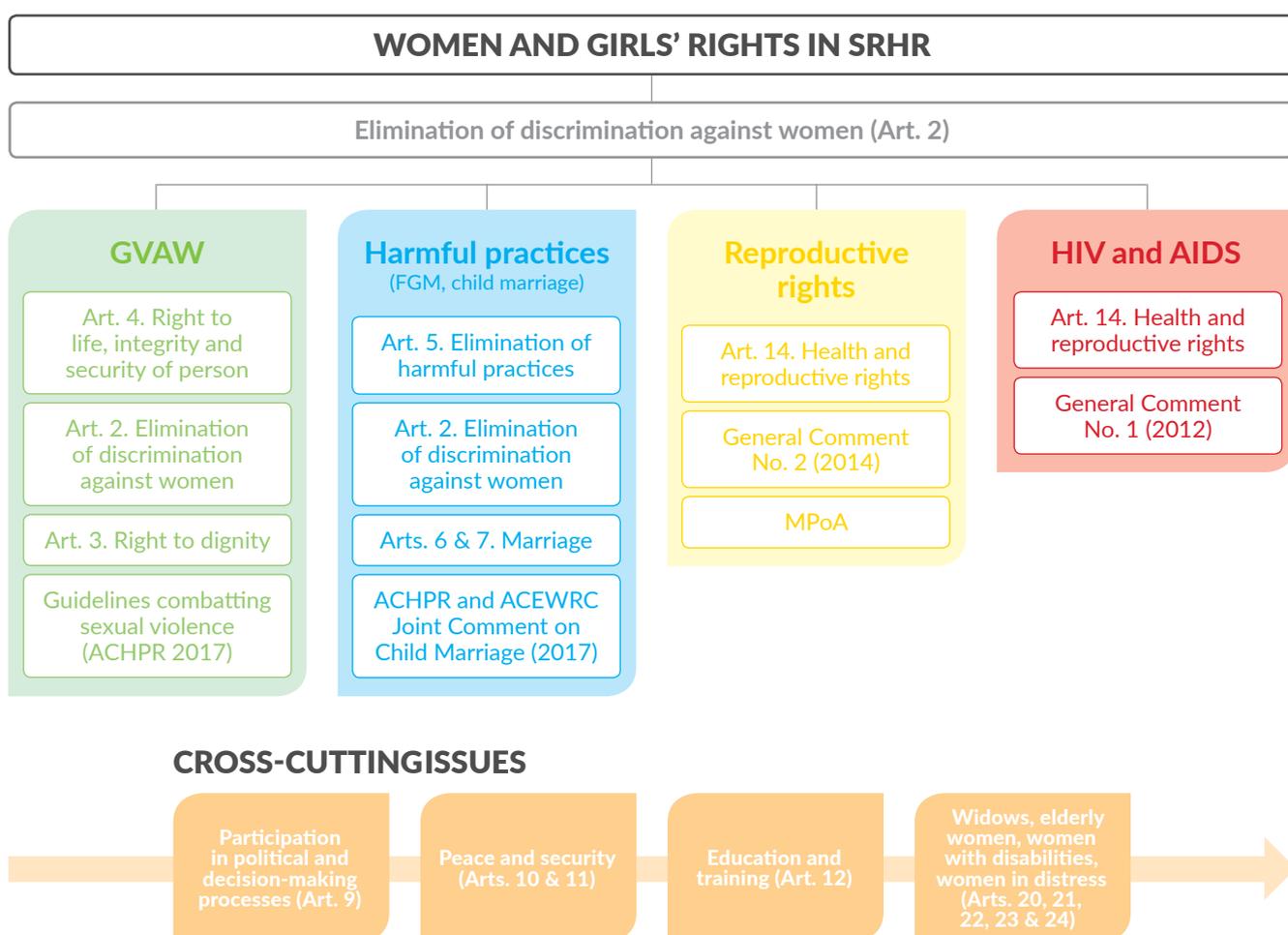
- |   |   |
|---|---|
| <b>Art. 1</b> – Definitions   | <b>Art. 17</b> – Right to Positive Cultural Context             |
| <b>Art. 2</b> – Elimination of Discrimination against Women                         | <b>Art. 18</b> – Right to a Healthy and Sustainable Environment |
| <b>Art. 3</b> – Right to Dignity  | <b>Art. 19</b> – Right to Sustainable Development               |
| <b>Art. 4</b> – The Rights to Life, Integrity and Security of the Person            | <b>Art. 20</b> – Widows' Rights                                 |
| <b>Art. 5</b> – Elimination of Harmful Practices                                    | <b>Art. 21</b> – Right to Inheritance                           |
| <b>Art. 6</b> – Marriage  | <b>Art. 22</b> – Special Protection of Elderly Women            |
| <b>Art. 7</b> – Separation, Divorce and Annulment of Marriage                       | <b>Art. 23</b> – Special Protection of Women with Disabilities  |
| <b>Art. 8</b> – Access to Justice and Equal Protection before the Law               | <b>Art. 24</b> – Special Protection of Women in Distress        |
| <b>Art. 9</b> – Right to Participation in the Political and Decision-Making Process | <b>Art. 25</b> – Remedies                                       |
| <b>Art. 10</b> – Right to Peace   | <b>Art. 26</b> – Implementation and Monitoring                  |
| <b>Art. 11</b> – Protection of Women in Armed Conflicts                             | <b>Art. 27</b> – Interpretation                                 |
| <b>Art. 12</b> – Right to Education and Training                                    | <b>Art. 28</b> – Signature, Ratification and Accession          |
| <b>Art. 13</b> – Economic and Social Welfare Rights                                 | <b>Art. 29</b> – Entry into Force                               |
| <b>Art. 14</b> – Health and Reproductive Rights                                     | <b>Art. 30</b> – Amendment and Revision                         |
| <b>Art. 15</b> – Right to Food Security   | <b>Art. 31</b> – Status of Present Protocol                     |
| <b>Art. 16</b> – Right to Adequate Housing  | <b>Art. 32</b> – Transitional Provisions                        |

### 3.2.2 General Comments

With respect to the Maputo Protocol, three **General Comments** have been adopted. General Comments are human rights tools used for the interpretation of provisions in international or regional legal treaties and provide guidance to states in the implementation of their obligations. Two of these General Comments have been adopted by the ACHPR.<sup>17</sup> The first was adopted in October 2012 and concerns the intersections between *women's rights and HIV* (Art. 14.1(d) and (e) of the Protocol). The second was adopted in May 2014 and concerns the *rights to reproductive freedom, to family planning education and to safe abortion* (Art. 14.1(a), (b), (c) and (f) and Art. 14.2(a) and (c) of the Protocol). Both General Comments provide guidance on the normative content of the respective articles, and articulate general and specific measures to be taken by state parties to fulfil their obligations. The third General Comment was adopted jointly by the ACHPR and the African Committee of Experts on the Rights and Welfare of the Child (ACEWRC) in 2017 and speaks to *ending child marriage*, and refers to both the Maputo Protocol and the African Children's Charter.

Figure 3.2 provides insight into which articles of the Maputo Protocol and which General Comments are relevant to these four rights areas central in this report: GVAW, harmful practices, reproductive rights and HIV and AIDS.

Figure 3.2. Articles in the Maputo Protocol relevant to this report



<sup>17</sup> Article 45.1(b) of the African Charter authorises the ACHPR to formulate and adopt General Comments, by providing jurisdiction 'to formulate and lay down, principles and rules aimed at solving legal problems relating to human and peoples' rights and fundamental freedoms upon which African Governments may base their legislation'.



### 3.2.4 Reservations on the Protocol

Certain countries have ratified the Maputo Protocol while entering reservations on certain articles or declarations. In the Vienna Convention on the Law of Treaties (1969), a reservation on a treaty, which can also be referred to as an 'interpretative declaration/statement', is a unilateral statement that 'purports to exclude or to modify the legal effect of certain provisions of the treaty in their application to that State' (Art. 2(1)(d)). Eight countries have made such reservations to the Maputo Protocol (see Table 3.2). One of them, Rwanda, lifted its reservation in 2012 (see case study 24 in Chapter 7). Most reservations concern articles on marriage, fertility and abortion (in particular Arts 6 and 14).

**Table 3.2. Reservations by country on the Maputo Protocol**

Country	What	Reservation regarding?
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)

### 3.2.5 Periodic reporting under the Protocol

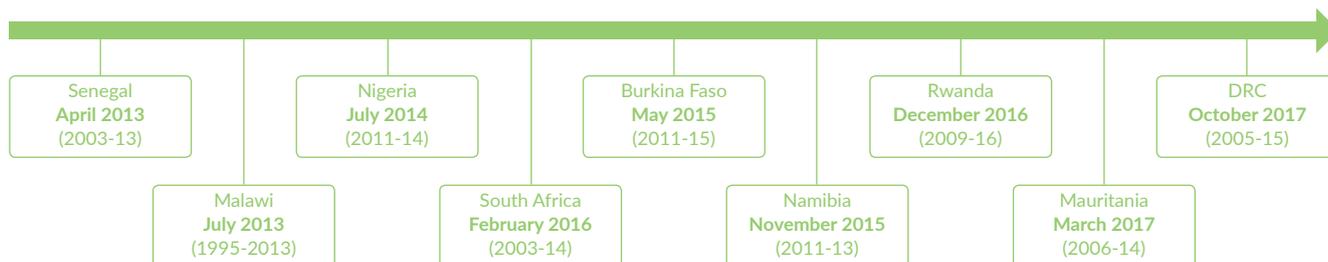
Under Art. 26 of the Maputo Protocol, states are required to submit Periodic Reports to the ACHPR (in accordance with Art. 62 of the African Charter). These reports have two parts, the first on implementation of the African Charter and the second on the Maputo Protocol.

In order to assist member states in drafting Periodic Reports and to encourage states to honour their obligations, the mechanism of the SRRWA developed the *Guidelines for State Reporting under the Maputo Protocol*.<sup>xiii</sup> These were adopted during the 46th Ordinary Session of the AUC on 11–25 of November 2009 in Banjul, The Gambia.

The state Periodic Reports should indicate the legislative and other measures the state has undertaken 'for the full realisation of the rights' recognised in the Maputo Protocol. States are also required to 'adopt all necessary measures' and 'provide budgetary and other resources for the full and effective implementation' of the right recognised in the Protocol (Art. 26.2). The ACHPR issues its concluding observations on the progress on implementation, after engaging in dialogue with the state. These concluding observations include recommendations on required actions. States are expected to report on progress in implementation in their next Periodic Report.

While the majority of states have reported on implementation of the African Charter, fewer have reported on their implementation of the Maputo Protocol. As at the ACHPR's 60th Ordinary Session (late 2017), nine states had submitted a report on the Maputo Protocol: Burkina Faso, Democratic Republic of Congo (DRC), Malawi, Mauritania, Namibia, Nigeria<sup>19</sup>, Rwanda, Senegal and South Africa. The compliance of these reports with the *Guidelines for State Reporting under the Maputo Protocol* varies. Some countries, such as Malawi, Mauritania, Rwanda and South Africa, have complied with the guidelines. Other states, while reporting on measures taken with regard to women and girls' rights under the Maputo Protocol, do not always do so as per the prescribed format.<sup>20</sup>

**Figure 3.4. Timeline of state reporting on the Maputo Protocol**



To inform constructive dialogue with the state as well as influence the concluding observations, NGOs with observer status can prepare and submit 'shadow reports'; these supplement, and where necessary, contradict the state reports. Shadow reports can alert the ACHPR to specific issues, raise questions or propose recommendations. It is also worth noting that NGOs have also been instrumental in growing the state reporting process. For instance, the Centre for Human Rights at the University of Pretoria was instrumental in the drafting of the *Guidelines for State Reporting under the Maputo Protocol*. The Centre has undertaken several state reporting trainings towards popularising the Guidelines and enhancing states officers' knowledge on state reporting, which has often resulted in reporting by the targeted states. To date, the Centre continues to offer technical expertise to a number of states in the drafting of state reports.

<sup>19</sup> In January 2018, Nigeria submitted their 2nd report under the Maputo Protocol and became the first country to do so. The report was examined during the 62nd Ordinary Session of the ACHPR.

<sup>20</sup> Togo and Angola submitted state reports that include reporting on the Maputo Protocol, but the same were not considered during the 62nd session of the ACHPR.

### 3.2.6 Implementation of the Protocol

After ratifying the Protocol, states face challenges in relation to actual implementation. In 2017, the AUC Directorate for Women, Gender and Development published the *State of Women's Rights Report*. This noted that the main challenges to further domestication and implementation of the Protocol included lack of awareness of human rights instruments such as the Maputo Protocol and lack of state reporting under Art. 26. Moreover, the report highlighted the continued contestation of the universality of human rights by African values and the use of culture and/or religion to justify harmful practices—and the way this affected the realisation of women's rights to hamper progress on implementation of the Maputo Protocol.

In 2013, SOAWR published *Journey to Equality: 10 Years of the Protocol on the Rights of Women in Africa*. This looks at specific articles<sup>21</sup> of the Maputo Protocol individually and reports on the related challenges. Overall, the SOAWR coalition encourages states to go further in addressing social and cultural norms and behaviour, including harmful practices, and women's access to justice, through advocacy, education and the inclusion of men and boys. In its 2015 report *Breathing Life into the Maputo Protocol*, the coalition highlighted as key challenges issues related to SRHR and the side-lining of the redistribution and valuing of unpaid care work. It also noted a tendency to focus on women's empowerment, rather than on taking a rights-based approach, in particular in relation to economic development. Terrorism, fundamentalism and land-grabbing were highlighted as key emerging issues, with implications for women's rights.<sup>22</sup>

In 2016, the Centre for Human Rights of the University of Pretoria published *The Impact of the African Charter and the Maputo Protocol in Selected African States*. The book covers 17 states,<sup>23</sup> and finds that the Maputo Protocol has had the most impact on judicial activities in Anglophone Africa, specifically in Ghana, Kenya and Nigeria. Key challenges include low levels of awareness and use of the Maputo Protocol among both legal actors, such as domestic judges and lawyers, and CSOs. Lack of political will across high-level political actors is also observed. At the same time, widespread poverty and illiteracy, as well as political instability, pose obstacles to the Maputo Protocol's impact. Lack of media coverage of the ACHPR and the African Court also works against the translation of the Maputo Protocol to domestic levels.

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<sup>21</sup> Art. 2 (Elimination of discrimination), Art. 6 (Marriage), Art. 8 (Access to justice and equal protection before the law), Art. 14 (Reproductive health rights) and Art. 21 (Right to inheritance).

<sup>22</sup> SOAWR identified seven priorities: women's access to decision-making; access to, control over and ownership of land and property; SRHR; women and HIV; maternal health; GVAW; harmful practices; and women and the private sector.

<sup>23</sup> Burkina Faso, Cameroon, Côte d'Ivoire, Ethiopia, The Gambia, Ghana, Kenya, Lesotho, Malawi, Mauritius, Nigeria, Sierra Leone, South Africa, Swaziland, Tanzania, Uganda and Zimbabwe.

### 3.3 AFRICA WOMEN'S DECADE AND KEY CAMPAIGNS ON WOMEN'S RIGHTS

Several initiatives have been launched at the AU to advance the promotion of women and girls' rights and gender equality. One key initiative is **African Women's Decade (AWD) 2010–20**, launched by the AU in Nairobi, Kenya, in October 2010. AWD aims to advance gender equality through accelerating the implementation of global and regional commitments and decisions regarding gender equality and women and girls' empowerment, through both a top-down and a bottom-up approach, including grassroots participation. The main objective of AWD is to 'enhance the implementation of the African Union Members States commitments related to gender equality and women's empowerment and to support activities resulting in tangible positive change for African women at all levels'. In order to achieve this objective, AWD focuses on one thematic area per year, which is derived from the critical areas identified in the Beijing Platform for Action, the MDGs and the ICPD PoA. AWD is currently in its second implementation phase (2015–20).

Since 2011, Make Every Woman Count (MEWC) has published a yearly report on the status and progress on women and girls' rights with respect to the goals of the AWD. The initiative for these reports was grounded in concerns about the information vacuum after the AWD was launched; there did not seem to be a systematic assessment of progress, or possibly lack thereof, on the ambitious commitments the AWD had set out to achieve. The MEWC report presents progress for each country on the continent, and addresses six core areas of women's right and gender equality (women, peace and security; violence against women; political participation and leadership; economic empowerment; education; and HIV, AIDS and reproductive health).

*The Mid-Term Report on the AWD*, published in 2016, observed considerable progress in many countries in a variety of areas, including women's political decision-making, legal reform on GVAW, maternal mortality and girls' education. Yet progress is also limited and highly uneven across countries, the extent to which women and girls' rights are realised on the ground remains disappointing and gender inequality and violations of women and girls' rights continue to be major concerns. The MEWC mid-term report underscores the importance of stronger monitoring and accountability on gender equality and women and girls' rights commitments and frameworks.

#### Box 3.11. Make Every Woman Count

MEWC is an organisation led by African women that serves as a (primarily online) platform to inform, mobilise, conduct advocacy through evidence-based research for, and provide information and training to women's organisations, grassroots movements and activists that work to empower women and girls to eventually strengthen women's leadership capacities in order to influence policy- and decision-making. The MEWC reports are launched at the AU Gender Pre-Summit.

In 2014, the **AU Campaign to End Child Marriage** was launched to promote, protect and advocate for the rights of women and girls in Africa. The campaign originally spanned from 2014 to 2017 and has since been extended; it serves overall to accelerate change across Africa by encouraging governments to develop strategies, raise awareness and address the harmful impact of child marriage.<sup>25</sup> In order to achieve this objective, the campaign focuses on mobilising continental awareness of the negative socioeconomic impact of child marriage and supporting legal and policy actions that protect and promote human rights. It also seeks to build social movements at the grassroots and national levels and strengthen the capacity of non-state actors to undertake evidence-based policy advocacy, including youth leadership, through, for example, new media technology and monitoring and evaluation. In 2014, the AU appointed a Goodwill Ambassador for Ending Child Marriage and the ACERWC appointed an AU Special Rapporteur on Child Marriage. In 2015, the AU Common Position on the AU Campaign to End Child Marriage in Africa was adopted.<sup>26</sup> In December 2017, 22 countries launched a campaign to end child marriage (see also Chapter 6).

In 2009, the **Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA)** was initiated by the AUC. To date, 46 countries have launched CARMMA chapters and 6 are in preparations to launch it. CARMMA's main objective is to expand the availability and use of universally accessible quality health services, including those related to SRH. The campaign aims to achieve this objective by generating and providing data on maternal and newborn deaths and increasing political commitment. By building on existing efforts, and mobilising domestic resources in support of maternal and newborn health, the campaigns seeks to accelerate actions to reduce maternal and infant mortality in Africa.<sup>27</sup>

<sup>25</sup> The AU has organised the campaign with the United Nations Children's Fund (UNICEF) and UNFPA, and cooperates with a wide variety of partners including the Ford Foundation, the United Nations Economic Commission for Africa (UNECA), Save the Children, Plan International, the Africa Child Policy Forum (ACPF) and the UK Department of International Development (DFID).

<sup>26</sup> This AU Common Position urges all member states of the AU to, among other things, 1) develop national strategies and action plans aimed at ending child marriage, 2) enact and implement laws that set the legal minimum age for marriage at 18 years of age or above, with no exceptions and applicable under all legal systems, and 3) implement all continental policies and legal instruments relating to human rights, gender equality, maternal and child health and harmful traditional practices for the empowerment and participation of girls and women in development. See [www.au.int/web/en/documents/31010/african-common-position-au-campaign-end-child-marriage-africa](http://www.au.int/web/en/documents/31010/african-common-position-au-campaign-end-child-marriage-africa)

<sup>27</sup> Partners in the CARMMA campaign are UNFPA, IPPF AR, the Partnership for Maternal, Newborn and Child Health (PMNCH), Marie Stopes International, the United States Agency for International Development (USAID), UKAid, UNICEF and Partners in Population Development Africa.

CARMMA has been successful in generating increased political commitment and leadership as well as broadening partnerships for maternal and child health. It has published three Maternal, Neonatal and Child Health Reports and has contributed to further data generation on these themes. Whereas its strengths lie in its country-driven nature, and the many countries that have launched the campaign, it has been challenged in relation to follow-up since its launch. This has owed to a lack of resources at the Secretariat, combined with weak accountability mechanisms on country level commitments.<sup>xiii</sup>

In January 2018, the AU and the Organisation of African First Ladies (OAFLA) launched a new Pan-African advocacy campaign, **Free to Shine**.<sup>xiv</sup> This seeks to end childhood AIDS by raising awareness on the HIV epidemic in children and on the critical importance of prioritising women and children. It also seeks to increase understanding of how to prevent HIV and AIDS in childhood by keeping mothers healthy, preventing mother-to-child transmission and ensuring fast and effective identification and treatment of HIV-infected children. The campaign aims to mobilise resources and prioritise the delivery of effective and sustainable HIV and AIDS health services that are accessible by all who need them. It also aims to highlight the importance of removing barriers that prevent women and mothers engaging with HIV- and AIDS-related health services for themselves and their children (see case study 29 on the Free to Shine campaign in Chapter 8).

## 3.4 THE INSTITUTIONAL INFRASTRUCTURE FOR GENDER EQUALITY AND WOMEN'S RIGHTS OF THE AU

There are several important actors and structures related to gender equality and women's rights in the AU institutional infrastructure. These are briefly presented in Section 3.4.1, which is followed by a reflection on the protective and promotional mandate of the ACHPR (Section 3.4.2). Section 3.4.3 looks briefly at important partnerships of the AU.

### 3.4.1 Gender and women's rights infrastructure

The **Women, Gender and Development Directorate (WGDD)** promotes gender equality on the continent and within the AU. It designs projects and programmes based on AU member state policies. In addition, it oversees development and harmonisation of gender-related policies; is responsible for initiating gender-mainstreaming strategies in the AUC and other AU organs and member states; and provides training on gender policies and instruments (including the Maputo Protocol). It was created in 2002 and is located under the AUC. The Directorate consists of two divisions: the Gender Policy and Development Division (GPDD) and Gender Coordination and Outreach and Women's Rights.

The Directorate also acts as the Secretariat for the **African Union Women's Committee (AUWC)**, also known by its longer name, the African Union Specialised Technical Committee on Gender Equality and Women's Empowerment.<sup>28</sup> This was inaugurated in 2006 as an advisory committee on gender and development issues to the chair of the AUC and the AUC as a whole.

The **African Commission on Human and Peoples' Rights (ACHPR)**, also called 'The Commission', monitors the implementation of the obligations for states articulated in, among others, the African Charter and the Maputo Protocol. The ACHPR was established in 1987 as the enforcement mechanism under the African Charter with the mandate to 'promote and protect human and people's rights in Africa'. It receives and examines state reports, and also elaborates General Comments. The ACHPR is based in Banjul, The Gambia, and consists of 11 commissioners.

The ACHPR has appointed five Special Rapporteurs<sup>29</sup> and Working Groups, which investigate and report on specific human rights issues and cases. They are dedicated to promoting and protecting specific rights or rights of specific vulnerable groups. In 1999, the **Special Rapporteur on Rights of Women in Africa (SRRWA)** was established (see more details in Section 3.4.2).<sup>xv</sup>

The **African Court on Human and Peoples' Rights (AfCHPR)**,<sup>30</sup> also called 'the African Court', is a human rights adjudicatory body with jurisdiction on the interpretation and application of the African Charter among states that have ratified the African Charter and the Maputo Protocol. The Court came into force in 2004, comprises 11 judges, elected by the AU Assembly, and sits in Arusha (Tanzania).<sup>31</sup> The first case of the Court was in 2009 and it has taken up several cases since.<sup>32</sup> The Court has an important role in safeguarding human and women/girls' rights across the AU as it can pass final and binding judgements against states violating these. Governments are then required to comply with the judgement and guarantee its execution.<sup>xvi</sup> Of the 30 countries that have ratified the African Court Protocol, only eight have declared that they recognise the competence of the Court to receive cases from NGOs and individuals.<sup>33</sup>

Lastly, the **African Committee of Experts on the Rights and Welfare of the Child (ACERWC)** was established in July 2001. This monitors implementation of the ACRWC. It comprises 11 experts and is supported by the AUC, with a mandate to promote and protect the rights enshrined in the Charter, monitor implementation, interpret provisions of the Charter by request and perform other tasks as entrusted by the AU Assembly.<sup>xvii</sup>

<sup>28</sup> Each specialised technical committee (STC) is composed of member states' ministers and senior officials responsible for sectors falling within their respective areas of competence. (See also AU Constitutive Act of 2000: [www.achpr.org/files/instruments/au-constitutive-act/au\\_act\\_2000\\_eng.pdf](http://www.achpr.org/files/instruments/au-constitutive-act/au_act_2000_eng.pdf).)

<sup>29</sup> There are Special Rapporteurs for (1) women, (2) human rights defenders, (3) freedom of expression, (4) prisons and conditions of detention and (5) refugees, migrants and IDPs.

<sup>30</sup> This is not the same as the African Court of Justice and Human Rights (ACJHR) Protocol, which was adopted in 2008 and will come into force once 15 countries have ratified it. The ACJHR Protocol mandates the merger of the African Court on Human and Peoples' Rights and the African Court of Justice; the latter was agreed to (in 2003) but never established.

<sup>31</sup> The Court was established by virtue of Art. 1 of the Protocol to the African Charter on the Establishment of an African Court on Human and Peoples' Rights, in Ouagadougou, Burkina Faso, in June 1998. See [www.african-court.org/en/](http://www.african-court.org/en/)

<sup>32</sup> In August 2017, the Court had received 146 applications and finalised 32 cases. See [www.african-court.org/en/](http://www.african-court.org/en/)

<sup>33</sup> The Court may receive cases filed by the ACHPR, state parties to the Protocol or African intergovernmental organisations. NGOs with observer status before the ACHPR and individuals can also institute cases directly before the Court as long as the state against which they are complaining has deposited the Art. 34(6) declaration recognising the jurisdiction of the Court to accept cases from individuals and NGOs. The eight states allowing individuals and NGOs access to the Court are Benin, Burkina Faso, Côte d'Ivoire, Ghana, Mali, Malawi, Tanzania and Tunisia. See <http://www.african-court.org/en/> (for earlier data, see also SOAWR. 2011. *Guide to Using the Protocol on the Rights of Women in Africa for Legal Action*).

### 3.4.2 The protective and promotional mandate of the ACHPR

The mandate of the ACHPR is to protect and promote human and peoples' rights. Under its *protective* mandate, human rights defenders and citizens can be litigants and present violations of human rights for the attention of the ACHPR. This is done via the individual 'Communications' procedure. The potential of this procedure for the ACHPR to advance women and girls' rights has not yet been fully seized. There have been only two cases exclusively addressing women's rights, and a few others relating to women's rights concerns. One of these two Communications at the ACHPR—of *Equality Now and the Ethiopian Women Lawyers Association v Ethiopia*—is documented as case study 8 in Chapter 6. As a result, the jurisprudence of the ACHPR is not well developed in this regard.

The African Charter, which all African states have ratified, offers specific and general provisions that can reliably be used in putting forward an allegation of women's rights violations.<sup>34</sup> In addition, the Maputo Protocol can be utilised as a basis for alleging violations where a state has ratified it, and as a source of persuasive authority where it has not. In spite of the rich framework in place, though, in practice, these laws have not been optimally utilised in the ACHPR's jurisprudence. In a number of cases, the ACHPR has missed critical opportunities to articulate the gender dimensions of human rights violations, such as in sexual violence cases, and the particular gendered nature of violations against women largely goes unrecognised. Consequently, the ACHPR has fallen short in relation to developing and expanding substantial jurisprudence for women's rights protection.

In a few progressive Communications the ACHPR does pronounce itself on women's rights violations. Yet, even in these noteworthy cases, discrimination and women's rights violations are framed and interpreted in a narrow way that fails to recognise the unique and disproportional and gender-specific ways in which women and girls experience discrimination.<sup>35</sup> The dearth of women's rights cases at the ACHPR cannot be attributed to the ACHPR alone; complex social, legal and practical reasons abound for this. That said, under-utilisation of the Communications procedure by NGOs contributes, and human rights defenders must be encouraged to utilise this platform to advance women's rights protection.<sup>xviii</sup>

With respect to its second mandate—that is, to *promote* women and girls' rights—the ACHPR has a wide array of avenues.<sup>xix</sup> The state reporting mechanism is at the core of its promotional mandate (see also Section 3.2.5 above). In addition, there are special mechanisms, comprising Special Rapporteurs, committees and working groups. The mechanisms most relevant to this report include the Special Rapporteur on the Rights of Women in Africa (SRRWA) and the Committee on the Protection of the Rights of People Living with HIV and Those at Risk, Vulnerable to and Affected by HIV (the HIV Committee). The SRRWA has been particularly active and trail-blazing in terms of standard-setting (see also her mandate in Box 3.12), for instance, in the development of three out of five of the ACHPR's General Comments. The Special Rapporteur could, however, bear to increase utilisation of promotional visits to engage with states on women's rights concerns.<sup>36</sup>

#### Box 3.12. Mandate of the Special Rapporteur on the Rights of Women in Africa

The mandate of the SRRWA includes:

- To serve as a focal point for the promotion and protection of the rights of women and girls in Africa
- To assist African governments in the development and implementation of policies for the promotion and protection of the rights of women and girls in Africa, particularly in accordance with the Maputo Protocol
- To undertake promotional and fact finding missions in member states of the AU
- To follow up on implementation of the African Charter and the Maputo Protocol by state parties, by preparing reports on the situation of women and girls' rights in Africa and proposing recommendations to be adopted by the ACHPR
- To conduct a comparative study on the situation of the rights of women and girls in various countries of Africa
- To draft resolutions on the situation of women and girls in the various African countries and propose them to the members of the ACHPR for adoption
- To define guidelines for state reporting that assist member states in adequately addressing women and girls' rights issues in their reports submitted to the ACHPR and
- To collaborate with relevant actors responsible for the promotion and protection of the rights of women and girls internationally, regionally and nationally

<sup>34</sup> Examples of these provisions in the African Charter are the non-discrimination clause (Art. 2) and that on the elimination of discrimination against women (in Art. 18.3). For a more detailed analysis of the strengths and challenges of these provisions, in particular the not unproblematic framing of Art. 18 in relation to upholding the family and morals and traditional values, see Chapter 2 of Rajab-Leteipan, S. and Kamunyu, M. (2017). *Litigating before the African Commission on Human and Peoples' Rights: A Practice Manual*. Nairobi: Equality Now.

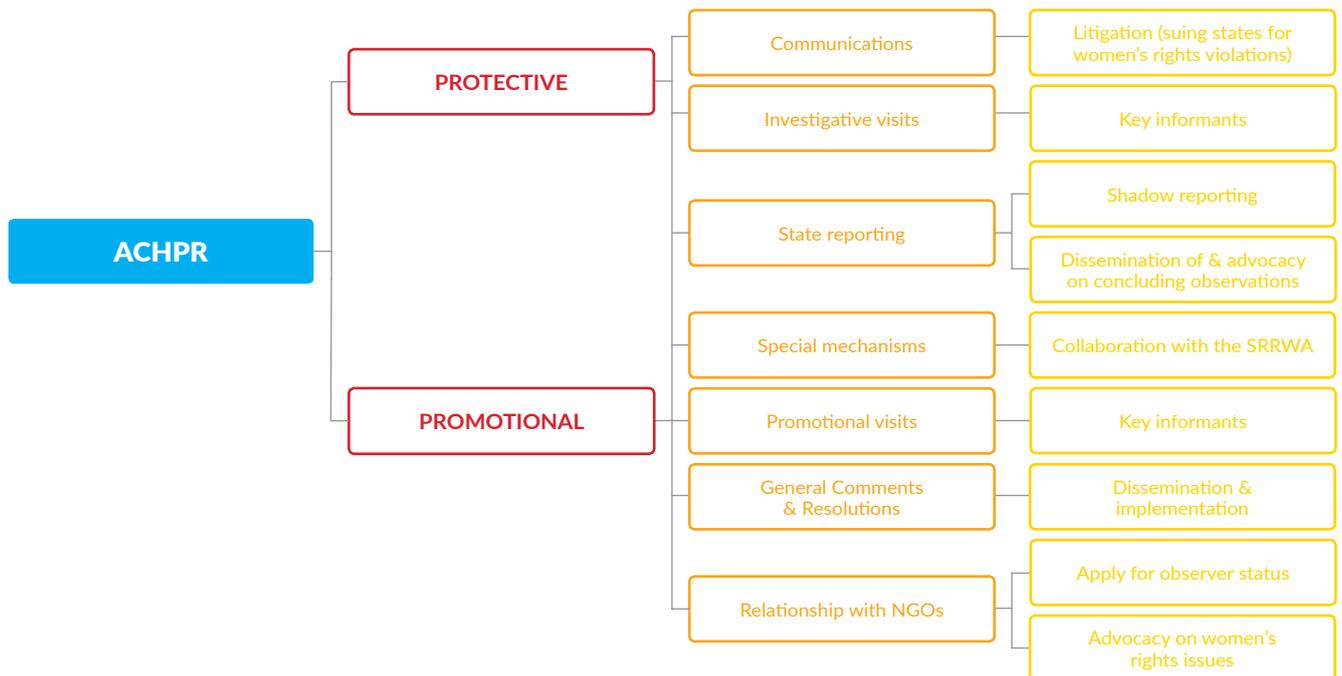
<sup>35</sup> For instance, the ACHPR has in two Communications found discrimination against women only by having applied a male-comparator standard—i.e. comparing a man and a woman in similar situations then establishing that treatment of the woman was unjust. This is problematic, as, in some instances, women and girls experience discrimination uniquely and disproportionately in a manner that it not comparable to the situation for men (see also Rajab-Leteipan and Kamunyu. 2017).

<sup>36</sup> In addition, the ACHPR itself undertakes promotional visits to states through a team of commissioners.

It is in the development of soft law that the ACHPR really comes into its own in utilising its promotional mandate. Initially, the ACHPR predominantly adopted resolutions, which can be thematic or country-specific in nature. The mechanism of adopting resolutions has been thoroughly underutilised in women's rights promotion, with only few resolutions developed in this area. More recently, the ACHPR has taken to adopting General Comments, as with the human rights treaty bodies of the UN system. The ACHPR has developed and adopted five General Comments; three are exclusively on women's rights concerns whereas two affect women generally. The three former are the General Comment No. 1 on HIV, General Comment No. 2 on sexual and reproductive health rights and the Joint General Comment on Child Marriage (see also Section 3.2.2).<sup>37</sup> Another example is the *Guidelines on Combatting Sexual Violence and its Consequences in Africa*, adopted in 2017 (discussed in more detail in Chapter 5).

From an outsider's perspective, the ACHPR's promotional mandate presents the greatest access and opportunity for civil society actors to simultaneously engage with the ACHPR and states. In fact, the ACHPR is mandated to collaborate with NGO actors and give an audience to NGOs with observer status during its ordinary sessions. Figure 3.5 offers an overview of the entry points for civil society actors in connection to both the protective and the promotional mandate of the ACHPR.

Figure 3.5. ACHPR mandate and related entry points for civil society actors



<sup>37</sup> The other two, General Comment No.4 (on the Right to Redress for Victims of Torture and Other Cruel, Inhuman or Degrading Punishment or Treatment) and General Comment No.3 (on the Right to Life) marginally address women's rights. General Comment No.4 is lauded in establishing that acts of sexual and gender based violence or the failure by states to prevent such acts amount to torture. In so doing, this expands the ambit of women's rights protection and right to redress in cases of violence. (see also: Kamunyu, Mariam 2018).

### 3.4.3 Important partnerships

The **New Partnership for Africa's Development (NEPAD)** is the strategic framework for socioeconomic development of the continent, adopted in 2002 by the AU. Its objective is 'to eradicate poverty, place African countries on a path of sustainable growth and development, halt marginalisation of Africa in the globalisation process, accelerate the empowerment of women and fully integrate Africa into the global economy'.<sup>xx</sup> NEPAD is mainly implemented at the REC level; Chapter 4 of this report looks in more detail at the role of the RECs.

In 2003, the NEPAD Heads of State and Government Implementation Committee established the **African Peer Review Mechanism (APRM)**. The APRM is a self-monitoring instrument with voluntary membership. Its objective is 'to foster the adoption of policies, values, standards and practices of political and economic governance that lead to political stability, accelerated sub-regional and continental economic integration, economic growth and sustainable development'. The APRM monitors gender indicators that cover, among others, issues relating to GVAW, HIV and AIDS, harmful practices and SRH. Nineteen countries have been reviewed so far, leading to countries prioritising and implementing many of the gender objectives in their national action plans. In 2016, a study<sup>38</sup> on gender equality and the APRM concluded that the APRM mechanism could serve as a catalyst for gender equality and women and girls' empowerment in Africa, especially with opportunities for participatory governance. To fulfil this promise of serving as an accountability framework for gender equality in Africa, the mechanism needs significant reorientation.<sup>xxi</sup>

#### Box 3.13 European relations with the African Union

The EU is one of the AU's most important partners. The relationship has a political and institutional as well as financial dimension. One important framework in the partnership between the EU and African (as well as Caribbean and Pacific) countries is the *Cotonou Partnership Agreement (CPA)*. This will expire in 2020, which means new discussions have been necessary on the future of the partnership, also in relation to Agenda 2030 and realisation of the SDGs. The CPA recognises the importance of investing in human development, and has offered a framework for cooperation in strengthening health systems and on youth and gender equality, such as in providing access to contraception and SRHR. The CPA is also unique in its recognition of the role of non-state actors, and of civil society in particular, in political dialogue and in the programming and implementation of development funds.

A second important framework is the *Joint Africa EU Strategy (JAES)*, which was established in 2007; this is the formal channel through which the AU and the EU work together. On 29–30 November 2017, an EU–AU Summit took place in Abidjan (Côte d'Ivoire). Over the past decade, the political discourse of the JAES seems to have shifted from a more thematic approach to an emphasis on the migration, security and defence agenda. In this context, there is less attention and commitment to the human development agenda, and to health and SRHR more specifically. Moreover, compared with the CPA, the JAES lacks a strong reference and support to the role of CSOs. When mentioned, civil society is often coupled with the private sector, without much detail on the specific roles of particular actors. At the recent Summit, there was very limited space for the involvement of civil society.<sup>xxii</sup>

<sup>38</sup> The study was published by UNECA, one of the five regional commissions of the UN, established in 1958 with the objective 'to promote the economic and social development of its member States, foster intra-regional integration and promote international cooperation for Africa's development'.

## Chapter 3

# ENDNOTES

- i Banda, F. (2006). 'Blazing a Trail: The African Protocol on Women's Rights Comes into Force'. *Journal of African Law*, 72–84.
- ii AUC. (2005). 'Guidelines for Reporting on the AU Solemn Declaration on Gender Equality in Africa'. Adopted at the First AU Conference of Ministers Responsible for Women and Gender, Dakar, October (AU/MIN/CONF/WG/2 (I)).
- iii African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases. (2001). *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases*. Abuja, Nigeria, 24–27 April (OAU/SPS/ABUJA/3).
- iv WHO. (2011). *The Abuja Declaration: 10 Years On*. Geneva: WHO.
- v AUC. (2010). 'MPoA 5 Year Review'.
- vi AUC. (2015). 'MPoA Review Report'.
- vii APHRC. (2010). 'Implementation of the Maputo Plan of Action: Opportunities and Challenges for CSO Action in Promoting Sexual and Reproductive Health and Rights in Sub-Saharan Africa'.
- viii AUC. (2015). 'Agenda 2063: First Ten Year Implementation Plan 2013-2024'.
- ix AUC. (2015). 'African Gender Scorecard'.
- x SOAWR and Equality Now. (2011). *A Guide to Using the Protocol on the Rights of Women in Africa for Legal Action*.
- xi [https://au.int/sites/default/files/treaties/7783-sl-protocol\\_to\\_the\\_african\\_charter\\_on\\_human\\_and\\_peoples\\_rights\\_on\\_the\\_rights\\_of\\_women\\_in\\_africa.pdf](https://au.int/sites/default/files/treaties/7783-sl-protocol_to_the_african_charter_on_human_and_peoples_rights_on_the_rights_of_women_in_africa.pdf)
- xii [www.chr.up.ac.za/images/files/research/gender/achpr/Guidelines%20on%20State%20Reporting%20on%20the%20Protocol%20English%20Version.doc](http://www.chr.up.ac.za/images/files/research/gender/achpr/Guidelines%20on%20State%20Reporting%20on%20the%20Protocol%20English%20Version.doc)
- xiii For more detailed review of the CARMMA campaign, see the most recent CARMMA evaluation report, submitted to the AU Department of Social Affairs (AUC/SAD/C/155).
- xiv <http://freetoshineafrica.org/>
- xv <https://au.int/en/organs/cj>; AU, OHCHR and UN Women. (2017). *Women's Rights in Africa*.
- xvi <https://au.int/en/organs/cj>
- xvii Ibid.
- xviii For an in-depth discussion of and guidance on the protective mandate of the ACHPR, see Rajab-Leteipan, S. and Kamunyu, M. (2017). *Litigating before the African Commission on Human and Peoples' Rights: A Practice Manual*. Nairobi: Equality Now; Kamunyu, M. (forthcoming 2018). 'Analysing the Gender Responsiveness of the African Commission on Human and Peoples' Rights'. PhD thesis, University of Pretoria.
- xix The analysis here draws heavily on the in-depth analysis and consideration of the promotional mandate of the ACHPR vis-à-vis women's rights provided in Kamunyu, M. (forthcoming 2018). 'Analysing the Gender Responsiveness of the African Commission on Human and Peoples' Rights'. PhD thesis, University of Pretoria.
- xx <https://au.int/fr/node/3625>
- xxi UNECA. (2017). *Gender Equality and the African Peer Review Mechanism*. Addis Ababa: UNECA.
- xxii For analysis of the different frameworks in the EU-AU relations, see: *Analysis of Human Development in the EC Draft Negotiating Mandate on EU-ACP relations* (Fact Sheet, March 2018). <https://rightbyher.org/wp-content/uploads/2018/05/Factsheet-EU-Draft-Mandate.pdf>

## Chapter 4

# The Regional Economic Communities and women and girls' rights

The AU recognises eight Regional Economic Communities (RECs), which are regional groupings of African states. These differ in role and structure: they are mostly trade blocs; some also involve political cooperation. They form the pillars of the African Economic Community (AEC) and work on regional integration through a range of activities and programmes.<sup>1</sup> In this regard, progress has varied, with some RECs achieving more and others lagging behind in certain sectors.<sup>i</sup>

RECs are increasingly also involved in the coordination of interests in other areas, such as development and governance, peace and security, and gender. In the development of the draft AU Gender Strategy, the gender equality and women and girls' rights commitments of the RECs were explicitly taken into account. This points to the role for the RECs in facilitating the adaptation and adoption of AU initiatives, including the forthcoming Gender Strategy.

In total, the AU comprises eight different RECs:

- Economic Community of West African States (ECOWAS)
- East African Community (EAC)
- Intergovernmental Authority on Development (IGAD)
- Southern African Development Community (SADC)
- Common Market for Eastern and Southern Africa (COMESA)
- Economic Community of Central African States (ECCAS)
- Arab Maghreb Union (UMA)
- Community of Sahel–Saharan States (CEN-SAD)

In this chapter, we present and analyse the normative and institutional frameworks of the RECs and look at what they offer with regard to the advancement and realisation of women and girls' rights, in particular the four rights areas that are prioritised in this report. For each REC, we look at the entry points for gender equality and women and girls' rights in their treaty, and then at the key normative documents and framework they have developed and adopted on these. Where appropriate, we discuss the monitoring mechanisms on these normative frameworks.

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<sup>1</sup> RECs work on integration in areas such as trade, investment promotion, infrastructure, macroeconomic convergence, agriculture and food security, peace and security, social affairs, tourism, industry and planning, and monitoring and evaluation (AU. 2017. *Status of Integration in Africa, SIA V*).

Next, we present the institutional arrangements, in particular the gender infrastructure in place within each REC. In addition, we discuss regional advocacy networks and highlight campaigns on women and girls' rights and gender equality that have taken place in the region. Each REC section ends with a short reflection on the strengths, opportunities and challenges of that particular REC in realising women and girls' rights in the region. Each section also includes a table that provides an overview of the key data. The concluding chapter of the report presents an overarching analysis across the RECs.

Unfortunately, the sections on ECCAS, UMA and CEN-SAD offer less in-depth exploration of these issues. This is for two main reasons: first, this information could not be retrieved and second, these RECs show a lower level of activity. In particular, UMA seems to be largely inactive, with no summits having taking place since 1994. In the case of CEN-SAD, the Revised Treaty has attempted to revive and restructure the REC, but this is still a work in progress. ECCAS is more active, but for this REC we could obtain only very limited information on activities and strategies regarding gender equality and women and girls' rights, despite various efforts to find out more on this.

### Key insights on women and girls' rights and the RECs

ECOWAS, EAC, IGAD, SADC and COMESA have an explicit gender equality and/or women and girls' rights normative framework in place; many of these are recently formulated or have recently been revised (see overview table below).

SADC has a monitoring framework on these commitments; COMESA is preparing one. ECOWAS, EAC and IGAD need to development monitoring frameworks on their gender equality and women and girls' rights commitments.

ECOWAS, EAC, IGAD, SADC and COMESA have a gender infrastructure in place; these play an important role in driving the gender equality and women and girls' rights work, but often are challenged by financial and human resources constraints.

Regional advocacy networks of civil society actors are active at the level of the RECs, most prominently in SADC, EAC and, to some extent, ECOWAS. Civil society engagement is limited in COMESA and underdeveloped in IGAD.

The key opportunities that these five RECs provide in terms of advancing women and girls' rights are (1) harmonisation of legal and policy frameworks in the respective regions, (2) regional coordination of policies, (3) monitoring and accountability on REC commitments and (4) in the case of ECOWAS, the regional Court.

ECCAS has some important initiatives and 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 but there is little information on its activities and strategies.

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.

**Table 4.1. Overview table of gender equality and women's rights commitments of the RECs**

	Normative framework on gender equality/women and girls' rights	Other commitments on the four priority rights areas of this report
ECOWAS	Supplementary Act on Equality of Rights between Women and Men (2015)	<ul style="list-style-type: none"> <li>Dakar Declaration on the Implementation of UNSCR 1325</li> <li>ECOWAS Gender Policy</li> <li>ECOWAS Regional Action Plan for combatting obstetric fistula in West Africa</li> </ul>
EAC	(EAC Gender Equality and Development Bill 2016; awaiting assent from EAC Heads of State)	HIV and AIDS Prevention and Management Act
IGAD	IGAD Gender Policy Framework (2012–20)	Regional Action Plan for Implementation of UNSCRs 1325 and 1820
SADC	SADC Protocol on Gender and Development (2008; amended 2016)	
COMESA	Revised Gender Policy (2016)	<ul style="list-style-type: none"> <li>Social Charter</li> <li>Framework for Multi-Sectoral Programme on HIV &amp; AIDS (2012–15); HIV AIDS policy, and tracking plan</li> </ul>

## 4.1 ECONOMIC COMMUNITY OF WEST AFRICAN STATES (ECOWAS)

ECOWAS was created on 28 May 1975 by the Treaty of Lagos in Nigeria. Its formal aim is to promote economic and political cooperation for growth and development, including social and cultural aspects.<sup>ii</sup> The Lagos Treaty contributed to further integration in the West African region by establishing previously non-existing unified trade relations among the Francophone and Anglophone countries. After the region confronted different types of crises in the 1980s, including civil wars and military coups, the security agenda became one of ECOWAS' top priorities.<sup>iii</sup> ECOWAS is funded 90% by member states.<sup>2</sup>

### ECOWAS: created May 1975

**Member states:** Benin, Burkina Faso, Cape Verde, Côte d'Ivoire, The Gambia, Ghana, Guinea-Bissau, Guinea, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone and Togo



Since its creation, ECOWAS has made important strides by setting up an institutional framework in terms of policies and laws for the promotion of gender equality. One notable example is the specific Provision on Women and Development in the 1993 Revised Treaty.<sup>3</sup> This states that, 'Member States should undertake to formulate, harmonise, co-ordinate and establish appropriate policies and mechanisms, for enhancement of the economic, social and cultural conditions of women.' Art. 63 of the Revised Treaty further urges member states to identify gaps and challenges that are slowing down women's contribution to the development of the region. It also urges member states to take necessary measures such as policies, laws and programmes to ensure women's needs are met to facilitate their full participation in the social, political and economic development of the region.<sup>iv</sup>

### 4.1.1 The Supplementary Act 2015 and the normative framework for gender equality

In 2004, the ECOWAS Gender Development Centre (EGDC), which had just come into existence (in 2003), facilitated the development and adoption of a **Gender Policy**. This seeks to promote the gender parity principle, strengthen institutional frameworks for the promotion and protection of all human rights for women and girls and actively promote the implementation of legislation to guarantee women and girls' rights.

In May 2015, the ECOWAS Heads of State adopted the **Supplementary Act on Equality of Rights between Women and Men for Sustainable Development in the ECOWAS Region**, during the 47th Ordinary Session in Accra, Ghana. The Act came to life after lengthy consultations between member states, CSOs and technical and financial partners on gender equality issues in the region, and is grounded in international as well as continental frameworks, including the Maputo Protocol and the Solemn Declaration. This Act, also called the Supplementary Act 2015, is a binding instrument on the rights of women and men, and is the definitive reference work for gender equality across all countries in the region (see Box 4.1).<sup>v</sup>

<sup>2</sup> ECOWAS has established a community levy of 0.5% tax imposed on goods from non-ECOWAS member states in order to realise and sustain its activities and projects: [www.ecowas.int/doing-business-in-ecowas/vat-customs/](http://www.ecowas.int/doing-business-in-ecowas/vat-customs/)

<sup>3</sup> Other articles that deal with gender equality and women and girls are Arts 3, 61, 64 and 82.

**Box 4.1. Supplementary Act on Equality of Rights between Women and Men for Sustainable Development in the ECOWAS Region (2015)**

The Supplementary Act 2015 guarantees a comprehensive set of individual rights relating to equality of rights between women and men for sustainable development, particularly those of women, girls and boys. The Act addresses economic, social and cultural rights, access to justice, matrimonial and family rights, rights for vulnerable populations (including people with disabilities, widows and widowers) and child protection. It focuses on a wide range of issues including education and training, youth and development, GVAW, health and HIV and AIDS, conflict prevention and management, and peace-building and security.

The Act specifies eight objectives:

- To provide a legal document that harnesses all synergies for the harmonisation of national legislations with international commitments to protect and promote women's rights in West Africa
- To harmonise existing legislation and policies in the ECOWAS region into a single regional instrument that will provide a basis and a common reference for all member states
- To establish, within the framework of the implementation of the commitments made in this Supplementary Act, an agenda and a mechanism for periodic evaluation at both national and regional levels
- To strive to strengthen the economic activities of women, eliminate discrimination and achieve gender equality and equity through the development and effective implementation of laws and policies
- To improve the living conditions of vulnerable groups, mainly women, girls and boys, the elderly and persons living with disabilities, in line with the demands of sustainable development
- To increase the rate of women's participation at all levels of decision-making in the different sectors, particularly in the political sphere, notably the processes of conflict prevention and management and the restoration of peace and security
- To ensure a greater role for women in early warning mechanisms within the ECOWAS region
- To consolidate regional integration and sustainable development through the effective participation of women in the regional integration process

In February 2017, the ECOWAS Commission adopted a **Roadmap for the Implementation of the Supplementary Act 2015**, linking it to the SDGs and Africa's Agenda 2063. The main purpose of the Roadmap is 'to promote the equality of rights and life-chances between men and women by means of the implementation of priority programmes in ECOWAS Member States'<sup>vi</sup> The Roadmap identifies five priorities areas for the next five years that are relevant to gender equality and to member states: (1) organisational and institutional strengthening of gender-aware procedures at national level and of civil society groups, (2) gender and economic empowerment, (3) gender and integrated management of natural resources, (4) good governance, women, peace, security and citizen participation and (5) gender, population and migration. For this framework to be effective, it needs to be translated into concrete action and efforts.

In comparison with other RECs, ECOWAS has made great strides in terms of developing a framework for sustainable peace in response to the various crises taking place in the region. In September 2010, ECOWAS adopted the **Dakar Declaration on the Implementation of United Nations Security Council Resolution (UNSCR) 1325** and its related Regional Action Plan. This calls on member states to:<sup>vii</sup>

- Elaborate a National Action Plan on UNSCR 1325
- Ensure the effective participation of women in peace-building, mediation, security sector reforms, elections and decision-making bodies
- Reinforce measures in place to fight GVAW and sexual violence and adopt new laws and strengthen existing laws to bring to justice perpetrators of sexual violence
- Facilitate the availability and accessibility of humanitarian services to women and girls

Last but not least, and an important reference for this report, is the creation of the **West African Health Organisation (WAHO)** in 1987.<sup>4</sup> The objective of this is defined as 'the attainment of the highest possible standard and protection of health of the people in the sub-region through the harmonisation of the policies of the Member States, pooling of resources, and cooperation with one another and with others for a collective and strategic combat against the health problems of the sub-region'.<sup>viii</sup>

4 The WAHO was established by the Protocol a/p2/7/87 in July 1987. Its headquarters are in Burkina Faso.

### 4.1.2 Gender infrastructure

ECOWAS has put in place a number of institutional mechanisms and structures in a bid to step up gender mainstreaming within the region.<sup>ix</sup> These include the **Gender Commission**, which provides technical expertise on policy formulation and implementation within the ECOWAS community, formally known as the Commission on Human Development and Gender.<sup>5</sup> The **ECOWAS Secretariat Gender Management Team (GMT)** comprises directors of departments. Its Gender Division is its lead agency, and coordinates the Secretariat's gender mainstreaming effort. There is also the in-house ECOWAS Gender Team, which comprises the Gender Focal Points in all relevant departments. These structures are based in Abuja, Nigeria.

In addition to these, there is the **ECOWAS Gender Development Centre (EGDC)**, based in Dakar, Senegal. This is in charge of the implementation, coordination and monitoring of strategies and programmes designed to incorporate gender issues into integration programmes of the ECOWAS member states.<sup>x</sup> The EGDC was created in January 2003 during the 26th Session of ECOWAS Authority and Head of States and Government.<sup>6</sup> It is a multi-purpose regional agency that is 'charged with the responsibility to contribute to gender equality and women's empowerment in the ECOWAS region'. In order to promote gender mainstreaming in all regional integration policies, strategies and programmes, the EGDC initiates and facilitates capacity-building through knowledge-based training and transfer of skills to national gender machineries in the region. It also works on programme development and management for women and men in the public and private sectors.<sup>xi</sup>

The EGDC put in place the EGDC Plan of Action during the period 2005–07 and the EGDC Strategic Plan for 2009–13 around the key priorities of the centre: education and health; economy and trade; governance, representation and decision-making; agriculture and environment; and peace and security.<sup>xii</sup> Activities undertaken through the EGDC include support provided to women and girls suffering from obstetric fistula through a regional action plan<sup>xiii</sup> (see case study 23 in Chapter 8) and scholarships of excellence to young girls in the 15 member states. ECOWAS also provides women with technical and financial support to set up and manage their businesses in the 50 Million African Women Speak (50 MAWS) project.

#### Box 4.2. 50 Million African Women Speak

The 50 MAWS Networking Platform is an initiative of ECOWAS, COMESA and EAC, with funding from the Africa Development Bank (AfDB) in 2016.<sup>xiv</sup> The main objective of the initiative is 'to contribute to the economic empowerment of women through the provision of a networking platform to access information on financial and non-financial services'. It seeks to address the gender-specific challenges women entrepreneurs continue to face, such as lower levels of education and business training and constraints in access to finance and financial services and information. Accessing finance, as well as relevant (non-)financial information, will assist women entrepreneurs to grow and sustain their businesses. The initiative mainly targets younger women, aged 25–54, who have an affinity for technology and social media.

In order to achieve this, the project aims to establish a platform that improves networking and information sharing among women entrepreneurs to network and to access financial services. Main components of the project include:

1. Support for ICT equipment and application
2. Support for platform, related statistical database, content development and targeted services for women entrepreneurs
3. Support for back office/in-country resources and
4. Project management

<sup>5</sup> Decision A/DEC.7/12/03.

<sup>6</sup> Decision A/DEC.16/01.03.

### 4.1.3 Regional advocacy networks

In its bid to promote women and girls' rights across the region, the EGDC has supported the formation and coordination of several regional advocacy networks.

The **Network on Peace and Security for Women in the ECOWAS Region** (NOPSWECO) was launched in July 2009 in Côte d'Ivoire to strengthen the mainstreaming of gender in all security and peace processes in the West Africa region. The network seeks to promote strategic partnerships for women and girls' empowerment and gender equity and equality by bringing together women's organisations in the ECOWAS region. Its purpose is 'to coordinate and optimise the role and initiatives of women in conflict prevention, peacekeeping, security and the promotion of human rights, particularly for women and other vulnerable groups for a sustainable peace in the ECOWAS region'.<sup>xv</sup>

The **West African Network of Young Women Leaders Network** (Réseau Ouest Africain des Jeunes Femmes Leaders, ROAJELF) was created in 2009. This initiative was designed to empower young female leaders and to encourage them to correct the imbalances that exist between men and women in decision-making processes in their various countries. ROAJELF initiates and leads programmes to support the integration and promotion of women and girls and works for the respect and promotion of the rights of young girls.

The **Association of ECOWAS Female Parliamentarians** (ECOFEPA) is a network of women parliamentarians from the West African region. Its aim is to 'create greater collaboration of female parliamentarians and to foster regional integration within the sub-region'.

The creation of the **Mano River Women's Peace Network** (MARWOPNET) in May 2003 was facilitated by ECOWAS in the pursuit of its mission to bring peace in the West African region. The network brings together women's groups organisations from Guinea, Liberia and Sierra Leone in response to the precarious security situation in the region and seeks to ensure the full participation of women and girls at all levels of peace-building and decision-making. MARWOPNET was instrumental in bringing the Head of States of its three countries back to the negotiation table in 2001, when many high-profile actors had failed to do so. In addition, MARWOPNET was one of the mediators and signatories of the 2003 Liberian peace negotiation.<sup>xvi</sup>

### 4.1.4 Strengths, opportunities and challenges

In sum, ECOWAS has both a strong normative framework and the gender infrastructure in place for promoting and securing gender equality and women and girls' rights. In addition, there are important opportunities for promoting gender equality in the Strategic Framework for Strengthening National Child Protection Systems, adopted in October 2017. In this, all 15 West African countries agree to strengthen their legislation and take measures to protect children from violence, abuse and exploitation. Another promising opportunity is Vision 2020, which is planning to move from an 'ECOWAS of States' to an 'ECOWAS of People'. The Vision 2020 Statement is to 'create a borderless, peaceful, prosperous and cohesive region, built on good governance and where people have the capacity to access and harness its resources through the creation of opportunities for sustainable development and environmental preservation'.<sup>xvii</sup>

For the promotion of women and girls' rights in the region, the ECOWAS Court of Justice has particular significance. Individual from member states can file a complaint at the Court if their human rights have been violated either by another individual or by the state (see case study 3 in Chapter 5). An individual can directly bring a claim to the Court without pursuing justice nationally. In February 2018, after years of vagueness, ECOWAS finally clarified that there was no time limit related to filing a complaint in relation to human rights violations.<sup>xviii</sup>

ECOWAS faces challenges in terms of a lack of political will in some member states to follow up on implementation and domestication of the various gender instruments they have signed up to. So far, the mandate of ECOWAS to monitor this has been constrained. There is a need for a regional framework on monitoring gender mainstreaming mechanisms to ensure states are taking the necessary steps to implement the various regional and continental legal commitments.

The realisation of women and girls' rights in the region is challenged by conservative social attitudes and gender norms, and customary law and cultural practices complicate matters on SRHR, harmful practices and GVAW. Further efforts need to address core issues at the heart of society, creating more momentum from the bottom-up and for community-based approaches that confront conflicts and traditional values.

**Table 4.2. ECOWAS: strengths, opportunities and challenges**

Strengths	Opportunities	Challenges
<ul style="list-style-type: none"> <li>• Strong normative framework in the Supplementary Act and accompanying Roadmap</li> <li>• ECOWAS Court of Justice</li> <li>• Active gender infrastructure in place</li> <li>• ECOWAS conflict prevention frameworks and structures for sustainable peace</li> <li>• Active promotion of regional advocacy networks of/with women's organisations</li> </ul>	<ul style="list-style-type: none"> <li>• Strategic Framework for Strengthening National Child Protection Systems in October 2017</li> <li>• 50 MAWS platform, to promote voice, capacity and agency of women</li> <li>• ECOWAS Regional Action Plan of Action for Combatting Obstetric Fistula in West Africa</li> <li>• ECOWAS Vision 2020</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of political will in some member states to implement and domesticate gender equality instruments</li> <li>• Weak mandate to monitor implementation or domestication of gender equality legal instruments</li> <li>• Financial and human resources constraints for EGDC</li> <li>• Political instability and crises in the region</li> </ul>

**Table 4.3. ECOWAS: key documents and institutional infrastructure for women's rights and gender equality**

<b>Mandate and history</b>	
28 May 1975	Treaty of Lagos
24 July 1993	Revised Treaty
January 2003	Decision A/DEC.16/01.03 on the Creation of ECOWAS Gender Development Centre
June 2010	ECOWAS Vision 2020 – Towards a Democratic and a Prosperous Community
<b>Women and girls' rights/gender equality commitments</b>	
1993	Article 63 of the Revised Treaty
2004	Adoption of the ECOWAS Gender Policy
2005	Adoption of the Gender Management System
2010	Adoption of the ECOWAS Regional Action Plan for the Implementation of UNSCRs 1325 and 1820
2015	ECOWAS Policy for Gender Mainstreaming in Energy Access
2015	Supplementary Act A/SA.02/05/15 on Equal Rights between Women and Men for Sustainable Development.
2015	ECOWAS Regional Action Plan of Action for Combatting Obstetric Fistula in West Africa
2017	Roadmap of ECOWAS Supplementary Act A/SA.02/05/15 on Equal Rights Between Women and Men for Sustainable Development
<b>Gender infrastructure (institutional)<sup>7</sup></b>	
ECOWAS Gender Commission	Established in 2003 and provides technical expertise on policy formulation and implementation within ECOWAS
ECOWAS Secretariat Gender Management Team	Comprises directors of departments
Gender Division	Coordination of Secretariat's gender mainstreaming efforts; also responsible for coordinating youth and children activities in the Secretariat
Gender Focal Points in different departments	Set up at the Executive Secretariat headquarters in Abuja to engender plans, policies and programmes in every department; comprises focal points from critically relevant departments within the Secretariat
ECOWAS Gender Development Centre	Created in 2003, <sup>8x</sup> in charge of implementation, coordination and monitoring of strategies and programmes designed to incorporate gender issues into integration programmes of ECOWAS member states <sup>8x</sup>

<sup>7</sup> E.g. women's parliament, gender policy unit, special rapporteur/ambassador.

## 4.2 EAST AFRICAN COMMUNITY (EAC)

The EAC is a regional intergovernmental organisation that was initially established in 1967. It became defunct in 1977 and was re-established in 1999 via the adoption of a new treaty: the Treaty for the Establishment of the East African Community (2000) ('the EAC Treaty'). The EAC is both state- and donor-funded. Its main mandate is that of economic and social integration, the achievement of which should take into cognisance human rights and gender equality.

**EAC: created in 1977 (and re-established 1999)**

**Member states:** Burundi, Kenya, Rwanda, South Sudan, Tanzania and Uganda

The **EAC Treaty** provides that the *fundamental principles* include 'good governance including adherence to the principles of democracy, the rule of law, accountability, transparency, social justice, equal opportunities, gender equality, as well as the recognition, promotion and protection of human and peoples' rights in accordance with the provisions of the African Charter on Human and Peoples' Rights' (Art. 6.2). The EAC's *operational principles* equally require states 'to abide by the principles of good governance, including adherence to the principles of democracy, the rule of law, social justice and the maintenance of universally accepted standards of human rights' (Art. 7.2).

More specifically, the entry point for women's rights promotion within EAC work is found among the objectives of the Community in Art. 5(3)(e) of the EAC Treaty, which requires the EAC to ensure 'the mainstreaming of gender in all its endeavours and the enhancement of the role of women in cultural, social, political, economic, and technological development'. Further, Art. 121 calls on states to recognise and enhance the role of women and girls in socioeconomic development through legislative and other measures on participation in decision-making; addressing harmful practices and discrimination; and awareness creation aimed at countering prejudices against women and girls, among others. Art. 122 makes a similar call with regard to the role of women in business.



### 4.2.1 EAC Gender Equality and Development Bill and normative framework on gender equality

The EAC Treaty provides a strong normative framework for the promotion of women and girls' rights. Further to this, the finalisation of the **draft Gender Policy** together with the enactment of the EAC Gender Equality and Development Bill 2016 will present the greatest opportunity to strengthen women and girls' rights protection in the EAC. The Policy will offer clear modalities and strategic priority areas and guide the EAC on the planning, implementation, monitoring and evaluation of programmes to address women and girls' rights issues in the region.

The **EAC Gender Equality and Development Bill 2016**, once it becomes law, will be binding on states and therefore will create a greater imperative for gender mainstreaming and for states to harmonise and align their laws and programmes across the region. The alignment of the EAC Gender Equality and Development Bill 2016 with the Maputo Protocol—such as in the definition of GVAW—represents a useful step towards harmonisation, as all but one of the EAC member states have ratified the Maputo Protocol. Burundi has not yet ratified the Protocol but has signed it, which carries along an obligation not to undermine it.<sup>xxi</sup>

**Box 4.3. EAC Gender Equality and Development Bill 2016**

The EAC Gender Equality and Development Bill has been passed by the East African Legislative Assembly (EALA)<sup>8</sup> and is awaiting assent from Heads of State. Its objectives include to realise the EAC's commitment to gender equality as set out in the EAC Treaty, to promote non-discrimination as a process of governance and to harmonise gender equality commitments so as to ensure women and girls' rights are uniformly protected across the sub-region. The legislation prohibits **discrimination** and calls for various legislative, programmatic and other measures to be implemented in order to realise gender equality.

The legislation prohibits **SGBV** and follows the definition of the Maputo Protocol. Its provisions are drafted within a human rights-based approach and relate SGBV to the protection of women and girls' various rights, including the right to life, dignity, integrity and security of the person. All forms of exploitation and cruel and inhuman degrading treatment are prohibited. **Harmful practices**, including SGBV and FGM, early and forced marriage, widow inheritance and albino and child sacrifices, are prohibited. States are required to enact laws to protect women and girls in relation to human trafficking and sexual exploitation and notably to enact specific penal laws against rape during conflict: sexual violence during conflict is considered a crime against humanity. It further calls for the harmonisation of SGBV penal laws across the EAC countries and for ratification, domestication and implementation of the Maputo Protocol.

On **health**, the legislation has in place provisions covering the reduction of maternal mortality and a call for the development of policies and programmes for SRHR. It also calls for the enactment of gender-sensitive laws, policies and programmes for the management of HIV and AIDS.

On **peace and security**, there is recognition of the need for special protection for women and girls during conflict. The provisions also include measures to ensure women have equal representation in conflict resolution and peace-building processes. The legislation also highlights interrelationships with UNSCRs, such as 1325 on Women, Peace and Security.

Other provisions in the legislation relate to the requirement to mainstream gender in media policies programmes and the right to free and quality education for children. Also provided for is inclusion of women and girls in power and decision-making, economic empowerment, agriculture and food security, land rights, trade, environmental management and special measures for marginalised groups.

In terms of more specific rights areas, the **HIV and AIDS Prevention and Management Act** sets out to regulate an effective response to HIV across the region from a rights-based approach. In addition, the Act classifies women and girls as a vulnerable or most at-risk population and highlights their rights to information, equality, non-discrimination and protection from all forms of violence, among other contextualised rights (see also case study 28 in Chapter 8). A **Sexual and Reproductive Health Rights Bill** has been drafted 2017, in recognition of the AU Maputo Plan of Action and ICPD commitments. It is currently waiting for its second and third reading in the EALA.

**4.2.2 Gender institutional arrangements**

The EAC Secretariat has designated a **Gender Department** to lead on the mainstreaming of gender-related issues. In addition, the Department is charged with overseeing the inclusion of children, youth, persons with disabilities and the elderly and further tasked with matters of community development. This huge spread of issues undermines the effectiveness of the gender mainstreaming project. The Department in fact comprises only one officer; the limited human and financial resources allocated seem to be at a mismatch with its broad mandate.

The budget of the EAC is internally sourced through member state contributions, with a significant part supported by development partners. However, in practice, states are often late or non-compliant in disbursing their contributions, thereby hindering operations.<sup>9</sup> This general challenge in finances is particularly crippling for the implementation of gender activities. Women and girls' rights work is yet to attract prioritisation, and not deemed worthy of independent funding, under the explanation that gender issues will be mainstreamed in all other endeavours.

<sup>8</sup> The core mandate of the EALA relates to the passing of laws, oversight and ensuring representation of state parties and their interests. Once its bills are assented to by the Heads of States they become law and legally binding.

<sup>9</sup> For instance, as at September 2017, only Kenya had fully met its payment obligations. See Ligami, C. (2017). 'Cash-Strapped EAC Raids Reserve Funds'. *The East African*, 4 September; Karuhanga, J. (2017). 'Council of Ministers Says No to Increase in 2017/18 EAC Budget'. *The New Times*, 8 May.

### 4.2.3 Regional advocacy networks

There are a number of regional-level advocacy networks working on human rights issues. These are largely concerned with enhancing the space for participation at the EAC and influencing policies, laws and implementation on various rights areas including women and girls' rights. These regional actors have made significant contributions from a rights perspective, among others in the piloting of the Barometer. Many cite the development and passing of the HIV and AIDS Prevention and Management Act as a civil society-led initiative and victory. The Gender Equality and Development Bill is equally civil society-driven.

The **Eastern African Sub-Regional Support Initiative for the Advancement of Women (EASSI)** has had a leading role in the development of and advocacy for the Gender Equality and Development Bill. EASSI is a sub-regional CSO working on women and girls' rights issues in the Eastern African region across eight countries.<sup>xxii</sup> Further, in terms of monitoring the impending gender equality and development legislation as well as the general gender responsiveness of EAC member states, EASSI in partnership with national focal points has developed an **EAC Gender Equality and Development (GED) Barometer**.

#### Box 4.4. The EAC Gender Equality and Development Barometer

The GED Barometer is a tool to track implementation of the EAC's gender equality and development legislation, once it is in effect. It also has utility beyond the legislation and can therefore be utilised prior to its passing. The Barometer is intended to be used by member states to monitor, measure and document the progress of gender equality in key result areas. This will further facilitate a regional conversation on strategies for the enhancement of substantive gender equality and sustainable development. The result areas include legal and state obligations to protect human rights; power and decision-making; GVAW; SRH and HIV and AIDS; economic justice; employment, land, trade and agriculture; education; peace and security; media; climate change and environmental management; and extractive industries.<sup>xxiii</sup>

The GED Barometer undertakes documentation from three perspectives, which enable it to give a holistic view of gender responsiveness in the sub-region.

1. An *index* presenting the statistics on the various result areas
2. A *scorecard* capturing information sourced from EAC residents/respondents using a questionnaire<sup>10</sup>
3. *Case studies* highlighting lessons learnt and areas for improvement

The Barometer is intended to have various impacts. To begin with, it enhances evidence-based advocacy using empirical data, beyond reliance on anecdotal evidence and rhetoric. It contributes to increased awareness among rights-holders and human rights advocates, who will accordingly be in a stronger (more informed) position to engage their respective governments. At the national level, the Barometer has great potential to further facilitate gender-responsive budgeting, planning and advocacy. The comparisons on compliance are also likely to enhance compliance with commitments among member states.

Other regional advocacy networks include the **East African Law Society (EALS)**.<sup>xxiv</sup> This regional bar association concerns itself with professional development of its members as well as advocacy and public interest litigation on human rights issues within the East African region. Its projects include those on women and girls' rights issues. EALS has observer status before the EAC and access to many institutions and processes. The **East African Civil Society Organisations' Forum (EACSOFF)**<sup>xxv</sup> is an umbrella body that provides a platform for the representation and participation of East African CSOs with the EAC. Its work areas are aligned with EAC working areas, including gender equity and equality, and it has been very involved in the EAC Gender Equality and Development Bill and the GED Barometer.

The **East African Health Platform (EAHP)**<sup>xxvi</sup> is mandated by the EAC Treaty to bring together the voices of non-state actors from civil society, the private sector and faith-based organisations on health as part of the EAC's consultative dialogue framework of engagement. It does this primarily through advocacy with a focus on reproductive health rights issues, HIV and sexually transmitted infections (STIs). The **Eastern Africa National Networks of AIDS Service Organisations (EANNASO)**<sup>xxvii</sup> is a regional network comprising national networks of AIDS service organisations. It works with the EAC with a view to influencing policies on HIV response. EANNASO was at the forefront of efforts that led to the passing of the EAC HIV and AIDS Prevention and Management Act 2012.

Towards creating an enabling environment for the participation of advocacy actors, the EAC adopted the **Consultative Dialogue Framework (CDF)**. This is grounded in the EAC Treaty, which envisages that other actors be consulted and contribute to the development agenda. The CDF creates structured avenues for dialogue and consultation for CSOs, the private sector and other interest groups with the EAC Secretariat as well as states. One example of this is the Secretary General's Forum (SG's Forum). For various civil society actors, the annual SG's Forum is a platform to interface with the Secretariat, dialogue on various issues and make recommendations. Aside from this, the EAC Secretariat has not yet engaged in any women and girls' rights campaigns such as those seen at the regional level, for instance the AU Campaign to End Child Marriage. There may be room for such an engagement in collaboration with regional-level advocacy actors.

<sup>10</sup> Eventually, it is envisaged that the scorecard will reach and be informed by 10% of the population in the EAC countries.

#### 4.2.4 Strengths, opportunities and challenges

The normative framework of the EAC on gender equality and women and girls' rights is potentially strong, in anticipation of the formal adoption of the Gender Equality and Development Bill. There are also frameworks in place or developed for specific areas of women and girls' rights, such as HIV legislation. The binding nature of EAC legislation offers leverage for harmonisation and implementation in the region. Moreover, the EAC has in place an **East African Court of Justice (EACJ)** that has in the past adjudicated on human rights issues. The EACJ is charged with the interpretation of and compliance with the application of the EAC Treaty. It can hold states accountable for violation of laws and presents an opportunity for holding states to account for the violation of women and girls' rights.

With its CDF, the EAC is the only REC that speaks to the consultation of civil society in an institutionalised, as opposed to *ad hoc*, manner. The CDF both is envisaged in the EAC Treaty and has been provided for within EAC structures. In combination with the presence of strong regional networks working on women and girls' rights issues, with a dedicated advocacy programme on the EAC's work, this has contributed to significant involvement of civil society in driving legislation within the EAC (HIV and AIDS Act, Gender Bill, SRHR Bill). CSOs have a strong role to play in influencing and driving the women and girls' rights agenda here.

Gender equality and women and girls' rights issues are not yet prominent at the EAC in practice. This may owe to a lack of both political will and strong guidance on gender mainstreaming. This also has to be understood in the stronger emphasis of the EAC on economic interests than on social and human rights issues. At the Secretariat, the mainstreaming of gender that is envisaged by the Treaty is yet to be realised, with women and girls' rights not prioritised. Funding issues in light of unpaid state dues and insufficient resource mobilisation have in turn affected the implementation of gender-related interventions. These challenges equally present opportunities for growth as the EAC has in place structures to deal with all actors ranging from states to civil society and private actors.

Taking into account current human resource constraints and financial challenges, the greatest opportunity here lies in the planning, gender mainstreaming and genuine implementation of women and girls' rights issues within all mandates of the institutional infrastructure. In this regard, the pending draft Gender Policy may prove critical.

**Table 4.4. EAC: strengths, opportunities and challenges**

Strengths	Opportunities	Challenges
<ul style="list-style-type: none"> <li>• Alignment with existing international and continental commitments, contributing to harmonisation</li> <li>• Binding nature of EAC legislation, contributing to harmonisation</li> <li>• Both comprehensive gender equality frameworks and specific ones relating to HIV and AIDS and SRHR in place or in development</li> <li>• Institutionalisation of role and consultation of CSOs in CDF</li> <li>• Existence and active engagement of regional networks on women and girls' rights issue in EAC</li> <li>• Significant involvement of CSO in driving legislation within the EAC (HIV and AIDS Act, Gender Bill, SRHR Bill), with a strong role in influencing and driving the women and girls' rights agenda</li> </ul>	<ul style="list-style-type: none"> <li>• Gender Equality and Development Bill 2016, which is awaiting assent</li> <li>• The EACJ offers an opportunity for holding states to account for violation of women's rights</li> <li>• Focus on the role of women in business and socioeconomic development can serve as an entry point for advocacy on SRHR issues</li> </ul>	<ul style="list-style-type: none"> <li>• Practice on gender equality and women and girls' rights issues is not yet prominent</li> <li>• Human resource capacity constraints, combined with broad mandate for gender department</li> <li>• Funding constraints</li> </ul>

Table 4.5. EAC: key documents and institutional infrastructure for women's rights and gender equality

<b>Mandate and history</b>	
2000	Treaty for the Establishment of the EAC
2011	4th EAC Development Strategy (2011/12–15/16)
2016	EAC Vision 2050
TBA	5th EAC Development Strategy ( <i>in development</i> )
<b>Women and girls' rights/gender equality commitments</b>	
2011	EAC Framework for Gender and Social Development Outcome Indicators for EAC Development Strategy (2011–16)
2012	EAC Strategic Plan for Gender, Youth, Children, Persons with Disability, Social Protection and Community Development (2012–16) ( <i>renewal in progress</i> )
2012	EAC HIV and AIDS Prevention and Management Act
2012	EAC Consultative Dialogue Framework
2013	Guidelines and Checklists for Gender Mainstreaming in EAC Organs and Institutions
2013	Gender Mainstreaming Strategy for EAC Organs and Institutions
2013	EAC Youth Policy
2016	EAC Regional Health Policy
2016	EAC Integrated Reproductive Maternal, Newborn, Child and Adolescent Health Policy
2016	EAC Integrated Reproductive Maternal, Newborn, Child and Adolescent Health Policy Guideline (2016–30)
2016	EAC Integrated Reproductive Maternal, Newborn, Child and Adolescent Health Strategic Plan (2016–21)
2016	Gender Equality, Equity and Development Bill ( <i>passed by EALA, awaiting assent by Heads of State</i> )
2016	EAC Gender Equality and Development Barometer ( <i>pilot and civil society-led</i> )
TBA	Draft Gender Policy ( <i>in development</i> )
TBA	EAC Sexual and Reproductive Health Rights Bill (2017)
<b>Gender infrastructure (institutional)</b>	
Council of Ministers	Policy-making organ of the EAC, determines development and implementation of development strategies
Sectoral Council on Gender, Youth, Children, Social Protection and Community Development	Conceptualising and mainstreaming cross-cutting issues, including gender, in EAC policies and programmes
EAC Secretariat—Gender, Community Development and Civil Society Sector	Guides implementation and domestication of gender-related policies, laws and standards in EAC and states
East African Health Research Commission	Advisory, research and knowledge generation institution of the EAC on health-related matters
East African Legislative Assembly	The legislative organ of the EAC
East African Court of Justice	The key judicial organ of the EAC
<b>Regional and/or REC-level CSO networks</b>	
Eastern African Sub-Regional Support Initiative for the Advancement of Women	
East African Law Society	
East African Civil Society Organisations' Forum	
East African Health Platform	
Eastern Africa National Networks of AIDS Service Organisations	

### 4.3 INTERGOVERNMENTAL AUTHORITY ON DEVELOPMENT (IGAD)

IGAD was established in 1996. It succeeded the Intergovernmental Authority on Drought and Development (IGADD), founded in 1986. The mandate of IGAD is mainly coordination of programmes and projects, harmonisation of policies and strategies and capacity-building to add value to the efforts of member states in the areas of development. The operational cost of IGAD is covered by member states' contributions, while most programmes and projects are implemented through mobilisation of funds from development partners.

**IGAD: created 1996 (IGADD in 1986)**

**Member states:** Djibouti, Eritrea, Ethiopia, Kenya, Somalia, South Sudan, Sudan and Uganda

*(Eritrea is presently not an active member)*

The Agreement Establishing IGAD does not have a specific provision on women and girls' rights or gender issues. That said, a *draft IGAD Treaty* has been developed and is in the final stages before policy organ endorsement. This contains a provision on the role of women in development and will therefore serve as an express entry point for the promotion of women and girls' rights endeavours in IGAD. IGAD has nonetheless been engaged in the promotion of women and girls' rights and gender equality. Gender is articulated as a cross-cutting theme in all priority programmes and projects as indicated in the overall *IGAD Strategy*.



#### 4.3.1 Gender equality and women's empowerment normative framework

A legal and policy framework supports the women and girls' rights work at IGAD level. In 2004, the IGAD Gender Policy and Strategy was formulated and launched. This has been revisited and updated into a new **Gender Policy Framework for 2012–20**. This updated framework focuses on 'facilitating the mainstreaming of gender perspectives into IGAD's policies, strategies, programmes, projects and activities to make them gender responsive and to contribute to achieving sustainable socio-economic development in the region'.<sup>xxviii</sup> It underscores gender inequality as a cross-cutting development challenge in all IGAD's priority areas of interventions, and notes pervasive gender inequalities in access to education, information, employment, credit, land, inputs and decision-making power in all IGAD member states. 'More often than not, these inequalities reflect a female disadvantage and have in the past been viewed as either human rights or social policy issues with little impact on overall economic performance.'<sup>xxix</sup>

The Gender Policy Framework identifies eight thematic areas, which, while not exhaustive, reflect IGAD's strategic priority issues. Some relate to this report's focus areas. Gender and health is one of the themes, listing SRHR, HIV and AIDS, maternal morbidity and mortality, GBV and harmful traditional practices as some of its strategic objectives. Priority issues under gender, peace and security relate to women and girls' involvement in conflict prevention, management and resolution. In practice, it appears that this latter theme has received the greatest focus. The Gender Policy Framework is complemented by a **Gender Strategy 2016–20**.

Two other important regional commitments are the **Regional Action Plan for Implementation of the UNSCRs 1325 and 1820**, and the **Regional Strategy for Higher Representation of Women in Decision-Making Positions**. A number of countries in IGAD have been fractured by conflict, therefore the former commitment is commendable. The UNSCRs urge participation of women and the incorporation of gender perspectives in all peace and security efforts and also condemn the use of sexual violence as a tool of war. These instruments are further buttressed by regional and global frameworks and initiatives on gender equality and women and girls' empowerment.<sup>11</sup>

Moreover, IGAD has developed **Gender Institutional Technical Documents** for use internally, to guide the work of the Secretariat: the Workplace Gender Policy, Gender Management System Handbook and Customised Gender Mainstreaming Tools/Guidelines. These are informed by international and continental commitments and IGAD member state policies. The Secretariat reports that implementation plans and monitoring and evaluation indicators accompany these documents.

Overall, while IGAD advocates for its member states to be guided by the normative framework it has established by way of its various policies and strategies, these are not binding and there are no accountability mechanisms to obligate states to incorporate them. In addition to its own normative standards, IGAD monitors the adoption and ratification of international and continental treaties by its member states.

<sup>11</sup> These include among others the Maputo Protocol; the Solemn Declaration on Gender Equality; the AU Gender Policy; Africa's Agenda 2063; AWD 2010–20; CEDAW; and the Beijing Declaration and Platform for Action.

### 4.3.2 Gender institutional arrangements

IGAD's **Gender Affairs Programme** has been institutionalised at the IGAD Secretariat since 2005 and one officer oversees its work. An IGAD Gender Policy and Strategy that ran from 2004 to 2008 guided the programme. In terms of the organogram, the Gender Affairs Programme comes under IGAD's Executive Secretary's Office. Its main mandate is to mainstream gender within IGAD, particularly the Technical Documents mentioned above. The programme also trains and advocates for other programmes within IGAD to endeavour to incorporate gender issues in their work. The programme aims to align its policies and strategies with those of the AUC while also urging member states to harmonise their policies with those of IGAD.

IGAD's relations with **regional advocacy networks** are underdeveloped. Yet the Gender Affairs Programme works closely with a range of stakeholders, including member states, and particularly women/gender ministries, women parliamentary caucuses of national parliaments, CSOs and women/gender centres within universities. IGAD also works closely with women/gender units of the AUC, UNECA, UN Women and other relevant organisations. They are all engaged in order to drive the gender equality and women and girls' empowerment agenda at different levels. In addition, IGAD reportedly engages its partners at member state and regional level and from civil society and the academic community whenever it has forums.

IGAD plans to establish an **IGAD Women and Peace Forum** in 2018 to coordinate women, peace and security activities. This will draw its members from state nominees as well as CSOs. Their role is to oversee and lobby for the implementation of UNSCRs on women, peace and security. With respect to peace and security, IGAD was instrumental in facilitating the Comprehensive Peace Agreement between the then-Sudan People's Liberation Movement and the Government of Sudan in 2005. The Gender Affairs Programme at the time had interventions in Sudan, among other countries, to nurture women's economic empowerment and train female mediators.

IGAD has in the past had and continues to hold topical **campaigns** that emphasise training. It is currently engaged in trainings around UNSCRs 1325 and 1820, and the *Unite Campaign to End Violence Against Women and Girls*.<sup>12</sup> The actors in these campaigns are women/gender ministries, women parliamentary caucuses, CSOs and academia.<sup>13</sup>

### 4.3.4 Strengths, opportunities and challenges

IGAD's normative framework on gender equality and women and girls' empowerment is aligned with existing international and continental norms and frameworks. Since member states have multiple commitments, this harmonisation is laudable, enhances chances of compliance and reduces inconsistencies in the application of norms. The normative framework targets both the IGAD member states and the working of the IGAD Secretariat. There is a consistent focus on women, peace and security issues, which responds to the particular challenges of the region. This is backed up in policy by way of the Regional Action Plan for Implementation of UNSCRs 1325 and 1820 and in practice by IGAD's campaigns and networks, particularly the Women and Peace Forum.

The non-binding nature of the normative framework on gender equality poses a challenge, as does the lack of accountability mechanisms. Other challenges concern the gender infrastructure, which is present but weak, with only one officer having to respond to a large gender mandate. This ostensibly limits the impact the programme has. IGAD's focus on gender mainstreaming does not always translate into practice, with departments not including gender perspectives as much as they should in their interventions. Furthermore, the assertion that gender is a cross-cutting issue makes it difficult to direct funds to standalone gender equality activities. This also hampers IGAD's women and girls' rights work visibility within the region. More broadly, poor resource mobilisation limits the programmatic interventions that can be undertaken to foster gender equality and women and girls' empowerment. This also constrains the visibility of IGAD's work in this field. Finally, IGAD's networks in this regard are underdeveloped. Stronger ties, particularly with regional CSO, could be beneficial here.

<sup>12</sup> This campaign is not an IGAD-initiated campaign. It originates from the UN and is a multi-year effort aimed at ending violence against women and girls.

<sup>13</sup> In the past, IGAD has also worked on the UNSCRs on women, peace and security in order to build the capacity of member states in reconciliation and peace-building. There has also been a campaign in South Sudan focused on peace-building and reconciliation.

**Table 4.6. IGAD: strengths, opportunities and challenges**

Strengths	Opportunities	Challenges
<ul style="list-style-type: none"> <li>• Alignment with existing international and regional norms and frameworks, to promote harmonisation</li> <li>• Gender Policy Framework in place</li> <li>• Specific framework on women in decision-making positions</li> <li>• Internally focused technical documents on gender mainstreaming developed and in place</li> </ul>	<ul style="list-style-type: none"> <li>• Consistent focus on women, peace and security issues (including Regional Action Plan, main theme in the Gender Policy Framework and actions in practice)</li> <li>• Women, Peace and Security Forum</li> </ul>	<ul style="list-style-type: none"> <li>• Normative framework is non-binding and lacks accountability mechanisms</li> <li>• Institutional infrastructure is weak in terms of human resource capacity</li> <li>• Low level of gender mainstreaming in practice by other IGAD departments</li> <li>• Poor resource mobilisation (further limited by gender mainstreaming approach)</li> <li>• Low visibility of IGAD's women and girls' rights work visibility</li> <li>• Underdeveloped networks with CSOs</li> </ul>

**Table 4.7. IGAD: key documents and institutional infrastructure for women's rights and gender equality**

<b>Mandate and history</b>	
1996	Agreement Establishing IGAD
Draft	Draft IGAD Treaty
<b>Women and girls' rights/gender equality commitments</b>	
2012–20	Gender Policy Framework
2016–20	Gender Strategy
	Strategy for Higher Representation of Women in Decision-Making Positions
	Regional Action Plan for Implementation of UNSCRs 1325 and 1820
	IGAD Workplace Gender Policy
	IGAD Gender Management System Handbook
	Customised Gender Mainstreaming Tools/Guidelines
<b>Gender infrastructure (institutional)</b>	
Office of the IGAD Executive Secretary	Managing the daily affairs of the IGAD Secretariat, consulting with government officials of IGAD member states and representatives of development partners and representing IGAD at various international and regional forums
Gender Affairs Programme	Established within the Office of the Executive Secretary, with main mandate to mainstream gender within IGAD
<b>Regional and/or REC-level CSO networks</b>	
Women Peace Forum	

## 4.4 SOUTHERN AFRICAN DEVELOPMENT COMMUNITY (SADC)

The Southern African Development Coordination Conference (SADCC), established in 1980 in Lusaka, Zambia, was formed to advance the cause of national political liberation in Southern Africa through effective coordination and utilisation of the specific characteristics and strengths of each country and its resources. In 1992, Heads of Government of the region agreed to transform SADCC into the SADC, with the focus on integration for economic development. SADC funding is 9% from member states and 91% from international cooperating partners.<sup>xxx</sup>

**SADC: created in 1992 (SADCC 1980)**

**Member states:** Angola, Botswana, Comoros<sup>14</sup>, Democratic Republic of Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland<sup>15</sup>, Republic of Tanzania, Zambia and Zimbabwe



While the SADC Treaty focuses primarily on regional integration towards economic development, it provides a strong basis for women and girls' rights and gender equality as part of the development agenda. Art. 1 declares that one of its objectives is to mainstream gender in the process of community building. Art. 6.2 prohibits discrimination against any person on the basis of, among others, sex or gender. Art. 12 establishes a number of sectoral committees charged with overseeing activity in the core areas of integration, with gender and social affairs identified as one such area.

### 4.4.1 SADC Protocol on Gender and Development and normative framework for gender equality

To further its gender equality objective, the **SADC Declaration on Gender and Development**, passed in 1997, calls on member states to increase women's participation in politics and decision-making to at least 30% by 2005; reform all discriminatory laws and social practices; promote women's full access to and control over productive resources such as land, livestock and markets; address, prevent and eradicate violence against women and children; promote women and girls' access to education; and cultivate and promote a culture of gender equality and respect for the human rights of women and girls in the SADC region. The Declaration was amended shortly after, in 1998, via the **Addendum to the SADC Declaration on Gender and Development on the Prevention and Eradication of Violence against Women**.

Already in 2003, the **SADC Gender Policy** was passed to provide a framework for achieving the aims of the Declaration. Building on international, continental and regional frameworks for women and girls' human rights, its goal is to provide guidelines for institutionalising and operationalising gender as a key development strategy for achieving gender equality, equity and women and girls' empowerment within SADC member states and the region as a whole. One of its guiding principles is that 'Women's rights are human rights.'

Because of the non-binding nature of the 1997 Declaration, there was a need to put in place a legally binding instrument. In 2008, the **SADC Protocol on Gender and Development** was adopted, as the legal and policy framework for gender equality and women and girls' rights. Six of its objectives focus on women and girls' rights and gender equality, and it takes cognisance of the Maputo Protocol. Apart from its binding nature, the SADC Gender Protocol is unique in that it translates its women and girls' rights and gender equality provisions into 28 concrete targets, to be reached by 2015. Botswana is the most recent country to ratify the Protocol, in May 2017, leaving Mauritius as the only country in SADC that has not ratified it. The Protocol also sets out to 'strengthen, monitor and evaluate the progress made by members states towards reaching the targets and goals set out in the Protocol' (Art. 3).

<sup>14</sup> Comoros became a member of SADC in 2017: [www.sadc.int/news-events/news/union-comoros-becomes-16th-sadc-member-state/](http://www.sadc.int/news-events/news/union-comoros-becomes-16th-sadc-member-state/)

<sup>15</sup> The report uses Swaziland but notes that very recently the country has been renamed the Kingdom of eSwatini: <https://edition.cnn.com/2018/04/20/africa/swaziland-eswatini-africa-monarchy-intl/index.html>; [www.theguardian.com/world/2018/apr/19/swaziland-king-renames-country-kingdom-of-eswatini](http://www.theguardian.com/world/2018/apr/19/swaziland-king-renames-country-kingdom-of-eswatini)

**Box 4.5. SADC Protocol on Gender and Development (2008, amended 2016)**

The SADC Protocol on Gender and Development brings together global and continental commitments to women and girls' rights and gender equality in one instrument that is used to enhance accountability. This Protocol has as one of its objectives to eliminate discrimination and achieve gender equality and equity through the development and implementation of gender-responsive legislation, policies, programmes and projects as well as harmonising the implementation of various global, continental and regional instruments on gender equality and equity (Art. 3). *Discrimination* is defined as 'any distinction, exclusion or restriction which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise, by any person of human rights, and fundamental freedoms in the political, economic, social, cultural, civil or any other field' (Art. 1).

The Protocol focuses on 11 key thematic areas: Constitutional and Legal Rights; Governance (Representation and Participation); Education and Training; Productive Resources and Employment; Economic Empowerment; GBV; Health (SRH and Reproductive Rights); HIV and AIDS; Peace-Building and Conflict Resolution; Media, Information and Communication; and Implementation.

The Protocol defines GBV as 'all acts perpetrated against women, men, girls and boys on the basis of their sex which cause or could cause them physical, sexual, psychological, emotional or economic harm, including the threat to take such acts, or the 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 or other forms of conflict' (Art. 1). It defines SRHR as 'universal human rights relating to sexuality and reproduction, sexual integrity and safety of the person, the right to sexual privacy, the right to make free and responsible reproductive choices, the right to sexual information based on scientific enquiry, and the rights to sexual and reproductive health care' (Art. 1).

The Protocol was amended in 2016 to align it with the SDGs, Agenda 2063 and Beijing+20. The Gender Alliance (see below) was an important driver of this review of the Protocol.<sup>16</sup> Some of these amendments directly relate to the four priority rights are of this report, in particular with respect to the girl child and to gender-based violence (GBV).<sup>17</sup> A key amendment concerns Article 26, which is a stand-alone provision, on 'Health, sexual reproductive health and reproductive rights', whereas it was previously a broader health article. This refers explicitly to eliminating, rather than reducing, maternal mortality, and also provides for policies and programmes on women and men's mental, sexual and reproductive health, with a reference to ICPD and the Beijing Platform for Action. By 2017, 10 countries had signed the agreement amending the Protocol (Angola, Botswana, Democratic Republic of Congo (DRC), Lesotho, Madagascar, Mozambique, Swaziland, Tanzania, Zambia and Zimbabwe) and 11 countries had ratified it (Angola, Lesotho, Malawi, Mozambique, Namibia, Seychelles, Swaziland, South Africa, Tanzania, Zambia and Zimbabwe).

Moreover, the Revised Regional Indicative Strategic Development Plan (2015–20) establishes gender and development as one of the critical cross-cutting issues in all SADC programmes. Other key documents include the Sexual and Reproductive Health Strategy for the SADC Region (2006–15); the SADC Workplace Gender Policy; the 10-year SADC Strategic Plan of Action on Combating Trafficking in Persons, especially Women and Children (2009–19); and the SADC Gender Monitor/Framework for Achieving Gender Parity in Political and Decision-Making Positions by 2015.

<sup>16</sup> In 2014, the Committee for Ministers in Charge of Women/Gender Affairs agreed to review the Protocol and in 2015 ministers agreed the Protocol should be aligned with the SDGs, the Beijing+20 Review and Agenda 2063.

<sup>17</sup> Art. 11 (in Part II) on 'The Girl and Boy Child' provides for concrete measures to prevent and eliminate violence, harmful practices, child marriage, teenage pregnancies, genital mutilation and child labour. Art. 20 (in Part VI) more specifically refers to harmful social and cultural practices, such as child marriage, forced marriage, teenage pregnancies, slavery and FGM. It also explicitly refers to trafficking in persons. Other amendments concern Art. 14 (on Gender Equality in Education); Art. 16 (on Multiple Roles of Women); Art. 17 (on Economic Empowerment); Art. 19 (on Equal Access to Employment and Benefits); Art. 29 (on Gender in Media, Information and Communication); Art. 31 (on Gender and Climate Change); and Art. 35 (on Implementation, Monitoring and Evaluation). For the updated SADC Protocol on Gender and Development, see <http://genderlinks.org.za/wp-content/uploads/2016/01/ADOPTED-REVISED-PROTOCOL-ON-GAD.pdf>

#### 4.4.2 Monitoring and indicators

The Protocol has a **Monitoring, Evaluation and Reporting Framework (MERF)**, adopted by the region's gender ministers in June 2017. This sets out 121 gender indicators at various levels to monitor progress towards achieving gender equality. However, Part 8 of the SADC Protocol on Gender and Development, on Peace-Building and Conflict Resolution, is not included in the SADC Monitoring Tool for Reporting Progress on Implementation.<sup>xxxii</sup>

State parties are bound to ensure implementation of the SADC Gender Protocol at the national level through national action plans with measurable timeframes, through monitoring and evaluation mechanisms and through collecting and analysing baseline data against which progress can be monitored. State parties are bound to submit progress reports to the Executive Secretary of SADC once every two years. The SADC Secretariat publishes the **SADC Gender and Development Monitor**, set up around eight clusters.<sup>18</sup> This draws on national reports, and provides a regional perspective that, in turn, can guide national implementation and monitoring of the objectives of the protocol.<sup>xxxiii</sup>

The Protocol contains measurable targets, timeframes and indicators that require a tool to capture member states' progress towards achieving its objectives. A Monitoring Tool was thus designed to capture all the critical indicators on gender under the Protocol, in order to standardise reporting by SADC member states.<sup>xxxiii</sup> The tool comprises the SADC Gender Conditions Indicator (SAGI) and the SADC Women's Progress Scoreboard.<sup>xxxiv</sup> The MERF was adopted in June 2017 to monitor the Revised Protocol. It tracks progress on 17 indicators on economic justice and empowerment.<sup>xxxv</sup>

The SADC Gender Alliance, a regional advocacy and civil society network (see below), has published the **SADC Gender Protocol Barometer** since 2009. The Barometer consists of 15 annual country publications and one regional publication that tracks progress in achieving the targets of the SADC Gender Protocol. The Barometer is an important advocacy and accountability tool with strong outreach that has substantially strengthened the effectiveness of the SADC gender equality and women and girls' rights framework. It consists of the *Southern Africa Gender and Development Index (SGDI)*, introduced in 2011, based on empirical data on indicators that have increased in number over the years from 23 to 45 as of 2017. This is complemented by the *Citizen Score*, which gives ordinary citizens an opportunity to hold their governments to account. The Barometer is very thorough in its assessment of women and girls' rights, and covers 12 areas.<sup>19</sup>

#### 4.4.3 Gender institutional arrangements

The *SADC Committee of SADC Ministers Responsible for Gender/Women's Affairs* is mandated to ensure implementation of the Protocol. These ministers are able to lobby at both the regional level and the national level for convergence towards the Protocol, including allocation of sufficient resources, and proper monitoring. In 2016, the Committee reviewed the Protocol in light of the SDGs. There is also a *Committee of Senior Officials Responsible for Gender/Women's Affairs*; this committee reports to the Committee of SADC Ministers Responsible for Gender/Women's Affairs on implementation of the Protocol and supervises the work of the SADC Secretariat in this regard.

The **SADC Gender Unit** was established in June 1998, to facilitate, coordinate and monitor implementation of SADC gender commitments at regional and national level. It was formerly placed under the Executive Secretary but is now under the Gender and Social and Human Development Directorate. It is currently run by three staff.<sup>20</sup> The Unit has achieved prominence and effectiveness through its close cooperation with CSOs in the region. Its aims are to:

- Facilitate gender training and build the capacity of public officers in gender analysis and mainstreaming for all SADC structures and institutions
- Integrate gender into all SADC regional integration priorities, such as trade, agriculture, health, education, HIV and AIDS, infrastructure development, water, peace and security, etc.
- Promote and facilitate the achievement of 50% representation of women in politics and decision-making structures at all levels
- Facilitate the promotion of women's equal access to and control of productive and economic resources
- Coordinate and facilitate the eradication of GBV, including combating trafficking in persons and violence against women and children in armed and post-conflict situations and
- Undertake research and monitor and evaluate progress made by SADC member states in implementing gender commitments with a view to documenting and disseminating best practices

<sup>18</sup> (1) Constitutional and Legal Rights, (2) Politics and Decision-Making, (3) Education and Training, (4) Health and HIV and AIDS, (5) Access to and Control over Productive Resources, (6) GBV, (7) Media, Information and Communication and (8) Implementation and Institutional Arrangements.

<sup>19</sup> (1) Constitutional and Legal Rights, (2) Gender and Governance, (3) Education and Training, (4) Economic Justice, (5) Productive Resources and Employment, (6) GBV, (7) SRHR, (8) HIV and AIDS, (9) Peace-building and Conflict Resolution, (10) Media, Information and Communication, (11), Gender, Climate Change and Sustainable Development and (12) Implementation.

<sup>20</sup> A senior programme officer (gender), a secretary and a research, monitoring and evaluation officer.

The **SADC Parliamentary Forum** (SADC-PF) has been an important partner in work around the SADC Gender Protocol.<sup>21</sup> Gender equality and women and girls' empowerment is one of the five programmes of this inter-parliamentary institution. A recent important event was the adoption of the *Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage* (3 June 2016). The model law will encourage and guide member states to harmonise their domestic laws, and addresses many of the inconsistencies and loopholes in laws and customs that have allowed child marriages to proliferate (see case study 9 in Chapter 6). A Zimbabwean parliamentarian (Innocent Gonese) moved a motion on 29 November 2016 for Zimbabwe to adopt and domesticate the SADC model law.<sup>xxxvi</sup>

A second important recent event was the adoption in July 2017 of the Mahe Declaration on Sustained Engagement by SADC Parliaments to Implement Resolution 60/2 of the Commission on the Status of Women (CSW) on 'Women, the Girl Child and HIV and AIDS', at the Regional Women's Parliamentary Caucus of SADC-FP. Under this, SADC commits to, among other things, addressing the structural barriers underlying HIV prevalence, focusing on human rights and gender norms and frameworks, reducing stigma and discrimination, providing holistic approaches that involve youth and recognising the centrality of sexuality in human life and in individual, family and community well-being. Third, the SADC-PF has taken the initiative to identify and build the capacity of SRHR champions.<sup>22</sup>

#### 4.4.4 Regional advocacy networks

A key regional advocacy network is the **SADC Gender Protocol Alliance**, a regional 'network of networks' that championed adoption of the SADC Protocol on Gender and Development. The Alliance was formally founded in 2005 but has its roots in the 1990s.<sup>xxxvii</sup> The Alliance network is made up of 15 national gender networks and 10 regional NGOs. Coordination of the network and the campaign is with Gender Links. The national and regional members are national focal point organisations and/or lead on the various themes of the SADC Gender Protocol.<sup>23</sup>

The Alliance was the driving force behind the adoption as well as the implementation and review of the SADC Gender Protocol. The Alliance also publishes the above-mentioned Barometer on an annual basis to promote and advocate for women and girls' rights and gender equality in the region, using the SADC Gender Protocol as its reference point. In 2015, the Alliance lobbied for review of the Protocol and development of the accompanying MERF.

For a long time, the relationship between the Alliance and the Gender Unit was symbiotic, as exemplified by their shared agenda and coordinated collaboration strategies. More recently, the relationship has not been completely trouble-free. The 2017 Barometer points to shrinking space for civil society in recent times. It notes that the Alliance was, for the first time, not invited to the Gender Ministers' Meeting in Swaziland in June 2017. As a result, the Alliance was not present for the adoption of the MERF that it had lobbied for.

However, there is an opportunity for streamlining relations between civil society and the SADC Secretariat, as the latter is working on a framework agreement for interaction with non-state actors. The Alliance, as the gender sector representative in the SADC Congress of NGOs (SADC-CNGO), is actively engaged in these discussions. The SADC Treaty recognises that non-state actors are important stakeholders in the implementation of the SADC Agenda (Arts 5(2b), 16A and 23). The Alliance and the Gender Unit also actively participate in the Annual 16 Days of No Violence Against Women Campaigns that take place every year.<sup>24</sup> Gender Links also actively engages in the 50/50 Campaign on women's equal representation and participation in decision-making.

#### Box 4.6. 50/50 Campaign

The *SADC Framework for Achieving Gender Parity in Political and Decision-Making Positions by 2015*, adopted in 2009, declared a 30-day campaign for 50/50 representation in SADC member states. The campaign promotes women's equal representation and participation in decision-making at local and national levels throughout Southern Africa. This campaign gained momentum beyond the 30 days; Gender Links re-launched it in July 2011.<sup>xxxviii</sup>

<sup>21</sup> This was launched in 1996 and officially approved in 1997. It is the higher policy-making and deliberative organ where all 15 national parliaments of SADC are represented. It meets twice a year, and makes policy decisions and recommendations to the SADC Summit of Heads of State and Government.

<sup>22</sup> For details, see [www.newera.com.na/2018/01/09/support-for-lesotho-mps-in-sadc-pf-srhr-hiv-project/](http://www.newera.com.na/2018/01/09/support-for-lesotho-mps-in-sadc-pf-srhr-hiv-project/)

<sup>23</sup> For more details on the Alliance's members, visit <http://genderlinks.org.za/what-we-do/sadc-gender-protocol/>

<sup>24</sup> This runs from 25 November to 10 December and provides a rallying point for governments, NGOs, community-based organisations and other stakeholders in the region to run events aimed at raising awareness, influencing behaviour change and securing high-level political commitment to end GBV. SADC is also making an effort to counter GBV through research and awareness-raising on World Day against Trafficking in Persons (30 July) and building the capacity of law enforcement officials to identify and respond to victims of trafficking.

#### 4.4.5 Strengths, challenges and opportunities

In sum, SADC has a strong, comprehensive and binding normative framework on women and girls' rights and gender equality in place, accompanied by an explicit set of targets and indicators. The gender commitments are monitored both by the SADC Secretariat and, from the civil society side, by the SADC Gender Alliance. The Gender Unit has experience in developing policies, conducting research and implementing projects on women and girls' rights and gender equality. It has worked closely with the Gender Alliance in an effective way. Recent opportunities for further enhancing women and girls' rights are the 2016 amendments to the Protocol on Gender and Development, as well as, for instance, the use of model law (in this case on child marriage).

SADC lacks a strong and operational court. The SADC Tribunal, officially established in 2005, originally had the competence to hear cases from individuals regarding human rights violations. The Tribunal was *de facto* suspended at a 2010 SADC Summit, after several judgements ruling against the Zimbabwean government. The 2012 SADC Summit agreed to limit the Tribunal's mandate to disputes between member states, and as such barred cases from individuals and companies.

One of the challenges facing SADC is that not all member states have signed and ratified the Gender Protocol. Domestication is also undermined by lack of political will, and by gaps in the data needed to implement and monitor progress on women and girls' rights and gender equality in the region. Recently, the space for civil society to engage with the Gender Ministers' Meeting was challenged, but opportunities are emerging to streamline and consolidate interaction with civil society actors and networks.

**Table 4.8. SADC: strengths, opportunities and challenges**

Strengths	Opportunities	Challenges
<ul style="list-style-type: none"> <li>• Comprehensive legal framework on women and girls' rights and gender equality, covering Health and HIV and AIDS, Peace and Conflict Resolution, GBV and Harmful Practices, etc.</li> <li>• Binding legal framework, with concrete targets, with timeframes, formulated</li> <li>• Strong MERF on SADC Gender Protocol in place</li> <li>• Regular reporting on progress by both SADC Secretariat and Gender Alliance</li> <li>• Dedicated Gender Unit in SADC Secretariat with proven track record</li> <li>• Strong regional civil society network (SADC Gender Alliance), with thematic leads and national-level networks</li> <li>• Collaboration between Gender Unit and Gender Alliance</li> </ul>	<ul style="list-style-type: none"> <li>• Protocol and related policies, action plans and strategies being reviewed to align with major regional and continental standards</li> <li>• Regular monitoring, and continuous improvement of indicators</li> <li>• Use of model law, to guide and harmonise legal reform aligned with the Protocol (e.g. on ending child marriage)</li> <li>• Engagement at the national level on the Gender Protocol themes</li> </ul>	<ul style="list-style-type: none"> <li>• Not all countries have signed/ratified the Protocol</li> <li>• Data not readily available in all countries on issues covered by the Protocol</li> <li>• Domestication of updated changes does not always reflect commitment to the revised Protocol and related plans, strategies and policies</li> <li>• Shrinking space for civil society to engage effectively with the Secretariat</li> <li>• SADC Tribunal suspended</li> </ul>

**Table 4.9. SADC: key documents and institutional infrastructure for women's rights and gender equality**

<b>Mandate and history</b>	
1980	SADC Treaty
1993	Treaty for the Establishment of the SADC
<b>Women and girls' rights/gender equality commitments</b>	
1997	SADC Declaration on Gender and Development 2008 (updated in 2015)
1998	Addendum to the SADC Declaration on Gender and Development on the Prevention and Eradication of Violence against Women
2003	SADC Gender Policy
2008	SADC Protocol on Gender and Development
2008	Sexual and Reproductive Health Strategy for the SADC region (2006–15)
2008	Model Law on HIV in Southern Africa
2009	SADC Workplace Gender Policy
2009	10-year SADC Strategic Plan of Action on Combating Trafficking in Persons, especially Women and Children (2009–19)
2009	SADC Framework For Achieving Gender Parity in Political and Decision Making Positions by 2015 (2009-2015)
2009	Gender Mainstreaming Resource Kit
2009	SADC Gender Protocol Barometer
2010	SADC HIV and AIDS Strategic Framework (2010–15)
2013	SADC Gender Monitor
2013	Framework for Achieving Gender Parity in Political and Decision-making Positions by 2015
2015	Regional Indicative Strategic Development Plan: gender a cross-cutting issue/Gender Mainstreaming Programme
2017	Mahe Declaration
Dates unknown	<ul style="list-style-type: none"> <li>• SADC Strategy to Address Gender-Based Violence</li> <li>• SADC Women's Economic Empowerment Framework</li> </ul>
<b>Gender infrastructure (institutional)</b>	
Gender Unit	Established in June 1998, in SADC Secretariat, placed under office of Executive Secretary, aims to facilitate, coordinate and monitor implementation of SADC gender commitments
<b>Regional and/or REC-level CSO networks</b>	
SADC Gender Protocol Alliance	

## 4.5 COMMON MARKET FOR EASTERN AND SOUTHERN AFRICA (COMESA)

The COMESA Treaty entered into force in 1994 to replace the Preferential Trade Area (PTA) Agreement of 1981. COMESA was established as 'an organisation of free independent sovereign states which have agreed to co-operate in developing their natural and human resources for the good of all their people'.

**COMESA: created in 1994 (Preferential Trade Area, 1981)**

**Member states:** Comoros, DRC, Djibouti, Egypt, Eritrea, Ethiopia, Kenya, Libya, Madagascar, Malawi, Mauritius, Rwanda, Seychelles, Sudan, Swaziland, Uganda, Zambia and Zimbabwe<sup>25</sup>



Art. 154 of the Treaty acknowledges that 'Women make significant contribution towards the process of socio-economic transformation and sustainable growth and that it is impossible to implement effective programmes for rural transformation and improvements in the informal sector without the full participation of women.' Art. 154(b) also calls on member states through appropriate legislative and other measures to eliminate regulations and customs that are discriminatory against women and girls.

### 4.5.1 COMESA Gender Policy and normative framework on gender equality

Initially, the gender focus of COMESA was more on women's participation in business. Over time, however, COMESA has adopted a gender equality approach. Many of its policy documents consistently adopt rights language, providing an opportunity for gender mainstreaming and emphasis on the rights of women and girls, even within the integration and trade paradigm.

In 2002, the **Gender Policy** was developed and adopted to guide and direct the planning and implementation of COMESA programmes and activities from a gender perspective. One of its specific objectives was to lobby member states to facilitate the sensitisation of customs officials on women and girls' rights. The Policy stated that the majority of COMESA member states had increasingly realised the need to integrate gender in mainstream development. It took note of states' commitments to international, continental and regional gender instruments as well as being part of the AU's gendered approach to development, which provides a strong basis for women and girls' rights.<sup>26</sup>

The current guiding document for women and girls' rights and gender equality is the **revised COMESA Gender Policy of 2016**. This objective of this is 'to create an enabling policy environment for mainstreaming gender perspectives in all policies, structures, systems, programs and activities of COMESA Member States and the Secretariat towards gender equality, women and youth empowerment and social development'.<sup>27</sup> The Gender Directorate is working on a Gender Policy Implementation Plan, which is still in draft.<sup>27</sup>

<sup>25</sup> There is considerable overlap of COMESA member states with membership of IGAD and SADC. COMESA members also in IGAD are Comoros, Djibouti, Eritrea, Ethiopia, Kenya, Madagascar, Rwanda, Sudan and Uganda. COMESA members also in SADC are DRC, Madagascar, Malawi, Mauritius, Seychelles, Swaziland, Zambia and Zimbabwe.

<sup>26</sup> This includes member states being signatory to CEDAW; the Nairobi Forward Looking Strategies; the Dakar Declaration and African Platform for Action; the Beijing Declaration and Platform for Action; and the SADC Declaration on Gender and Development.

<sup>27</sup> In February 2018, the COMESA Technical Committee on Gender and Social Affairs met in Khartoum, with the Draft Gender Policy Implementation Plan and Monitoring Tracking Matrix one of the agenda points: [www.comesa.int/gender-experts-meeting-underway-in-khartoum/](http://www.comesa.int/gender-experts-meeting-underway-in-khartoum/)

**Box 4.7. Revised Gender Policy (2016)**

The Guiding Principles of COMESA's revised Gender Policy relate to six areas: (1) transparency and accountability, (2) human rights approach and equity,<sup>28</sup> (3) evidence-based policies and programmes, (4) gender-responsiveness and equality, (5) people with disabilities<sup>29</sup> and (6) minorities.<sup>30</sup> The Gender Policy formulates specific objectives and policy measures for the following 17 priority policy areas:

- Women's economic empowerment
- Women participation in decision-making structures
- Gender management systems
- Trade; agriculture; investment promotion and private sector development
- Transport and telecommunications
- Energy; science, technology and innovations; environment and climate change
- Extractive industry
- Peace-building, conflict resolution, transformation and terrorism
- SRHR
- Maternal health
- Adolescent SRH
- HIV and AIDS
- People with disabilities
- Minorities
- Human trafficking
- Youth
- Child marriage and child labour

The Gender Policy also specifies the implementation arrangements, in particular with regard to the legal framework, resource mobilisation and monitoring and evaluation.

The Gender Policy was revised to align with the COMESA Social Charter, Africa's Agenda 2063, Beijing+20 outcomes and the SDGs. In its Preamble, the COMESA **Social Charter** states that 'Gender equality and equity are the underpinning guiding principles of the Charter in accordance with the COMESA Gender Policy.' The Social Charter focuses on social development and identifies the following areas of cooperation and programming: employment and working conditions (Art. V); labour laws (Art. VI); social protection (Art. VII); education, training and skills development (Art. XII); health care, including HIV and AIDS and sexual and reproductive health care (Art. XIII); and the elimination of harmful social and cultural practices (Art. XVI). Community development, well-being of the child and youth empowerment also feature prominently in the Social Charter.<sup>xli</sup> Since its approval 2014, officials in the Gender Directorate are sensitising member states to ratify and sign the Social Charter to operationalise it. Twelve COMESA states out of nineteen had signed by September 2017.

Since 2011, COMESA has developed annual progress reports that review various issues including GBV and women's participation in decision-making.<sup>31</sup> COMESA has also developed **gender mainstreaming manuals** in a range of sectors,<sup>32</sup> which are intended to equip users with appropriate language to articulate gender perspectives, and also to serve as tools for monitoring member states' implementation of gender-focused programmes in line with the COMESA Gender Policy and the Strategic Action Plan.<sup>xliii</sup>

An important initiative is the **50 Million African Women Speak (50 MAWS) Platform Project**.<sup>xliii</sup> This targets 36 countries in EAC, COMESA and ECOWAS (see also Box 4.2 in Section 4.1.2) and will be implemented by the COMESA Secretariat, member states through ministries responsible for gender and women's affairs, women in business associations, women's groups and other stakeholders.<sup>xliii</sup> It will provide an opportunity to share information to 50 million women on the broad areas COMESA works in.

<sup>28</sup> The Human Rights Approach and Equity Principle: all human beings should enjoy equal status and have equal entitlements and opportunities for the full realisation of their human rights, making choices and accessing assets, services and public goods without limitations imposed by legislation, policies, gender norms and stereotypes (COMESA Gender Policy 2016, pp. 17–18).

<sup>29</sup> Principle Regarding People with Disabilities: because of their inherent vulnerability, women and girls need targeted socioeconomic empowerment policies and programmes (COMESA Gender Policy 2016, pp. 17–18).

<sup>30</sup> Principle Regarding Minorities: women and girls are among minority populations who are vulnerable and, therefore, require protection (COMESA Gender Policy 2016, pp. 17–18).

<sup>31</sup> These annual progress reports are not yet available online.

<sup>32</sup> Gender mainstreaming manuals have been developed for the following sectors: trade; infrastructure development; investment promotion and private sector development; information and communication; gender and environment; health and HIV and AIDS; peace and conflict resolution; and COMESA institutions.

### 4.5.2 COMESA HIV and AIDS frameworks and policy

The COMESA **Framework for the Multi-Sectoral Programme on HIV & AIDS (2012–15)** adopted a rights-based perspective, although the emphasis could have been stronger on the rights of women and girls. The Framework pinpointed risks that certain environments cause in terms of human rights violations in child labour, trafficking in human beings and commercial sexual exploitation of children and adolescents, which are all potential vehicles for HIV transmission. It identifies among its strategies the need to lobby member states to intensify education on women and girls' rights; to enforce domestic violence bills; to improve access to information on GVAW, human trafficking and women and girls' rights; and to train female traders and various other actors on the rights of women and girls.

The Framework is backed up by a regional **HIV AIDS Policy (2016)**, which responds to continental and global frameworks in trying to prevent and end HIV deaths by 2030. COMESA seeks to move in tandem with the AU Catalytic Framework to End AIDS, Tuberculosis and Malaria by 2030. The COMESA Secretariat targets trade corridors and border posts to raise awareness on relevant policies and strategies to combat HIV. It has conducted capacity-building with cross-border and customs officials and female traders, although it is not able to cover all 19 member states. The Secretariat assists member states to implement the HIV Multi-Sectoral Programme and work on awareness and behavioural change.

COMESA has an **HIV AIDS Policy Tracking Plan**, which elaborates policy measures for each of the sub-themes in the HIV AIDS Policy, with targets to be achieved in the medium and long term by member states by 2020 and 2030, respectively. The plan is in draft form, since the policy was only recently adopted. The various measures are to be addressed at regional and national level. The draft Tracking Matrix identifies possible interventions at regional level. In future, this may extend to harmonisation of policy measures such as on age of marriage, through regional consultations.

Women cross-border traders experience violence and COMESA is holding dialogues with them.<sup>xlv</sup> However, there is need for a regional guide to handle GBV related to cross-border trade and for COMESA to set a standard at regional level to drive convergence towards best practices in this area.

#### Box 4.8. Cross-border trading and women's rights

The majority of cross-border traders are women working in the informal sector, where they are unprotected and face rampant GVAW. GVAW has many causes and effects, criss-crossing SRH, harmful practices and HIV and AIDS. These communities also suffer from harmful practices that affect women disproportionately.

A project conducted by the COMESA Secretariat in the Great Lakes Region showed that border communities in remote areas lacked basic services such as those related to family planning and reproductive health. COMESA is advocating for a comprehensive programme along borders to respond to these needs. Different service providers could target the border management committees already in existence. There is a strong need to look at the plight of the male and female traders in a holistic manner, addressing issues of GBV and access to family planning. The Gender Directorate has done a great deal of work in the corridors and seeks to leverage itself strategically based on its mandate to deepen its work on addressing the rights of women and girls.

### 4.5.3 Gender institutional arrangements

The 2002 Gender Policy established the **COMESA Technical Committee on Gender** to be constituted in line with the COMESA Treaty and to facilitate operationalisation of the Policy.

In 2009, the **Division of Gender and Social Affairs** in COMESA was established.<sup>33</sup> The Gender Directorate works on various areas including HIV, harmful practices, GVAW and family planning and reproductive health. The Division in the COMESA Secretariat coordinates and oversees implementation of the COMESA Gender Policy in member states and at the Secretariat.

The 2016 Revised Gender Policy calls for the establishment of gender management systems in the Secretariat and at member state levels, and for a gender mainstreaming accountability system at the management level of the Secretariat and member states. There are five staff members in the Gender Directorate with gender mainstreaming expertise.

The 2016 Revised Gender Policy calls on states and the Secretariat to ensure the availability of sex-disaggregated data at national level. Member states submit performance reports to the COMESA Secretariat based on COMESA's Guidelines for Preparing Country Progress Reports on the Implementation of the COMESA Gender Mainstreaming Strategic Action Plan and Council Decisions.

<sup>33</sup> In line with its initial focus on women in business, the first institutional structure for gender equality was the COMESA Women in Business Unit, established in 1991.

The 2016 Revised Gender Policy notes that funding for gender-related programmes in COMESA has largely been constrained by low funding owing to the low prioritisation of gender in national budgeting frameworks. The Policy urges member states to recommit themselves to improved monetary and other resource contributions to the Secretariat's Gender Division and to proactively leverage resources from cooperating partners. In October 2017, the Secretariat noted with concern the decline in the proposed 2018 annual budget for the COMESA Secretariat and its agencies by US\$10 million dollars as several cooperating partners grants concluded.<sup>xvi</sup> This may affect the work of the Directorate, which is already overseeing 19 countries as per its mandate.

At regional level, COMESA Secretariat is trying to strengthen the knowledge bases of member states in the various implementation areas through research and capacity-building to address issues at service provision or policy level. The Secretariat serves as a channel for experience-sharing among member states on the replication of good practices and the elimination of bad practices. The Gender Directorate is well positioned to use advocacy at high-level policy organs, undertaking advocacy in partnership with COMESA first ladies and organising roundtable meetings around COMESA summits. In July 2016 in Addis Ababa, Ethiopia, the theme was 'Economic Empowerment of Women: A Pathway to Child and Maternal Health and Prevention and Management of Cervical, Breast and Cancer in Africa'.<sup>xvii</sup>

Despite an existing framework for accrediting **civil society** actors, there has been limited involvement of CSOs in COMESA activities. **The Federation of Women in Business (FEMCOM)** is composed of national chapters of women in business. FEMCOM supports business and technical training and the acquisition of equipment.<sup>34</sup> It promotes value addition by supporting the formation of national and regional clusters in agro-processing as a vehicle for boosting job creation and intra-regional trade and contributing to the achievement of development goals. FEMCOM is a foundation under COMESA and is regarded as a COMESA institution and not necessarily as a CSO.

Since 2012, the Secretariat and FEMCOM have been jointly implementing the Business Incubator for African Women Entrepreneurs<sup>35</sup> This supports women entrepreneurs by increasing the capacity of small and medium-sized enterprises (SMEs) run by women in Africa, especially in the area of agro-processing, handicrafts and information and communication technology (ICT), by providing credit guarantees, among other things. Additionally, in 2013, a Women's Economic Empowerment Fund (WEEF) was established.<sup>36</sup> The aim of this is to alleviate the challenges faced by women to access financial resources, including access to credit to enhance their businesses.

The Gender Directorate is mapping out where the key players are and what they do with a view to developing a database on this. It has been collaborating with regional CSOs on reproductive health and worked with regional and international NGOs to develop the Framework for the HIV Multi-Sectoral Programme.

#### 4.5.4 Strengths, opportunities and challenges

COMESA's normative framework on gender equality and women's rights has evolved considerably in recent years, especially with the Revised Gender Policy and its accompanying implementation plan. These recent gender equality frameworks not only have a stronger rights focus but also cover a wide range of highly relevant women and girls' rights areas, including SRHR, maternal health, HIV and AIDS and adolescent SRH as well as minorities, people living with disabilities and critical issues such as human trafficking. In addition, COMESA has a fairly elaborate framework on HIV and AIDS. Overall, the dual membership of COMESA countries with SADC has also provided an opportunity for member states to benefit from the evolving foundation of a strong women and girls' rights approach in SADC, which will hopefully influence COMESA going forward.

The Revised Gender Policy has also pushed for further development of the gender infrastructure and mechanisms, most notably the gender management system and a gender mainstreaming accountability mechanism. The limited resourcing of gender equality continues to be a challenge, however. The anticipated stronger engagement with CSOs offers an important emerging opportunity for regional and national NGOs and civil society across the region, given that their involvement has been limited so far.

<sup>34</sup> Mainly through capacity-building in commodity processing and production, post-harvest handling of cassava, improvement of finished textile products and management of waste related to raw 115 'Inclusive and Sustainable Industrialisation' materials in the textiles and garments clusters.

<sup>35</sup> Under the NEPAD Spanish Fund for African Women's Empowerment.

<sup>36</sup> The Convergence Committee of the Central Bank and Ministers of Finance included the WEEF on the agenda of the Central Bank Governors and Ministers of Finance Meeting held in Nairobi in November 2014, and adopted the recommendation that the PTA Bank should manage the WEEF to accelerate its implementation.

**Table 4.10. COMESA: strengths, opportunities and challenges**

Strengths	Opportunities	Challenges
<ul style="list-style-type: none"> <li>• Recognises importance of gender equality and women and girls' empowerment, mostly within the trade and services paradigm</li> <li>• Has policy instruments and programmes on GVAW, HIV and AIDS and harmful practices; these are mainstreamed within its programmes</li> <li>• The Gender Directorate is committed to undertaking advocacy, research, capacity-building and documentation and monitoring from a gender equality perspective</li> </ul>	<ul style="list-style-type: none"> <li>• Revision of key documents has been undertaken and resulted in more rights language and approaches, to reflect international norms and standards</li> <li>• The Gender Directorate is developing a database of CSOs in the region with a view to engagement with them on diverse issues</li> <li>• The Gender Directorate has worked with a few regional and Zambian-based NGOs and with international organisations</li> </ul>	<ul style="list-style-type: none"> <li>• Reluctance of some member states to engage with a more rights-based approach paradigm</li> <li>• Limited resourcing of gender equality; drop in funds for 2018 at the Secretariat</li> <li>• Limited involvement of CSOs</li> </ul>

**Table 4.11. COMESA: key documents and institutional infrastructure for women's rights and gender equality**

<b>Mandate and history</b>	
1981	PTA Agreement
1994	COMESA Treaty
2000	Free Trade Area formed
2011	COMESA Social Charter
<b>Women and girls' rights/gender equality commitments</b>	
2002	COMESA Gender Policy
2008	COMESA HIV and AIDS Workplace Policy
2011	AU Protocol on Gender Parity endorsed
2011	Regional Strategy on Gender Mainstreaming in Agriculture and Climate Change
2012	Framework for the Multi-Sectoral Programme on HIV & AIDS for COMESA (2012-15)
2015	Gender and Social Development Communication Strategy
2016	COMESA Gender Policy (Revised) and Gender Mainstreaming Strategic Action Plan (replaced 2002 Gender Policy)
2016	COMESA HIV AIDS Policy
Forthcoming	Draft Gender Policy Implementation Plan and Monitoring Tracking Matrix
Unknown	HIV AIDS Policy Tracking Plan
<b>Gender infrastructure (institutional)</b>	
Gender and Social Affairs Division	Mainstreaming gender in all COMESA programmes and projects to ensure equitable access to resources, opportunities, services and benefits for women, men and youth
<b>Regional and/or REC-level CSO networks</b>	
COMESA Federation of Women in Business (FEMCOM)	

## 4.6 ECONOMIC COMMUNITY OF CENTRAL AFRICAN STATES (ECCAS)

During the 1981 Head of States Summit of the Central African Customs and Economic Union, it was agreed to create a larger Economic Community of Central African States. On 18 October 1983, this Economic Community of Central African States (ECCAS) (or the Communauté Economique des Etats de l'Afrique Centrale) was formed in Libreville, Gabon.

**ECCAS: created in 1983**

**Member states:** Angola, Burundi, Cameroon, CAR, Chad, Republic of Congo, DRC, Equatorial Guinea, Gabon, Rwanda and São Tomé and Príncipe



Art. 4 of the Treaty establishing ECCAS articulates that the aim of the organisation is 'to promote and strengthen harmonious cooperation and balanced and self-sustained development in all fields of economic and social activity... in order to achieve collective self-reliance, raise the standard of living of its peoples, increase and maintain economic stability, foster close and peaceful relations between Member States and contribute to the progress and development of the African continent.' Cooperation and development are particularly focused on industry, transport and communications, energy agriculture, natural resources, trade, customs, monetary and financial matters, human resources, tourism, education, further training, culture, science and technology and the movement of persons. Art.

60b of the Treaty speaks to the promotion of collaborative research on women's empowerment. This collaborative research on the economic, social and cultural empowerment of women in rural and urban areas is expected to contribute to furthering the integration of women in development.

ECCAS became inoperative between 1992 and 1998 as a result of social and political unrest and conflict in the region, namely in the Great Lakes area. This was coupled with a financial pitfall, with member states not paying their membership fees.<sup>xlviii</sup> In February 1998, a decision to reactivate ECCAS was taken in Libreville. In response to the various conflicts in the region, the issue of peace and stability received close attention in the *Programme of Revival and Revitalisation*, which was adopted by the Head of States in 1999 in Malabo, Equatorial Guinea.<sup>xlix</sup> Although ECCAS has been reactivated, it continues to face challenges in its regional cooperation.<sup>i</sup>

The re-establishment of ECCAS stemmed from the political will of member states to enable successful sub-regional cooperation in the Central African region. A **Strategic Integration Plan and a Vision for 2025** was adopted in 2007 to ensure the region was peaceful and stable and to facilitate the free movement of people, goods and services.<sup>ii</sup> To attain this, Heads of State and Government agreed to retain three main focuses:

1. Peace, security and stability, including the functioning of the Peace and Security Council in Central Africa
2. Infrastructure, including transport, energy, water, IT and communication
3. The environment, including management of the Congo Basin ecosystems

The Secretariat was set up in Libreville in 1985. ECCAS has the following **infrastructure**: the Conference of Heads of State and Government, the Council of Ministers (the executive organ of the Community), the Advisory Committee and Specialised Technical Committees. The Court of Justice is not yet operational.<sup>iii</sup> There is also a Gender Unit in the Secretariat.<sup>37</sup>

In 2004, a **Declaration on Gender Equality** was made during the 11th Conference of the Heads of States of ECCAS, in Brazzaville in 2004. The declaration emphasised the need to ensure that women and men's particular needs and concerns were taken into account in policy formation and programmes to ensure lasting peace and stability in the region.<sup>iiii</sup>

In 2006, ECCAS in partnership with ECOWAS developed a *Multilateral Agreement on Regional Cooperation to Combat Trafficking in Persons, Especially Women and Children, in West and Central Africa*. The objective of this is 'to develop a common front to prevent, suppress and punish trafficking in persons through international cooperation' (Art. 2). This explicitly includes (1) to protect, rehabilitate, reintegrate and reintegrate victims of trafficking into their original environment, when necessary, and (2) to help each other in the investigation, arrest and the prosecution of offenders through the competent central authority of each state party. The agreement also seeks to promote friendly cooperation between the parties with a view to achieving these objectives.

<sup>37</sup> No further details could be established regarding the mandate, resources and activities of this unit.

More recently, on 1 September 2013, the ministers of health of ECCAS member states met at a roundtable and adopted the *Strategic Plan 2014–18 on the Fight against HIV & AIDS*.<sup>lv</sup> The theme of the meeting was shared responsibility and regional solidarity, and the Strategic Plan offered a new framework for the region to address HIV and AIDS. It comprises five main pillars, which include mother-to-child transmission as well as the supply and availability of ARVs.

In April 2014, a two-day forum was organised by the Chadian Parliament in collaboration with ECCAS. Parliamentarians from the Central Africa region adopted the **Ndjamena Declaration** to reaffirm their regional and international commitments to women, peace and security. They committed to 'promoting leadership and women's political participation, integration, gender equality and women's empowerment in the range of activities of their respective parliaments; and strengthening institutions for good governance as an important factor for conflict prevention in the sub region'.<sup>lv</sup>

This two-day forum of ECCAS parliamentarians noted that the social and political instability and conflict in ECCAS countries had been a major setback in terms of achieving gender equality in the region. Women are victims of sexual violence as well as discrimination, are excluded from the decision-making sphere and have limited access to resources.<sup>lv</sup> In order to bring peace, security and stability in the region, it is paramount for member states to include women in peace negotiations, and that they are equally represented with men in decision-making bodies, with their needs taken into account when developing legislation, policies and programmes.

**Table 4.12. ECCAS: key documents and institutional infrastructure for women's rights and gender equality**

Mandate and history	
1981	Treaty establishing the Economic Community of Central African States
1999	Programme of Revival and Revitalisation
2007	Strategic Integration Plan and a Vision for 2025
Women and girls' rights/gender equality commitments	
2004	Declaration on Gender Equality
2006	Multilateral Agreement on Regional Cooperation to Combat Trafficking in Persons, Especially Women and Children, in West and Central Africa
2013	Strategic Plan 2014–18 on the Fight against HIV & AIDS
2014	Ndjamena Declaration

## 4.7 ARAB MAGHREB UNION (UMA)

In February 1989, the Heads of State of Algeria, Libya, Mauritania, Morocco and Tunisia established the Arab Maghreb Union UMA by approving the Treaty instituting the Arab Maghreb Union. Member states agreed to coordinate, harmonise and rationalise their policies and strategies in order to achieve sustainable development in all sectors of human activity. The headquarters of UMA are situated in Rabat, Morocco.

**UMA: created in 1989**

**Member states:** Algeria, Libya, Mauritania, Morocco and Tunisia

Art. 3 of the **Treaty instituting the Arab Maghreb Union** states that the Union aims to (1) reinforce the fraternal links [sic] that unite the member states and their peoples; (2) realise the progress and prosperity of member societies and the defence of their rights; (3) contribute to the preservation of a peace founded on justice and equality; (4) pursue a common political policy in different domains; and (5) work towards the progressive realisation of the free movement of persons, services, goods and capital.

In light of these objectives, the Treaty also articulates economic and cultural goals to be achieved. The economic goal is 'to achieve industrial, agricultural, commercial and social development of member States'. The cultural goal is 'to establish a cooperation aimed at promoting education on its various levels, at safeguarding the spiritual and moral values emanating from the tolerant teachings of Islam, and at preserving the Arab national identity'. With respect to the latter, emphasis is placed on the importance of exchanging teachers and students and creating joint university and cultural institutions as well as joint institutions specialised in research.

The Treaty of 1989 instituted the UMA **infrastructure**.<sup>38</sup> The Presidency Council comprises the Heads of States and constitutes the main authority of UMA. In addition, the Presidency Council has set up four specialised ministerial committees, which are responsible for the focus areas of the Union: (1) food security, (2) economy and finance, (3) human resources and (4) infrastructure.

UMA has not been able to achieve much progress. The Union's state of inactivity and inefficiency can be seen in the fact that no summits have taken place between Heads of State since 1994.<sup>lvii</sup> This lack of progress owes to economic and political tensions between member states; one of these relates to tensions between Morocco and Algeria over the status of Western Sahara. The 'Arab Spring' has more recently affected political stability and encouraged the political aspirations of Islamic movements. This has created more uncertainty regarding UMA's future since 2011. In this context, UMA has not been able to establish substantial economic and political progress, nor has it developed commitments and/or initiatives on gender equality and women's rights in the region.



<sup>38</sup> UMA's infrastructure is composed of the Presidency Council, a Consultative Council, a Secretariat, a Monitoring Committee, a Meeting of the Prime Ministers, a Council of Foreign Ministers, specialised ministerial commissions, a judicial organ, the University of Maghreb and the Maghreb Bank for Investment and Foreign Trade.

## 4.8 COMMUNITY OF SAHEL-SAHARAN STATES (CEN-SAD)

In February 1998, following the Conference of Leaders and Heads of States of six countries<sup>39</sup> in Tripoli, Libya, the Community of Sahel-Saharan States (or Communauté des Etats Sahélo-Sahariens, CEN-SAD) was established. It was not until July 2000 that CEN-SAD became a REC, during the 36th Ordinary Session of the Conference of Heads of State and Government of the Organisation of African Unity in Togo. The REC has been given observer status in the UN General Assembly in 2001 by virtue of Resolution 56/92.<sup>lviii</sup>

### CEN-SAD: created in 1998

**Member states:** Benin, Burkina Faso, Cape Verde, CAR, Chad, Comoros, Côte d'Ivoire, Djibouti, Egypt, Eritrea, The Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Libya, Mali, Mauritania, Morocco, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Sudan, Togo and Tunisia



Art. 1 of the Treaty establishing CEN-SAD articulates the objectives of CEN-SAD as to (1) establish a comprehensive economic union with a particular focus on the agricultural, industrial, social, cultural and energy domains; (2) adopt measures to promote free movement of individuals and capital; (3) promote measures to encourage foreign trade, transportation and telecommunications among member states; (4) promote measures to coordinate educational systems; and (5) promote cooperation in cultural, scientific and technical fields.<sup>lix</sup>

CEN-SAD covers an area greater than half of the African continent, with states all directly connected to and affected by the Sahara Desert. In light of this, CEN-SAD is mandated to establish a knowledge-based economic union to face drought and aridity. This is reflected in its specific focus areas of programming, which include infrastructure, transport, environment, water, mines, energy, telecommunications, the social sectors, agriculture and animal health. The CEN-SAD region experiences a fair level of instability linked to migration, political unrest, conflict and presence of jihadist movements. Strengthening peace, security and stability are a key focus for CEN-SAD, in addition to achieving global economic and social development.

Key elements in CEN-SAD's **infrastructure** are the Conference of Heads of State and Government, the Executive Council and the General Secretariat.<sup>lx</sup> The Conference of Heads of State and Government normally meets once a year. Among its specialised agencies is the Special Solidarity Fund, which is set up for humanitarian purposes; this Fund has drafted the **Free Trade Area Treaty**.<sup>lx</sup>

The most recent conference of Heads of State and Government, held in February 2013 in Ndjamena, Chad, was held to restructure and revive CEN-SAD. A **Revised Treaty** was established and adopted, in order to make up for the institutional capacity gaps and imbalances prevailing across CEN-SAD as reflected in the original Treaty. This Revised Treaty is currently in the process of being ratified by member states; 13 states have ratified it<sup>lx</sup> and it will enter into force when it has reached 15 ratifications.

However, efforts towards achieving CEN-SAD's objectives have been weak, and the REC has been inefficient in economic and political integration, as a result of various socioeconomic, political, security, environmental and humanitarian challenges.<sup>lxii</sup> Some examples of challenges for CEN-SAD are emigration to Europe, weak institutional bodies caused by political instability, overlapping REC memberships and unwillingness of member states to pay CEN-SAD membership fees. CEN-SAD is also challenged by poor infrastructural bodies. One example is that the CEN-SAD Secretariat experiences a lack of resources, meaning it is unable to effectively coordinate regional programmes.

<sup>39</sup> Burkina Faso, Chad, Libya, Mali, Niger and Sudan.

<sup>40</sup> The infrastructure also includes the Permanent Peace and Security Council, the Permanent Council for Sustainable Development and the Committee of Ambassadors and Permanent Representatives. In addition, CEN-SAD has specialised agencies including the Economic Social and Cultural Council, mandated to assist all organs of CEN-SAD in the design and preparation of related programmes, and the Sahel-Saharan Bank for Investment and Trade.

<sup>41</sup> Benin, Burkina Faso, Chad, Côte d'Ivoire, Djibouti, Eritrea, Guinea, Mali, Morocco, Niger, Senegal, Sudan and Togo.

Currently, the Free Trade Area Treaty drafted by the Special Solidarity Fund has yet to be implemented. The overlap in REC membership, and the more significant progress in trade integration made by other RECs, has led to a lack of political will to improve integration for CEN-SAD and has affected implementation of the Free Trade Area Treaty.<sup>lxii</sup> The overlapping REC memberships have also led to successes and provided opportunities, especially in the establishment of macroeconomic and financial policies and interregional free movement of persons schemes. For example, states overlapping in membership with ECOWAS are far more progressed in terms of liberalisation of cross-border mobility.<sup>lxiii</sup>

As CEN-SAD's work has largely been focused on, and challenged by, achieving peace, security and stability, less priority has been given to other areas. There was no information available on the establishment of commitments and/or initiatives for women and girls' rights/gender equality. Nor was their information regarding a specific **gender infrastructure** in the CEN-SAD.

**Table 4.13. CEN-SAD: key documents and institutional infrastructure for women's rights and gender equality**

<b>Mandate and history</b>	
1998	Treaty establishing CEN-SAD
2013	Revised Treaty (has not yet entered into force)
<b>Women and girls' rights/gender equality commitments</b>	
2000	CEN-SAD Security Charter
2003	Niamey Declaration on Conflict Prevention and Peaceful Settlement of Disputes
2009	Revised Draft Protocol on Conflict Prevention, Management and Resolution Mechanism
2009	Sharm-El-Sheikh Declaration
2009	Draft Protocol for future establishment and operation of the Permanent Peace and Security Council

## Chapter 4

# ENDNOTES

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## Chapter 5

# Gender-based violence against women

## 5.1 ISSUE ANALYSIS

### 5.1.1 Defining gender-based violence against women

The Maputo Protocol defines violence against women (VAW) in a comprehensive way, to include acts or threats of violence in both private and public spheres, in peacetime as well as during war and armed conflict. Provisions cover all spheres in which women experience violence—that is, in the family, in the community (i.e. at school and at work) and at the hands of the state.<sup>i</sup>

This understanding is firmly grounded in and further specifies the understanding of VAW as articulated in the United Nations Declaration on the Elimination of Violence against Women (DEVAW) (1993), which was the first international instrument to explicitly define VAW.<sup>1</sup> DEVAW defined VAW as ‘all acts of gender-based violence that result in, or are likely to result in, physical, sexual, psychological or economic harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life’ (Art. 3).

The term VAW is often used interchangeably with the term **gender-based violence** (GBV). The latter underlines that violence directed at and experienced by women and girls is a manifestation of gender inequalities and power relations. GBV is hence closely linked to women’s subordinate position within families, communities and states. The term GBV emphasises that women and girls experience such violence because of their sex and in the context of these unequal gender relations. This is recognised in the understanding in CEDAW General Recommendation No. 19 (1992) of GBV as ‘violence that is directed against women because she is a woman or that affects women disproportionately’. Important to note is that GBV encapsulates forms of violence against both men and women deriving from unequal power relations and structures between men and women.<sup>ii</sup> The term **violence against women** underlines that women and girls are the ones that most frequently experience violence, often perpetrated by men.

#### Violence against women defined in the Maputo Protocol

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).

<sup>1</sup> The original CEDAW does not contain provisions regarding violence against women, which is addressed in the General Recommendations on CEDAW, in particular No. 12 (on Violence against Women, 1989) and No. 19 (on Violence against Women, 1992) and was most recently further updated in General Comment No. 35 (on Gender-based Violence against Women, 2017).

A third commonly used term, for instance by the United Nations High Commissioner for Refugees (UNHCR), is that of **sexual and gender-based violence (SGBV)**.<sup>iii</sup> SGBV refers to 'any act that is perpetrated against a person's will and is based on gender norms and unequal power relationships', and underlines that harm can be inflicted on women, girls, men and boys.<sup>2</sup>

A fourth prominently used term is **sexual violence**, as articulated in the 2017 *Guidelines on Combating Sexual Violence and Its Consequences in Africa of the ACHPR*.<sup>3</sup> These define sexual violence as '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', irrespective of the sex or gender of the victim or perpetrator (Section 3.1, definitions).<sup>iv</sup> This definition emphasises that 'acts are considered as non-consensual when they involve violence, the threat of violence, or coercion', and that coercion can take place through '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 understanding of sexual violence encompasses a broad range of forms of violence, including but not limited to rape, sexual assault, forced marriage and pregnancy, forced sterilisation and forced abortion, human trafficking and FGM.<sup>4</sup>

Building on the normative strength of the definition of violence against women in the Maputo Protocol, and simultaneously making explicit how VAW is inherently linked to and a manifestation of gender unequal power relations, this report uses the term **gender-based violence against women (GVAW)**. GVAW includes but is not limited to various types of physical, sexual or psychological violence, economic abuse and exploitation, deprivation or neglect (see Box 5.1). It also includes threats of such acts, coercion, intimidation, humiliation and other deprivations of liberty.<sup>v</sup> Apart from recognising different types of violence against women, it is critical to acknowledge the different settings in which GVAW occurs. These include the family, the community (including schools and the workplace) and state and formal institutions, as well as the context of war, armed conflict and insecurity (see Box 5.2).<sup>vi</sup>

#### Box 5.1. Types of gender-based violence against women

**Physical violence:** 'intentional use of physical force with the potential for causing death, injury or harm. It includes, but is not limited to, scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, poking, hair pulling, slapping, punching, hitting, burning, the use of restraints or one's body size or strength against another person, and the use, or threat to use, weapons.'

**Sexual violence:** 'any non-consensual sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.'

**Psychological abuse/violence:** 'any act or omission that damages the self-esteem, identity or development of the individual' or 'behaviour that is intended to intimidate and persecute, and takes the form of threats of abandonment or abuse, confinement to the home, surveillance, threats to take away custody of the children, destruction of objects, isolation, verbal aggression and constant humiliation.'

**Economic abuse/violence/exploitation:** 'causing or attempting to cause an individual to become financially dependent on another person, by obstructing her or his access to, or control over, resources and/or independent economic activity' or 'acts such as the denial of funds, refusal to contribute financially, denial of food and basic needs, and controlling access to health care, employment.'

Sources: Krug, E.G. et al. (2002). *World Report on Violence and Health*. Geneva: WHO.

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[www.endvawnow.org/en/articles/347-glossary-of-terms-from-programming-essentials-and-monitoring-and-evaluation-sections.html](http://www.endvawnow.org/en/articles/347-glossary-of-terms-from-programming-essentials-and-monitoring-and-evaluation-sections.html)

2 '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: <https://emergency.unhcr.org/entry/60283/sexual-and-gender-based-violence-sgbv-prevention-and-response>).

3 The ACHPR adopted these Guidelines during its 60th Ordinary Session in Niamey, Niger on 8–22 May 2017.

4 The Guidelines specify that sexual violence is not limited to physical violence and includes but is not limited to sexual harassment, rape (which includes penetration of the vagina, anus or mouth by any object or part of the body) (includes gang rape, marital rape or 'corrective' rape), compelled rape, attempted rape, sexual assault, anal and vaginal virginity tests, violent acts to the genitals (e.g. burning, electric shocks, blows), forced marriage, forced pregnancy, forced sterilisation, forced abortion, forced prostitution, forced pornography, forced nudity, forced masturbation (or any other forced touching that the victim is compelled to perform on himself/herself or a third person), human trafficking for sexual exploitation and slavery, castration, forced circumcision and FGM and threats of sexual violence used to terrorise a group or a community (Section 3.1, definitions, pp. 14–15).

### Box 5.2. Settings in which gender-based violence against women occurs

**In the family:** violence occurring between family members and intimate partners that is taking place in the home. Such violence includes intimate partner violence (IPV)—that is, spousal beatings, sexual abuse or marital rape—but also violence between other family members—that is, child abuse, abuse of the elderly.

**In the community:** violence occurring between unrelated individuals, who may or may not be familiar with one another, and which is taking place in community settings outside the home such as educational institutions, streets or other open spaces (e.g. public transportation). Such violence can be, for example, verbal abuse, physical assault, sexual harassment/<sup>5</sup>intimidation, sexual abuse or rape.

**In the workplace:** a specific type of community violence occurring against and/or between workers, taking place in or outside the work place (e.g. offices, factories and farms). Such violence can include, for example, verbal abuse, physical assault, sexual harassment/intimidation, sexual abuse or rape.

**In formal and state institutions:** violence in which a social structure or institution may commit violence against people by preventing them from meeting basic needs. Overall, such violence occurs in two major forms: (1) violence committed by the state or subsidiary bodies (i.e. state officials, police or security forces) against its own citizens taking place within police, correctional, health and social welfare settings and (2) violence committed by the state against other states, often of political nature leading to conflict or war.

**In situations of conflict and war:** violence exacerbated by or evolved from different stages of conflict and war. These include during conflict, prior to flight, during flight, in country of asylum, during repatriation and during reintegration and post-conflict (see also sub-section 5.1.7 below).

Sources: Krug, E.G. et al. (2002). *World Report on Violence and Health*. Geneva: WHO.

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## 5.1.2 Reliable data and underreporting

GVAW is a widespread human rights violation transcending geography, race, class, sexuality, ethnicity and religion.<sup>vii</sup> There is a strong need for reliable data on GVAW to understand the scope and nature of the problem. Yet the collection of reliable data on GVAW is difficult. Women find it hard to report GVAW and there is frequent withdrawal of reported cases. Factors that undermine reporting include risk and fear of being stigmatised, rejected, discriminated, insulted or blamed by legal, health and social service providers. Also, women are at risk of being turned away when reporting GVAW as it is perceived as a private matter, or even because of a preference to settle GVAW cases outside the court of law (e.g. by traditional authorities, within community or family), in order to preserve family privacy and respect. Limited capacity of service providers to adequately respond to cases of GBV can also lead to rights violations and in turn make it more difficult for women to report violence and seek care and support.

Lastly, the quality of the data collection tools and process is critical in producing reliable statistics on violence. Different organisations may use different ways of measuring GVAW, and this does not necessarily add to the reliability and comparability of data. Challenges regarding data reliability are further aggravated for human trafficking and violence in settings of conflict and war. Data concerning human trafficking is often incomplete and lacking sufficient detail, and not available from all countries.<sup>viii</sup> Underreporting of violence can be exacerbated by situations of conflict or war because of lack of legal, health and social services and infrastructure for data collection during or followed by a crisis. All this means that data on GVAW should be interpreted with caution.

<sup>5</sup> 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 (see definition in Box 5.1) (UN Women. 2012. 'Glossary of Terms from Programming Essentials and Monitoring and Evaluation Sections'. [www.endvawnow.org/en/articles/347-glossary-of-terms-from-programming-essentials-and-monitoring-and-evaluation-sections.html](http://www.endvawnow.org/en/articles/347-glossary-of-terms-from-programming-essentials-and-monitoring-and-evaluation-sections.html)).

### 5.1.3 Physical and sexual violence

Worldwide, one in three women are estimated to have experienced some form of physical and/or sexual violence during their lifetime.<sup>ix</sup> While GVAW includes different forms of violence, most studies and data focus on intimate partner physical and/or sexual violence and non-partner sexual violence, given their prevalence and impact on women's lives.<sup>x</sup> Global estimates of IPV as well as non-partner sexual violence show GVAW is a pervasive problem in Africa, as it is worldwide.

In its 2013 report on VAW, the World Health Organization (WHO) estimated the lifetime prevalence of some form of physical and/or sexual violence by an intimate partner to be 36.6% among African women.<sup>6</sup> Moreover, the lifetime prevalence of **non-partner sexual violence** was estimated to be 11.9% among African women.<sup>xi</sup> As fewer studies include questions on non-partner sexual violence, comparative country data on this indicator is hard to obtain. However, regional data on non-partner sexual violence is available (Table 5.1), and suggest that one in ten women in Western and Eastern Africa experience non-partner sexual violence, and that these figures are even higher for Eastern and Southern Africa, at almost or more than one in five women.<sup>xii</sup>

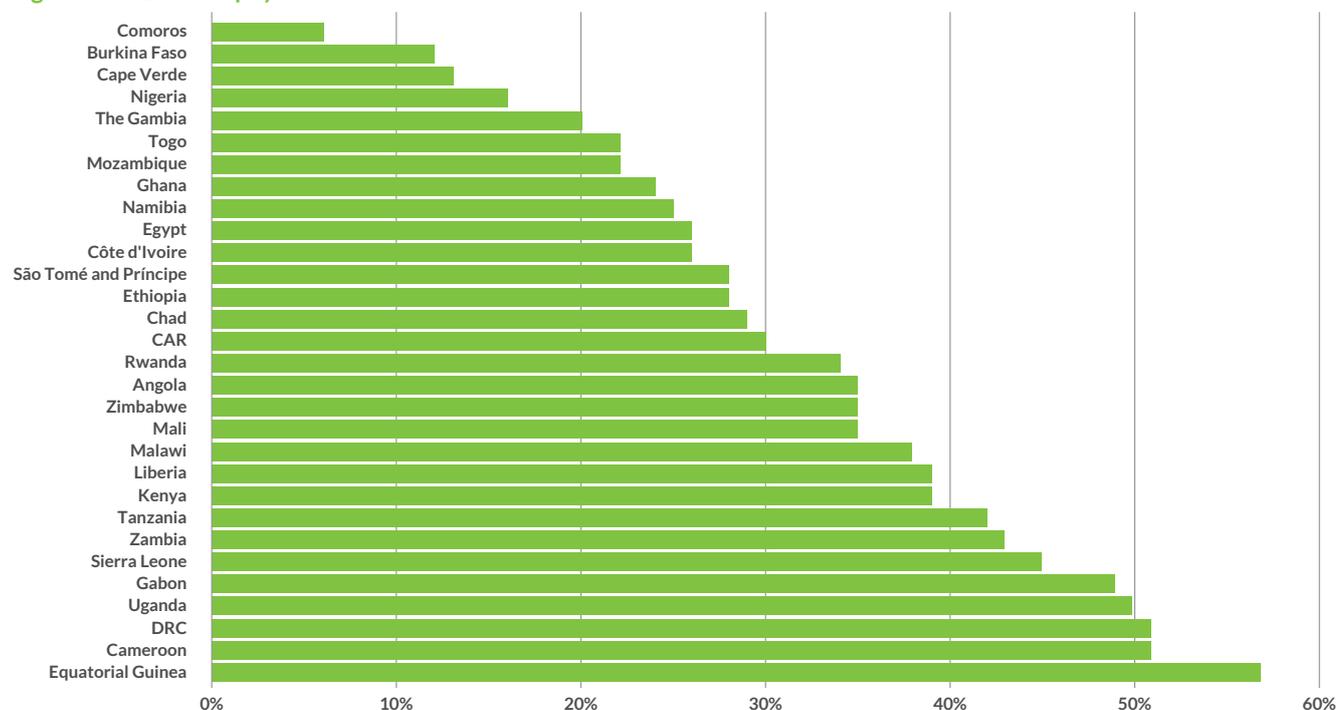
**Table 5.1. Prevalence of non-partner sexual violence across African regions**

African region*	Prevalence of non-partner sexual violence among women (age 15–69)**
North (including Middle East)	4.5%
Western	9.2%
Eastern	11.5%
Southern	17.4%
Central	21%

Notes: \* Based on WHO Global Burden of Disease regions. \*\* WHO data from 2010.

More research is done on **intimate partner violence**, and its inclusion in national Demographic Health Surveys (DHS) results in more data being available on its prevalence. As Figure 5.1 shows, prevalence of IPV varies highly between countries, with Comoros as low as 6% and Equatorial Guinea having the highest prevalence at 57%. There are no clear patterns between regions, but, overall, prevalence is high. In fact, in 19 out of the 28 countries for which data was available, between 20% and 45% of women aged 15–49 years old have experienced physical or sexual violence by their intimate partner at least once in their life.

**Figure 5.1a. Lifetime physical and/or sexual IPV**



<sup>6</sup> IPV is also a large factor in killings of women and girls. An estimated four out of ten murders of women are committed by intimate partners, and this share is much lower for men (WHO, 2013. *Global and Regional Estimates of Violence against Women*. [www.endvawnow.org/uploads/browser/files/who\\_prevalence\\_2013.pdf](http://www.endvawnow.org/uploads/browser/files/who_prevalence_2013.pdf)).

Figure 5.1b. Lifetime physical and/or sexual IPV



#### 5.1.4 Violence experienced by marginalised groups of women and girls

Whereas GVAW is to be understood as stemming from and reinforcing unequal gendered power relations, not all women and girls experience or are exposed to violence in the same way. For example, girls and young women can be exposed to other forms of violence than those facing elderly women, and women from minority and/or disadvantaged groups, including women with disabilities, also face particular challenges (as acknowledged in the Beijing Platform for Action of 1995). Women from marginalised groups are often confronted by multiple and reinforcing layers of discrimination, leading to more disadvantage and marginalisation. Women living in poverty are more exposed to various forms of violence, given reduced opportunities for education, employment and training and poor access to health and welfare services. In addition, men living in poverty are more at risk of perpetrating violence out of anger and frustration at not having an income or finding a job.<sup>xiii</sup>

**Girls and young women** are particularly vulnerable to certain forms of violence given their subordinate status within families and communities. These include rituals relating to their reproductive functions, such as FGM or initiation rites. Globally, violence is the second leading cause of death among adolescent girls, and this becomes more prominent when girls enter adolescence.<sup>xiv</sup> One study from Zambia indicated that, among female sexual assault survivors, 49% were younger than 14 and 85% younger than 19.<sup>xv</sup> Violence makes an early appearance in women's intimate and sexual relationships. A report by the United Nations Children's Fund (UNICEF) indicates that over 50% of ever-married girls have experienced IPV, with the highest rates in Equatorial Guinea, DRC, Gabon, Zimbabwe and Cameroon.<sup>xvi</sup> Child marriage and FGM are also acts of violence and violations of girls' rights to bodily integrity, and are discussed more in detail in Chapter 6.

**Women with disabilities** are vulnerable as their disability increases their dependency on others and can disempower them. A 2014 study from Uganda indicated that girls with disabilities were at particular risk of experiencing violence (sexual violence in particular) that mainly occurs in school settings.<sup>xvii</sup> Violence against women with disabilities can extend over larger periods, including through absence of mobility aids/assistive devices, laws enforcing deprivation of legal capacity and lack of access to information and counselling services, for example.<sup>xviii</sup> Violence against women as well as men living with albinism is of particular concern here, and in certain regions in Africa they are exposed not only to stigma and discrimination but also to assault and killings.<sup>xix</sup>

**Elderly women** face various forms of violence, including forms of abuse and neglect.<sup>xx</sup> One example, common in Tanzania and South Africa, is violence committed against older women accused of witchcraft. Such accusations are often based on sudden, unexpected events happening in the community (i.e. sickness and/or disease in humans or animals, sudden death, impotence, etc.). Witchcraft accusations are a critical violation of women's human rights and are used as a basis for torture and various forms of violence without evidence. Lack of reporting means the current amount of African women persecuted over witchcraft is unknown.<sup>xxi</sup>

Women's sexual identities and behaviours can also be a cause of violence. **Female sex workers** experience stigma associated with sex work, especially but not only in settings where sex work is criminalised. Violence against sex workers is related to exploitation and extortion of earnings by law enforcement officials or rape by clients. This violence also affects their sexual and reproductive health, and often goes hand-in-hand with lack of condom use, increasing the risk of an STI or HIV infection.<sup>xxii</sup>

**Lesbian, bisexual or transgender women** can be subjected to discrimination and hate crimes including sexual assault, torture, murder and rape, as well as denial of education, employment and other basic human rights. ACHPR Resolution 275 recognises and is alarmed by the acts of violence, discrimination and other human rights violations that are committed against individuals in many parts of Africa because of their actual or imputed sexual orientation or gender identity. These acts include 'arbitrary arrests, detentions, extra-judicial killings and executions, forced disappearances, extortion and blackmail', as well as violence and human rights violations 'by State and non-State actors targeting human rights defenders and civil society organisations working on issues of sexual orientation or gender identity in Africa' (see also Section 5.2 of this chapter).<sup>xxiii</sup> South Africa has seen a rise of 'corrective rape', which is when a man rapes a lesbian woman in order to punish and 'cure' her of their sexual orientation.<sup>xxiv</sup>

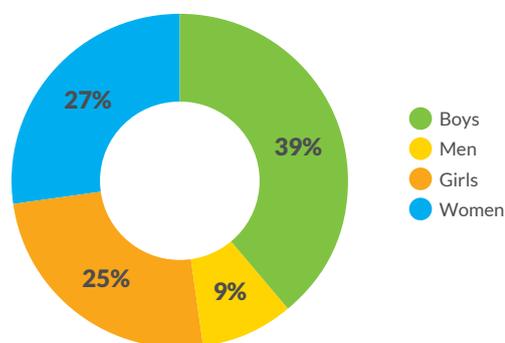
### 5.1.5 Trafficking of women and girls

A particular form of violence concerns **human trafficking**. Nearly two-thirds of detected victims of human trafficking in 2012–14 in Sub-Saharan Africa were children (see Figure 5.2).<sup>xxv</sup> Women and girls made up more than half of all victims, mostly for sexual slavery and forced marriage. Among adult victims, trafficking among women is more prevalent. Among children, the majority are boys, and this mainly concerns trafficking for forced labour and for use as child soldiers. Trafficking is commonly defined in terms of three core elements: (1) the act, (2) the means and (3) the purpose.<sup>7</sup>

In Sub-Saharan Africa, the most prevalent form of trafficking is for the purpose of forced labour, including domestic servitude (53% of all detected cases; affecting both girls and boys). A total of 29% of detected cases concern sexual exploitation; these are reported throughout the region and include sexual slavery in the context of conflict and war as well as trafficking into prostitution, mainly in urban centres and tourist areas. The remaining share of trafficking cases (18%) comprises trafficking in children as armed combatants; this also includes forced marriage and is widely reported in both Western and Eastern Africa.

Most of the trafficking in human persons in Sub-Saharan Africa takes place within countries (83%), with victims for instance trafficked from rural to urban areas. Trafficking in persons occurs to a much lesser extent across borders (15%). As in many other parts of the world, about half of convicted traffickers are women, which suggests women play a prominent role in the trafficking process.<sup>xxvi</sup> Trafficking is affected by push and pull factors, which respectively make people vulnerable to trafficking or contribute to 'demand' for trafficking in persons. The latter include differences in levels of economic wealth between regions or cities, as well as demand for soldiers (owing to conflict), the adoption trade and the use of body parts in rituals. Poverty, poor living conditions and lack of social and economic opportunities, as well as political instability and the lack of a legal and policy framework, are among the push factors contributing to trafficking.<sup>xxvii</sup>

Figure 5.2. Victims of human trafficking in Sub-Saharan Africa (by age and sex, 2014)<sup>xxviii</sup>



<sup>7</sup> The 'act' refers to recruitment, transportation, transfer, harbouring and receipt in a trafficking process. The 'means' points to the threat or use of force or other forms of coercion or abuse of power, as well as abduction, fraud, deception and giving or receiving payments to gain control over another person. The 'purpose' can range from exploitation to the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or servitude or the removal of body organs. For more information: <https://www.unodc.org/unodc/en/human-trafficking/what-is-human-trafficking.html>

### 5.1.6 Causes and impacts of gender-based violence against women

While there is no single factor behind GVAW, gender inequality and discrimination are root causes of GVAW. GVAW is influenced by structural and historical power imbalances between men and women. Women's lack of control and power, combined with social norms that justify or legitimise the use of force or abuse against them, contributes to prevalence of GVAW. Inequalities across social, economic, cultural and political rights increase the risk. GVAW is both a cause and a consequence of gender inequality, and it reinforces women and girls' subordinate status in society. Male dominance and control in the family and community, and lack of sanctions against perpetrators of violence, contribute to GVAW. Other factors include low socioeconomic status or educational levels and the social acceptance of attitudes condoning violence. Community values that link masculinity to dominance and honour and to male entitlement, as well as family responses to addressing violence and/or marital conflict, can also contribute to GVAW. Limited economic opportunities and high economic dependency of women on men is also an important factor. Women who are part of a marginalised or excluded group may also be more exposed to GVAW.<sup>xxxix</sup>

Social norms and attitudes are key to social acceptability of violence. Many forms of GVAW continue to be accepted among both men and women in Africa owing to persisting social norms, beliefs and practices that legitimise the acceptance and tolerance of GVAW. In Malawi, for example, men can use violence as a means to 'discipline' or 'correct' their wife or children. In South Sudan, acceptance and normalisations remain drivers of GVAW.<sup>xxx</sup> A 2014 report by UNICEF on violence against children and adolescents showed that, regarding attitudes towards wife-beating, over half of adolescent girls in Northern (~53%), Eastern and Southern Africa (~55%) acknowledged this to be justifiable under certain circumstances.<sup>xxxi</sup> Table 5.2 shows that attitudes towards wife-beating vary across countries but demonstrate a pattern of high levels of acceptability among women and girls aged 15–49 towards wife-beating in certain circumstances.<sup>xxxii</sup>

**Table 5.2. Attitudes of women and girls (aged 15–49) towards wife-beating in certain circumstances**

Country	Women thinking wife-beating is justified in certain circumstances
CAR	80%
DRC	76%
Niger	60%
Ghana	44%
Swaziland	28%

Besides being a human rights violation, GVAW is detrimental to women's mental, physical, sexual and reproductive health. More specifically, GVAW violates women's self-esteem, self-efficacy and inherent dignity. It can lead to depression, posttraumatic stress, anxiety disorders, sleep difficulties, eating disorders and suicide (attempts). Its impacts include long and short-term physical injuries, limited mobility, chronic pain or even fatal outcomes like homicide or suicide. It can lead to unintended/unwanted pregnancies, (forced) abortions, complications, genital lesions, vaginal and anal tears, obstetric fistula, miscarriage and increased risk of STIs such as HIV (discussed in Chapters 6 and 7). Besides all this, GVAW can also destroy community and family structures.<sup>xxxiii</sup> Lastly, GVAW has great social and economic costs for countries as it can lead to women being isolated, unable to work and lacking in participation in society.<sup>xxxiv</sup>

### 5.1.7 GVAW in situations of conflict and war

GVAW merits specific consideration in settings of conflict, war, insecurity and disaster. Women continue to be disproportionately affected by conflict and war as refugees or internally displaced persons or through the experience of devastating forms of physical and sexual violence. More specifically, physical and sexual violence is being used as a weapon of war, against men and boys as well as women and girls,<sup>xxxv</sup> in order to destabilise and degrade populations (e.g. through mass rape).<sup>xxxvi</sup> Reports show that sexual violence against women and girls is a pervasive problem linked to conflict and war:<sup>xxxvii</sup>

- In Rwanda, during the 1994 genocide, it was estimated that up to 250,000 women were raped over a period of three months.
- In Sierra Leone, over 60,000 women were raped during the civil war (1991–2002).
- In Liberia, over 40,000 women were raped during the civil war (1989–2003).
- In DRC, over the past decade of conflict in the country, at least 200,000 women have been raped.<sup>xxxviii</sup>

Various actors perpetrate conflict-related GVAW, including combatants, state security forces, peacekeepers and humanitarian workers.<sup>xxxix</sup> A 2017 study indicates that soldiers, militia and community members in Sudan have used sexual violence as a weapon of war, specifically targeted marginalised groups of women in order to destabilise and victimise communities.<sup>xl</sup>

Settings of instability, conflict and war not only increase women and girls' exposure to GVAW but also are related to other detrimental effects on their sexual and reproductive health. High maternal mortality rates have been observed in countries as Burundi, CAR, Chad, DRC, Guinea-Bissau, Liberia, Sierra Leone and Somalia, which were either facing or emerging from conflict.<sup>xli</sup> Another study points to higher vulnerability of girls to child marriage in situations of conflict.<sup>xlii</sup>

Even after conflict has ended, GVAW can continue to occur. Women and girls face specific threats and types of violence in different phases of conflict:<sup>xliii</sup>

- *During conflict*, women can suffer from rape as tool of war, sexual slavery, sexual mutilation, forced prostitution, trafficking and other prevalent forms of physical violence. Conflict and war can lead to displacement and women seeking refuge.
- *During the state of flight*, women can be confronted with sexual attack/exploitation by military and border security.
- *When residing in the country of asylum*, women can suffer sexual attack when collecting water and food, etc., or experience violence committed by persons in authority (camp representatives, country officials).
- *During repatriation*, women separated from family can experience sexual attack/exploitation.
- *During reintegration*, women who return to their country may be subjected to sexual attack as retribution, human trafficking and domestic violence.<sup>xliv</sup>

Displaced women and refugee women are particularly vulnerable to violence as they are often separated from their community and family and traditionally protective structures. A study on Sudan indicates that refugee women in Sudan may face disproportionate targeting by the Public Order Regime, which is a set of discriminatory laws based on *sharia* that enforce certain moral standards of dress and hours of work on the streets, from which refugee women in particular may divert.<sup>xlv</sup>

The political use of violence/GVAW is not restricted to settings of open conflict and war (Box 5.3).

Conditions of poverty are most extreme in settings of conflict and war, especially where state economies have collapsed, with high levels of insecurity, and large populations are displaced. The erosion of community support and protection structures and services and the breakdown of social norms and displacement can exacerbate GVAW.<sup>xlvi</sup>

Human trafficking is importantly and inherently linked to situations of conflict or war. Political instability, conflict or war, oppression and the lack of a legal and policy framework are important push factors in the trafficking of persons. Internally displaced or destabilised populations are more vulnerable to becoming victims of trafficking.<sup>xlvii</sup>

GVAW in situations of conflict, insecurity and war has long remained a largely hidden issue, because it has historically been widely held that women are part of 'the spoils' of war to which combatants or soldiers are entitled.<sup>xlviii</sup> In this context, rape has been normalised as collateral damage of conflict and war and thereby accepted as unavoidable, and has gone recognised as a crime of war.

#### Box 5.3. Justice for victims of the 28 September 2009 massacre and rapes by Guinean security forces

On Monday 28 September 2009, around 50,000 protesters gathered in a stadium to protest the military regime and the presidential elections in Guinea, despite a ban on protests. In order to silence the protesters, security forces opened fire, with at least 157 people killed and over 1,000 injured. After the incident, witnesses saw security forces raping women publicly and women being subjected to other forms of sexual violence.

Since this time, Guineans have been fighting for justice for the events. While progress by Guinean judges has been made in terms of overcoming various political, logistical and financial obstacles, the investigation into the crimes is yet to be completed. Some people have now been charged, but several still hold influential positions in the country.

Source: HRW. (2017). 'Guinea: 8 Years Later, Justice for Massacre Needed'. [www.hrw.org/news/2017/09/27/guinea-8-years-later-justice-massacre-needed](http://www.hrw.org/news/2017/09/27/guinea-8-years-later-justice-massacre-needed)

## 5.2 CONTINENTAL AND REGIONAL POLICY FRAMEWORKS

### 5.2.1 Prohibiting and eradication of all forms of violence against women

The Maputo Protocol provides extensive provisions on the eradication of all forms of GVAW. It articulates every woman's right to dignity, and requires states to take measures to ensure the 'protection of women from all forms of violence, particularly sexual and verbal violence' (Art. 3.4). This is strongly grounded in the elimination of discrimination against women, as articulated in Art. 2, which requires state parties to combat this based on the principle of equality between women and men. It commits states to eliminate all practices 'based on the idea of the inferiority or the superiority of either of the sexes, or on stereotyped roles for women and men' (Art. 2.2). Prohibition of all forms of violence against women is at the heart of Art. 4, which explicitly includes in this 'unwanted or forced sex whether the violence takes place in private or in public' (Art. 4.2.a). Art. 4.2.b is comprehensive in its call for 'measures as may be necessary to ensure the prevention, punishment and eradication of all forms of violence against women'.

#### Right to Dignity and Right to Life, Integrity and Security of the Person (Maputo Protocol)

##### Art. 3 – Right to Dignity

3.1 Every woman shall have the right to dignity inherent in a human being and to the recognition and protection of her human and legal rights.

3.4 States Parties shall adopt and implement appropriate measures to ensure the protection of every woman's right to respect for her dignity and protection of women from all forms of violence, particularly sexual and verbal violence.

##### Art. 4 – Right to Life, Integrity and Security of the Person

4.1 Every woman shall be entitled to respect for her life and the integrity and security of her person. All forms of exploitation, cruel, inhuman or degrading punishment and treatment shall be prohibited.

4.2 States Parties shall take appropriate and effective measures to:

- a) enact and enforce laws to prohibit all forms of violence against women including unwanted or forced sex whether the violence takes place in private or public;
- b) adopt such other legislative, administrative, social and economic measures as may be necessary to ensure the prevention, punishment and eradication of all forms of violence against women.

The prohibition and eradication of all forms of GVAW are grounded in fundamental human rights as articulated in the Universal Declaration on Human Rights (UDHR) of 1948. In its first article, the UDHR states that 'All human beings are born free and equal in dignity and rights.' Furthermore, Art. 3 recognises that 'Everyone has the right to life, liberty and security of person.' In addition, the commitments of the Maputo Protocol are in line with key provisions in the African Charter, including Art. 4, on respect for life and integrity of person, which states that 'Human beings are inviolable.' They are also grounded in Art. 5, on respect for dignity and prohibition of exploitation, degradation, torture, cruel inhuman and degrading treatment and slavery, and Art. 6, on the right to liberty and security of the person.

Importantly, the UDHR, the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR) and African Charter all remain gender-neutral in their formulation of rights. In 1979, CEDAW was the first human rights document to make reference to discrimination of women specifically, but it remained silent on GVAW.<sup>xix</sup> The 1993 DEVAW broke this silence, and was the first international document stating that 'States should pursue by all appropriate means and without delay a policy of eliminating violence against women' (Art. 4).<sup>8</sup>

The MPoA, formulated in 2014, addresses GVAW in the third of its ten key strategies, which concerns ensuring gender equality, women and girls empowerment and respect of human rights. This strategy includes a call for 'eliminating all forms of discrimination and violence against women and girls', as well as 'eradicating harmful traditional practices such as child marriage and female genital mutilation/cutting and other harmful practices'. This third strategy also underlines the need to 'promote social values of equality, non-discrimination and non-violent conflict resolution' (p.11).

<sup>8</sup> GVAW also addressed in Cairo, Beijing and Vienna. The Committee on the Elimination of Discrimination against Women has adopted two general recommendations that address GVAW: General Recommendation No. 12, adopted in 1989, and the more elaborate General Recommendation No. 19, adopted in 1992. <http://www.un.org/womenwatch/daw/cedaw/recommendations/index.html>

## 5.2.2 Violence in schools and at work, and violence experienced by marginalised groups

The provisions in the Maputo Protocol are extensive not only in terms of their comprehensive understanding of violence against women and the responsibilities of state parties but also in pinpointing the many guises under which women and girls experience such violence. The explicit references to GVAW in many articles of the Protocol point to important settings in which GVAW needs to be addressed.<sup>1</sup>

- Art. 5 (on the elimination of harmful practices) requires states to take all necessary measures to eliminate harmful practices, including 'protection of women who are at risk of being subjected to **harmful practices** or all other forms of violence, abuse and intolerance' (Art. 5d).
- Art. 12 (on the right to education and training) explicitly addresses forms of GVAW against girls in schools and educational institutions. It specifically requires states to take appropriate measures to protect women, especially the girl-child, from all forms of abuse, including sexual harassment **in schools and other educational institutions** and provide for sanctions against the perpetrators of such practices' (Art. 12.1c). It also requires states to 'provide access to counselling and rehabilitation services to women who suffer abuses and sexual harassment' (Art. 12.1d).
- Art. 13 (on economic and social welfare rights) requires states to 'combat and punish **sexual harassment in the workplace**' (Art. 13c) and 'prevent the exploitation and abuse of women in advertising and pornography' (Art. 13m). It also explicitly calls on states to protect women 'from exploitation by their employers' (Art. 13d), and in particular 'prohibit, combat and punish all forms of exploitation of children, especially the girl-child' (Art. 13g).

The Maputo Protocol provisions also extend specific attention to GVAW experienced by marginalised groups of women. It highlights attention to ensuring the protection of poor women and women heads of households including women from marginalised population groups (Art. 24 on special protection of women in distress). Freedom from violence is explicitly articulated with respect to elderly women, widows and women with disabilities:

- In Art. 22 (on special protection of **elderly women**), state parties are required to 'ensure the right of elderly women to freedom from violence, including sexual abuse, discrimination based on age and the right to be treated with dignity' (Art. 22b).
- Art. 20 (on widow's rights) underlines that states should ensure **widows** enjoy all human rights and 'are not subject to inhuman, humiliating or degrading treatment' (Art. 20a).
- Art. 23 (on special protection of women with disabilities), in a similar vein, requires state parties to 'ensure the right of **women with disabilities** to freedom from violence, including sexual abuse, discrimination based on disability and the right to be treated with dignity' (Art. 23b).

The Maputo Protocol also specifically addresses GVAW in armed conflict situations. Art. 11 (on protection of **women in armed conflicts**) requires state parties to 'protect asylum seeking women, refugees, returnees and internally displaced persons, against all forms of violence, rape and other forms of sexual exploitation' (Art. 11.3). GVAW in the context of insecurity, conflict and war is further discussed below. Finally, the Maputo Protocol addresses GVAW in 'authorizing medical abortion in cases of sexual assault, rape, incest', among other grounds (Art. 14c; see more detailed discussion on safe abortion in Chapter 7).

### 5.2.3 Obligations of states

The Maputo Protocol sets a high bar for state responsibility regarding violence against women.<sup>9</sup> It calls for the enactment and enforcement of legal prohibition of all forms of violence against women (Art. 4.2a); for prevention and elimination by addressing the causes and consequences (Art. 4.2c); for the punishment of perpetrators (Art. 4.2e) and rehabilitation and reparation for victims (Art. 4.2e and 4.2f); for states to eradicate 'elements in traditional and cultural beliefs, practices and stereotypes which legitimize and exacerbate the persistence and tolerance of violence against women', by promoting peace education in schools and social communication (Art. 4.2d); and for adequate allocation of budgets and resources to implement and monitor progress on prevention and eradication (Art. 4.2i).

#### Required measures regarding violence against women (Maputo Protocol, Art. 4)

##### 2. States Parties shall take appropriate and effective measures to:

- a) *enact and enforce laws to prohibit* all forms of violence against women including unwanted or forced sex whether the violence takes place in private or public;
- b) adopt such *other legislative, administrative, social and economic measures* as may be necessary to ensure the prevention, punishment and eradication of all forms of violence against women;
- c) identify the causes and consequences of violence against women and take appropriate measures to *prevent and eliminate* such violence;
- d) actively *promote peace education* through curricula and social communication in order to eradicate elements in traditional and cultural beliefs, practices and stereotypes which legitimise and exacerbate the persistence and tolerance of violence against women;
- e) *punish the perpetrators* of violence against women and implement programmes for the rehabilitation of women victims;
- f) establish mechanisms and accessible services for *effective information, rehabilitation and reparation for victims of violence against women*;
- g) prevent and condemn trafficking in women, prosecute the perpetrators of such trafficking and protect those women most at risk;
- h) prohibit all medical or scientific experiments on women without their informed consent;
- i) provide adequate budgetary and other resources for the implementation and monitoring of actions aimed at preventing and eradicating violence against women;
- j) ensure that, in those countries where the death penalty still exists, not to carry out death sentences on pregnant or nursing women;
- k) ensure that women and men enjoy equal rights in terms of access to refugee status determination procedures and that women refugees are accorded the full protection and benefits guaranteed under international refugee law, including their own identity and other documents.

The principles and obligations of states are articulated in detail in the *Guidelines on Combating Sexual Violence and Its Consequences in Africa*, adopted by the ACHPR in 2017 (see also Chapter 3 on the mandate of the ACHPR). These Guidelines serve to provide guidance and support to AU member states in the effective implementation of their commitments to combat sexual violence and its consequences. They are grounded in the existing normative frameworks at continental and regional level (AU as well as RECs) and the international (UN) level. The principles for state responses are threefold (Part 1B of the Guidelines):

1. The **non-discrimination** principle: This requires that states take the necessary measures to ensure the rights of *all* victims of sexual violence are guaranteed and cannot be discriminated against 'irrespective of their race, colour, national origin, citizenship, ethnicity, profession, political opinions, and any other opinions, and health including HIV status, disability, age, religion, culture, marital status, socio-economic status, status as a refugee, migrant or any other status, sexual orientation and identity, gender expression or any other factor that could lead to discrimination against them' (see also Box 5.4 on ACHPR Resolution 275).
2. The **'do-no-harm'** principle: This requires states to take all legislative and other measures to guarantee the well-being and security of both victims and witnesses of sexual violence. This also includes minimising 'the negative impact that actions to combat sexual violence and its consequences can have on victims and witnesses', in particular investigative procedures on sexual violence acts, as well as the prosecution of perpetrators.
3. The **due diligence** principle: This requires that states adopt the necessary legislative and regulatory measures to act with due diligence in the prevention, investigation, prosecution, punishment and provisions of remedies in cases of sexual violence committed by state as well as non-state actors. This is important for holding states to account for violations committed by non-state actors, and in particular for violations in the private sphere.<sup>9 iii</sup>

<sup>9</sup> This is in line with CEDAW General Recommendation No. 19 (1992), that states 'take all appropriate measures to eliminate discrimination against women by any person, organization or enterprise' (Point 9, p. 2, emphasis ours). CEDAW General Recommendation No. 35 (2017) further articulates this due diligence obligation. It states that, 'under the obligation of due diligence, States parties have to adopt and implement diverse measures to tackle gender-based violence against women committed by non-State actors. They are required to have laws, institutions and a system in place to address such violence. Also, States parties are obliged to ensure that these function effectively in practice, and are supported and diligently enforced by all State agents and bodies. Failures or omissions to this effect constitute human rights violations (Part III.B.2, pp. 8–9).

**Box 5.4. Violence and Human Rights Violation on the Basis of Sexual Orientation or Gender Identity (Resolution 275, ACHPR, 2014)**

In May 2014, the ACHPR adopted Resolution 275 on *Protection against Violence and other Human Rights Violations against Persons on the basis of their real or imputed Sexual Orientation or Gender Identity*. This resolution recalls that the African Charter prohibits discrimination on the basis of distinctions of any kind (Art. 2) and entitles every individual to equal protection of the law (Art. 3). The resolution also recalls that the African Charter entitles every individual to respect of their life and integrity of their person, and prohibits torture or other cruel, inhuman and degrading treatment or punishment (Art. 4 and 5).

The ACHPR is deeply disturbed by 'the failure of law enforcement agencies to diligently investigate and prosecute perpetrators of violence and other human rights violations targeting persons on the basis of their imputed or real sexual orientation or gender identity'.

Resolution 275:

1. **Condemns** the increasing incidence of violence and other human rights violations, including murder, rape, assault, arbitrary imprisonment and other forms of persecution of persons on the basis of their imputed or real sexual orientation or gender identity
2. **Specifically condemns** the situation of systematic attacks by state and non-state actors against persons on the basis of their imputed or real sexual orientation or gender identity
3. **Calls on** state parties to ensure that human rights defenders work in an enabling environment that is free of stigma, reprisals or criminal prosecution as a result of their human rights protection activities, including the rights of sexual minorities and
4. **Strongly urges** states to end all acts of violence and abuse, whether committed by state or non-state actors, including by enacting and effectively applying appropriate laws prohibiting and punishing all forms of violence including those targeting persons on the basis of their imputed or real sexual orientation or gender identities, ensuring proper investigation and diligent prosecution of perpetrators and establishing judicial procedures responsive to the needs of victims.

The obligations of states in combating sexual violence and its consequences are fourfold:

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 the perpetrators of sexual violence and
4. To provide effective **remedy and reparation** for victims of sexual violence

Box 5.5 summarises the key elements of these four obligations as well as the obligations regarding implementation of the guidelines.

**Box 5.5. State obligations on sexual violence and its consequences**

The ACHPR *Guidelines on Combating Sexual Violence and Its Consequences in Africa* (2017) provide an extensive explanation of the five sets of state obligations on sexual violence.

1. PREVENTING sexual violence and its consequences	A. Awareness-raising strategies B. Educational programmes and materials C. Training of professionals D. Urban and rural planning E. Cooperation with local stakeholders and civil society
2. PROTECTING and SUPPORTING the victims of sexual violence	A. Reporting sexual violence (including toll-free emergency numbers, counselling and support centres, social workers in police stations and posts) B. Measures to protect and support victims (including one-stop centres, shelters, and protection orders) C. Medical support and access to sexual and reproductive rights (including psychological support and care, sexual and reproductive health care, emergency contraception, medical abortion and post-abortion care and prevention and treatment of HIV) <sup>10</sup> D. Social support E. Information (on rights, and protection and prevention measures) F. Coordination and cooperation between stakeholders (including focal points and on-line national guidebooks)
2. INVESTIGATING sexual violence and PROSECUTING those responsible	A. Criminalisation of sexual violence <sup>11</sup> B. Initiation and progress of public prosecution <sup>12,13</sup> C. Investigation and prosecution in situations of conflict and crisis, as international crimes <sup>14</sup>
4. Right to REPARATION	A. General principles B. Types of reparation including restitution, compensation, rehabilitation, satisfaction and guarantee of non-repetition
5. IMPLEMENTATION of regional and international obligations	A. National legislation combating sexual violence <sup>15</sup> B. Governmental measures <sup>16</sup> C. National gender equality institutions and national institutions for the promotion and protection of human rights D. Measurements and statistical data E. Gender-responsive budgeting F. Implementation of the guidelines <sup>17</sup>

<sup>10</sup> Including treatment by gynaecologists, proctologists and urologists (especially to treat infections and STIs including HIV, and traumatic and gynaecological fistula), pregnancy tests, contraception (including emergency contraception), medical abortions, post-abortion care and psychological support.

<sup>11</sup> The national legislative framework criminalising sexual violence must also (1) guarantee the effectiveness of any investigation and prosecution, (2) guarantee the victim's right to free legal assistance and representation, (3) guarantee coverage of legal forensic and medical costs, (4) contain clear and specific provisions regarding gathering, preserving and archiving of evidence, (5) ensure the most serious sexual offences are not subject to prescription, (6) prohibit any type of mediation between the victim and the perpetrator before or during legal proceedings and (7) provide penalties commensurate with the seriousness of the act of sexual violence (*Guidelines for Combating Sexual Violence and Its Consequences*, p. 30).

<sup>12</sup> Including (1) warning and reporting mechanism, (2) specialised investigative and prosecution units, (3) legal assistance and legal representation, at no cost to the victim, (4) integrity and confidentiality consent of the victims in evidence-gathering, (5) informed consent, and reversal of the burden of proof. Including the right of victims to be heard and duly represented during public prosecution. Including measures for protecting victims and witnesses of sexual violence against intimidation, reprisals and all kinds of victimisation or trauma through all phases of investigation and prosecution of sexual violence (special measures taken for children victims or witnesses of sexual violence).

<sup>13</sup> Including proportional penalties to the seriousness of the act of sexual violence. Applicable penalties must take any aggravating circumstances into consideration, including but not limited to (1) vulnerability of the victim as a result of age, disability, status as displaced person or refugee or otherwise, (2) the relationship between victim and perpetrator, i.e. family relations or authority, (3) presence of a child, (4) number of attackers, (5) knowledge of the attacker that (s)he is infected with HIV, (6) repeated offences, (7) recidivism and (8) seriousness of physical and psychological damage (Guideline 43.1). They should *not* take the following into account as extenuating circumstances: sexual behaviour of the victim, the victim's status as a member of a given group or the conjugal relationship between the perpetrator and victim (Guideline 43.2) (*Guidelines for Combating Sexual Violence and Its Consequences*, p. 30–31).

<sup>14</sup> 'Enable the prosecution of crimes of sexual violence committed in situations of conflict and crisis as international crimes, providing for them to be prosecuted as crimes of genocide, crimes against humanity, and war crimes in their domestic legislation, in accordance with international criminal law' (Special Guidelines for Situations of Conflict and Crisis).

<sup>15</sup> Harmonisation with regional and international instruments; specific legislation to combat sexual violence.

<sup>16</sup> (1) Integrated public policy; national action plans; an implementing authority; ensuring monitoring and evaluation of implementation; (2) national action plans on women, peace and security.

<sup>17</sup> Present national reports to the ACHPR every other year, including a description of progress made in implementing these guidelines (pursuant to Art. 62 of the African Charter and Art. 26 of the Maputo Protocol).

## 5.2.4 Violence against girls and youth

As mentioned above, the Maputo Protocol specifically acknowledges gender-based violence against girls, including sexual harassment, in school and education institutions. Other important normative frameworks that address violence against children and/or youth are the United Nations Convention on the Rights of the Child (UN CRC) (1989), and at a continental level, the African Charter on the Rights and Welfare of the Child (ACRWC) (1990) and later the African Youth Charter (AYC) (2006) (see overview of key provisions in Box 5.6).

The UN CRC and ACRWC have similar provisions regarding protecting the child from all forms of violence, injury or abuse, and also both explicitly refer to sexual exploitation and sexual abuse. The ACRWC also highlights the abduction, sale and trafficking of children. The provisions in the UN CRC and ACRWC do not explicitly underscore gender-based violence against girls. The Solemn Declaration on Gender Equality in Africa (2004) does explicitly draw attention to the abuse of the girl child, in particular the recruitment of girls as wives and sex slaves in conflict settings.<sup>18</sup> The AYC in 2006 provided more of a focus on violence against girls and young women. The need to protect girls and young women from all forms of violence is articulated specifically, and placed in the context of eliminating discrimination against girls and young women.

### Box 5.6. Continental and international commitment on violence against children and/or youth

CRC (1989)	ACRWC (1990)
<p>Art. 19: 'measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse'</p> <p>Art. 34: 'to protect the child from all forms of <b>sexual exploitation and sexual abuse</b>', and 'to prevent:</p> <ul style="list-style-type: none"> <li>(a) The inducement or coercion of a child to engage in any unlawful sexual activity;</li> <li>(b) The exploitative use of children in prostitution or other unlawful sexual practices;</li> <li>(c) The exploitative use of children in pornographic performances and materials.'</li> </ul>	<p>Art. 16: 'measures to protect the child from all forms of torture, inhuman or degrading treatment and especially physical or mental injury or abuse, neglect or maltreatment including sexual abuse'</p> <p>Art. 27: 'to protect the child from all forms of <b>sexual exploitation and sexual abuse</b> and shall in particular take measures to prevent:</p> <ul style="list-style-type: none"> <li>(a) the inducement, coercion or encouragement of a child to engage in any sexual activity;</li> <li>(b) the use of children in prostitution or other sexual practices;</li> <li>(c) the use of children in pornographic activities, performances and materials.'</li> </ul> <p>Art. 29: 'to prevent:</p> <ul style="list-style-type: none"> <li>(a) the <b>abduction, sale of, or traffic</b> in children for any purpose or in any form, by any person including parents or legal guardians of the child.'</li> </ul>
<p>Maputo Protocol (2003)</p>	<p>Art. 12: to 'protect women, especially the girl-child from all forms of abuse, including <b>sexual harassment in schools and other educational institutions</b> and provide for sanctions against the perpetrators of such practices' and to 'provide access to counselling and rehabilitation services to women who suffer abuses and sexual harassment'</p>
<p>AYC (2006)</p>	<p>Art. 23: 'enact and enforce legislation that <b>protect girls and young women from all forms of violence, genital mutilation, incest, rape, sexual abuse, sexual exploitation, trafficking, prostitution and pornography</b>' and 'develop programmes of action that provide legal, physical and psychological support to girls and young women who have been subjected to violence and abuse such that they can fully re-integrate into social and economic life'</p>

<sup>18</sup> Heads of State and Government of AU member states agreed to, among other things, 'launch, within the next one year, a campaign for systematic prohibition of the recruitment of child soldiers and abuse of girl children as wives and sex slaves in violation of their Rights as enshrined in the African Charter on Rights of the Child'.

<sup>19</sup> This supplements the UN Convention against Transnational Organized Crime (also from 2000).

## 5.2.5 Trafficking of women and girls

Human trafficking or 'trafficking in persons' is a fundamental violation of women and girls' human rights. The Maputo Protocol makes explicit reference to the requirement that states prevent and condemn the trafficking of women (Art. 4), prosecute perpetrators and protect women and girls most at risk. Prior to the adoption and entry into force of the Maputo Protocol, in 2000, the UN adopted the *Protocol to Prevent, Suppress and Punish Trafficking in persons especially Women and Children*, to combat and prevent trafficking in persons, assist victims and promote international cooperation.<sup>19</sup> The Palermo Protocol is the first global legally binding instrument with an agreed definition on trafficking in persons (see Box 5.7).

### Trafficking of women (Maputo Protocol, Article 4)

4.2 State parties shall take appropriate and effective measures to:

- g) *prevent and condemn trafficking in women, prosecute the perpetrators of such trafficking and protect those women most at risk.*

#### Box 5.7. Definition of trafficking in persons (Palermo Protocol, 2000)

Art. 3(a) of the Protocol to Prevent, Suppress and Punish Trafficking in persons especially Women and Children defines trafficking in persons as '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.'

Several African countries are involved in a GLO.ACT, a joint initiative by the EU and the United Nations Office on Drugs and Crime (UNODC) to implement the Palermo Protocol. GLO.ACT is a four-year project, running from 2015 to 2019, that aims to address and prevent trafficking in persons and the smuggling of migrants, in, among others, Mali, Morocco, Niger and South Africa.<sup>iii</sup>

At the African continental level, the Ministerial Conference on Migration and Development in 2006 adopted the *Ouagadougou Action Plan to combat trafficking in human beings, especially women and children*.<sup>liv</sup> This is a migration policy aimed at combating and preventing trafficking in persons between the EU and the AU, and calls for prevention and awareness-raising, capacity-building for institutions, training of criminal justice officials and support to protection and rehabilitation centres for victims.<sup>lv</sup> In relation to implementation of the Action Plan by RECs, the AU has launched the AU Commission Initiative against Trafficking Campaign (AU.COMMIT) (see Box 5.8).

#### Box 5.8. AU.COMMIT campaign

AU.COMMIT is one of the flagship initiatives of the Africa–EU Migration Mobility and Employment Partnership (7th Partnership of the Africa–EU Strategy). The campaign has been launched in cooperation with ECOWAS, IGAD, SADC and EAC and reaches out to member states, RECs and CSOs to raise awareness regarding the challenge of trafficking in persons across the African continent. It also advocates for increased action within the framework of implementation of the Ouagadougou Action Plan.

The overall objective of the AU.COMMIT campaign is to set the pace for the fight trafficking in persons as a priority on the AU development agenda. The campaign focuses on prevention, prosecution of offenders and protection of victims. More specific objectives are to inform the public about AU.COMMIT and the AU's determination to address trafficking in persons in cooperation with RECs, member states and other partners. It also calls on the media and CSOs to popularise and advocate for implementation of the Ouagadougou Action Plan.

At a regional level, SADC is the only REC that has a policy framework specifically targeted at human trafficking: the *10-year SADC Strategic Plan of Action on Combating Trafficking in Persons, especially Women and Children (2009–19)* (see Box 5.9). ECOWAS adopted a *Declaration on the Fight against Trafficking in Persons* in 2001.

#### Box 5.9. The 10-year SADC Strategic Plan of Action on Combating Trafficking in Persons, especially Women and Children (2009–19)

This SADC Plan of Action on combating trafficking in persons articulates eight priority areas: (1) legislation and policy measures, (2) training for skills enhancement and capacity-building, (3) prevention and public awareness-raising, (4) victim support and witness protection, (5) coordination and regional cooperation, (6) research and information-sharing, (7) resource mobilisation and (8) monitoring and evaluation.<sup>lvi</sup>

### 5.2.6 GVAW and peace and security agenda and commitments

The Maputo Protocol explicitly addresses GVAW in settings of insecurity, conflict and war. This includes both women's right to a peaceful existence and the right to participate programmes and decision-making structures in conflict and post-conflict resolution and management and the promotion of peace (Art. 10). It also specifically calls for the protection of women in armed conflicts, against all forms of violence, and the prosecution of perpetrators (Art. 11). Art. 4, on the right to life, integrity and security of the person, explicitly requires states to ensure equal rights to access to procedures to determine refugee status, and that women refugees be accorded full protection.

The provision in Article 11.2, that states shall act in accordance with international humanitarian law, is of particular significance, as it implies that sexual violence during armed conflict constitutes a war crime, genocide and/or crime against humanity.<sup>lvii</sup> This means it constitutes 'preremptory norms' from which no state can derogate because violations under these crimes affect the whole international community. All states, also those not under a treaty prohibiting these crimes, are held by international humanitarian law and the obligations set there regarding war crimes, genocide and crimes against humanity.<sup>20</sup> The ACHPR *Guidelines on Combatting Sexual Violence and Its Consequences in Africa* (2017) also state that sexual violence can constitute an international crime, and specifically address sexual violence in situations of conflict and crisis in the obligations of states to investigate and prosecute (Part 4, Section C of the Guidelines; see also Box 5.5 above).

#### Provisions on GVAW and women, peace and security in the Maputo Protocol

##### Art. 4: Right to Life, Integrity and Security of the Person

States Parties shall take appropriate and effective measure to:

- 'ensure that women and men enjoy equal rights in terms of access to refugee status determination procedures and that women refugees are accorded the full protection and benefits guaranteed under international refugee law, including their own identity and other documents' (Art. 4.2k)

##### Art. 10: Right to Peace

- 'Women have the right to a peaceful existence and the right to participate in the promotion and maintenance of peace' (Art. 10.1).
- 'Ensure *increased participation* of women in peace education programmes; in conflict prevention, management and resolution; in decision-making structure on protection of asylum seekers, refugees, returnees and displaced persons; in structures for the management of camps and settlements; and in post-conflict reconstruction and rehabilitation' (Art. 10.2)

##### Art. 11: Protection of Women in Armed Conflicts

- 'State Parties undertake to respect and ensure respect for the rules of international humanitarian law applicable in armed conflict situations, which affect the population, particularly women' (Art. 11.1)
- 'State Parties shall, in accordance with the obligations incumbent upon them under international humanitarian law, protect civilians including women, irrespective of the population to which they belong, in the event of armed conflict' (Art. 11.2)
- 'State Parties undertake to protect asylum seeking women, refugees, returnees and internally displaced persons, against all forms of violence, rape and other forms of sexual exploitation, and to ensure that such acts are considered war crimes, genocide and/or crimes against humanity and that their perpetrators are brought to justice before a competent criminal jurisdiction' (Art. 11.3)

The Maputo Protocol provisions on GVAW in settings of conflict and insecurity endorse commitments expressed in the international Women, Peace and Security Agenda, in particular UNSCR 1325. The adoption of this landmark resolution in 2000 was stimulated by a big push from African stakeholders on issues of women in armed conflict or war, and was preceded by the 2000 *Windhoek Declaration of Namibia*.<sup>lviii</sup> UNSCR 1325 and later resolutions (see Box 5.10), alongside CEDAW (1979), CEDAW General Recommendation No. 30 in particular and the Beijing Platform for Action (1995), make up the Women, Peace and Security Agenda.<sup>lix</sup> This guides work to promote gender equality, to increase the participation of women in peace and security institutions and to ensure protection and rights across the conflict cycle, from prevention to reconstruction.<sup>21</sup>

<sup>20</sup> These obligations include universal jurisdiction, obligations to prosecute and extradite and the right to compensation (Dyani, N. 2006. 'Protocol on the Rights of Women in Africa: Protection of Women from Sexual Violence during Armed Conflict'. *African Human Rights Law Journal* 166–87, p. 83).

<sup>21</sup> In 2007, the UN pulled its work on sexual violence in conflict together under 'UN Action against Sexual Violence in Conflict'. This was a concerted effort by 13 UN entities to improve coordination and accountability, amplify programming and advocacy and support national efforts to 'prevent sexual violence and respond effectively to the needs of survivors' (see [www.stoprapenow.org](http://www.stoprapenow.org)). In 2008, the UN launched its campaign 'UNITE to End Violence against Women' in order to prevent and eliminate violence against women and girls worldwide in both settings of peace and settings of conflict (<http://endviolence.un.org>). In addition, the Secretary-General publishes an annual report on sexual violence in conflict (see [www.un.org/en/ga/search/view\\_doc.asp?symbol=S/2013/149](http://www.un.org/en/ga/search/view_doc.asp?symbol=S/2013/149)).

On the African continental level, both the Maputo Protocol and the Solemn Declaration endorse UNSCR 1325 provisions. In addition, the AU Gender Policy, AWD and Agenda 2063, including its 10-year implementation framework, among others, are relevant policy frameworks for women, peace and security in the AU.<sup>ix</sup> On the regional level, some of the RECs have frameworks or action plans in place to address peace and security issues in their specific region. For example, EAC has the Protocol for Peace and Security and Regional Strategy for Peace and Security and ECOWAS has a strong Conflict Prevention Framework and a Women, Peace and Security Action Plan (2008). Both ECOWAS and IGAD have a regional Plan of Action for implementation of UNSCRs 1325 and 1820. EAC has also formulated a Regional Action Plan, but this is still pending.

#### **Box 5.10. United Nations Security Council Resolutions on Women, Peace and Security**

**UNSCR 1325** (adopted 2000) calls member states to increase the participation of women in the 'prevention and resolution of conflicts' and in the 'maintenance and promotion of peace and security'.

**UNSCR 1820** (adopted 2008) calls for an end to the use of acts of sexual violence against women and girls as a tactic of war and an end to impunity of the perpetrators. It also calls for training troops on preventing and responding to sexual violence and for more deployment of women in peace operations.

**UNSCR 1888** (adopted 2009) reiterates that sexual violence can exacerbate armed conflict and calls for leadership to address conflict-related sexual violence and for deployment of experts to areas in which sexual violence is occurring. Specifically, UNSCR 1888 asks the Secretary-General to appoint a Special Representative on Sexual Violence in Conflict to provide strategic leadership and promote coordination and cooperation through UN action.

**UNSCR 1889** (adopted 2009) reaffirms UNSCR 1325 and calls for the development of indicators to measure the implementation of UNSCR 1325. It also focuses on the importance of women's participation in all stages of peace processes.

**UNSCR 1960** (adopted 2010) reiterates the importance of ending conflict-related sexual violence. It also establishes a listing mechanism for those suspected of committing or of being responsible for patterns of sexual violence in situations.

**UNSCR 2106** (adopted 2013) calls to strengthen monitoring and prevention of sexual violence in conflict.

**UNSCR 2122** (adopted 2013) affirms an integrated approach to sustainable peace and focuses on stronger measures and monitoring mechanisms to increase women's engagement in conflict resolution and peace-building.

**UNSCR 2242** (adopted 2015) calls for assessment of strategies and resources in the implementation of and integration of the agenda across all countries and highlights the importance of cooperation with CSOs.

**UNSCR 2272** (adopted 2016) provides measures to address sexual exploitation and abuse in peace operations.

## 5.3 NATIONAL LEGAL AND POLICY FRAMEWORKS

Having pointed out how different forms of GBV affect women (in Section 4.1) and articulated the commitments agreed to by African states (in Section 4.2), this section looks at how these commitments are being implemented at the national level. To what extent are women and girls' rights enshrined in national constitutions, laws and policies? And what changes have taken place in the institutional frameworks in countries?

In order to capture both progress and gaps, we have formulated a number of key legal and policy indicators and then tracked these for all countries. We present these below, accompanied by a narrative analysis that pulls out trends as well as key gaps and challenges in national-level legal and policy change. The legal and policy indicators on GVAW that we review in this section are fivefold, and further defined and explained in Box 5.11. The final section of this chapter complements this overview by presenting a number of case studies on initiatives that have contributed to legal as well as social norms change towards the realisation of women's and girls' rights.

**Table 5.3. 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

The narrative analysis that complements the legal and policy indicators brings in additional data and observations from the countries, especially regarding policy and institutional reforms that could not be captured under the legal and policy indicators. For each region, the narrative analysis also draws from the Trafficking in Persons (TIP) reports of the US State Department, which track the extent to which countries worldwide are meeting minimum standards for the elimination of trafficking in persons.<sup>22</sup> These minimum standards concern the prohibition and punishment of severe forms of trafficking in persons, and the seriousness of the efforts of the government to eliminate these forms of trafficking. These TIP reports distinguishes between countries that (1) meet the minimum standards for the elimination of TIP, (2) do not meet these minimum standards but are making significant progress and (3) do not meet the minimum standards and are also not making significant progress.<sup>22</sup> In the second category, special attention is given to countries on the so-called 'watch list';<sup>23</sup> these are countries that make progress but also observe worrisome trends—such as in levels of trafficking or in the government's response to it. The narratives for each region discuss to what extent countries are meeting the minimum standards, and which countries are making progress or are on the watch list.

<sup>22</sup> Definition of minimum standards for the elimination of TIP: '1) The government of the country should prohibit severe forms of trafficking in persons and punish acts of such trafficking. 2) For the knowing commission of any act of sex trafficking involving force, fraud, coercion, or in which the victim of sex trafficking is a child incapable of giving meaningful consent, or of trafficking which includes rape or kidnapping or which causes a death, the government of the country should prescribe punishment commensurate with that for grave crimes, such as forcible sexual assault. 3) For the knowing commission of any act of a severe form of trafficking in persons, the government of the country should prescribe punishment that is sufficiently stringent to deter and that adequately reflects the heinous nature of the offense. 4) The government of the country should make serious and sustained efforts to eliminate severe forms of trafficking in persons' (US Department of State. 2017. 'Trafficking in Persons Report'. [www.state.gov/j/tip/rls/tiprpt/2017/index.htm](http://www.state.gov/j/tip/rls/tiprpt/2017/index.htm), pp. 38–39).

<sup>23</sup> 'Countries whose governments do not fully meet the minimum standards, but are making significant efforts to bring themselves into compliance with those standards and: a) The absolute number of victims of severe forms of trafficking is very significant or is significantly increasing; b) There is a failure to provide evidence of increasing efforts to combat severe forms of trafficking in persons from the previous year; or c) The determination that a country is making significant efforts to bring itself into compliance with minimum standards was based on commitments by the country to take additional future steps over the next year' (US Department of State. 2017. 'Trafficking in Persons Report'. [www.state.gov/j/tip/rls/tiprpt/2017/index.htm](http://www.state.gov/j/tip/rls/tiprpt/2017/index.htm), p. 28).

Table 5.3 presents the overview of the findings on the legal and policy indicators by region (for explanation of the regional units used, see section 1.6.3 in Chapter 1). Please note that the totals for the continent do not equal the total of the columns, as some countries are included in more than one region.<sup>24</sup> The main trends that emerge from this overview are that *domestic violence* is not addressed in 3 out of 10 countries. Two thirds of the countries do have legislation on domestic violence, 27 have a specific law on this and 10 address it in only the penal or criminal code. *Lack of criminalisation of marital rape* continues to be a key gap across the continent, with almost three out of four countries not addressing rape within marriage in their legal framework. A total of 14 countries do have legal provisions that protect women in union from being raped—that is, 1 in 5 countries. Half of the Western African countries criminalise marital rape. Three quarters of the countries in the continent have legal provisions regarding *sexual harassment*. These are mostly articulated in specific legislation, and in quite a number of countries also in specific provisions regarding the workplace. The majority of countries have put in place legislation on *human trafficking*, with the exception of three countries in Eastern Africa, two in the Central region and one in Southern Africa. None of the countries in the continent is meeting the minimum standards on the elimination of trafficking in persons. Finally, 21 countries have adopted a *NAP 1325*. These include most of the countries in Western Africa and about half of those in the Eastern and Central regions. DRC is the only country in Southern Africa that has adopted a *NAP 1325*.

Subsequent sections in this chapter discuss regional and national details in terms of trends, gaps and key contestations in the national legal and policy frameworks on GVAW. Recognition of GVAW has increased greatly over the years. There have not only been legal reforms addressing domestic violence and sexual harassment but also various efforts regarding survivor support, improving access to justice and training of health, social and legal service providers, as well as education and awareness-raising. These efforts notwithstanding, GVAW remains persistent and largely hidden across society. Although advancements are being made, the lack of holistic frameworks, in terms of gaps in the legal framework, shortcomings in enforcement and implementation or under-resourced and suboptimal support services, can reinforce underreporting of violence and pose barriers to survivors, who refrain from seeking care.

**Table 5.3. Continental and regional overview on legal and policy indicators, GVAW**

GVAW	INDICATORS																	
	Law on domestic violence				Criminalisation of marital rape			Law on sexual harassment				Law on human trafficking			NAP 1325			
	Y	PC	N	M	Y	N	M	Y	WP	N	M	Y	N	M	Y	N	M	
Western (15)	8	3	4	0	6	7	2	10	1	4	0	15	0	0	13	2	0	
Eastern (11)	4	2	5	0	2	9	0	5	3	3	0	8	3	0	5	6	0	
Central (11)	6	2	3	0	2	9	0	7	2	2	0	9	2	0	5	6	0	
Southern (16)	11	1	4	0	5	11	0	7	7	2	0	15	1	0	1	15	0	
Northern (7)	1	2	3	1	0	6	1	5	0	1	1	6	0	1	0	6	1	
Country total (55—without duplications)	27	10	17	1	14	38	3	31	12	11	1	48	6	1	21	33	1	

<sup>24</sup> Five countries are considered in two regions. Burundi and Rwanda are included in both the Eastern and Central region; Tanzania is included in both Eastern and Southern; and Angola and DRC are included in both Southern and Central. The continental totals on the indicator scores are calculated by taking these duplications out, to come to a total of 55 countries.

### 5.3.1 Western region

#### Trends, gaps and contestations

The quality of the legal and policy framework in Western Africa looks fairly strong, with quite a number of strong performing countries and a few scoring very weakly. Burkina Faso, The Gambia, Ghana and Sierra Leone all score positively on all five indicators, and Benin, Cape Verde and Senegal have four positive scores. Guinea also does, but its provisions on domestic violence are in the Penal Code and not in a specific law. These same eight countries, except for Guinea and Senegal, also have a legal framework in place that addresses domestic violence as well as sexual harassment, and that includes the criminalisation of marital rape.

One country stands out for its weaker legal and policy frameworks. Mali has legislation on human trafficking and a NAP 1325 but no legislation on domestic violence, marital rape or sexual harassment. Six countries have three positive scores. Côte d'Ivoire, Niger and Togo lack legislation on domestic violence and do not criminalise marital rape, but do have a law on sexual harassment as well as human trafficking, and a NAP 1325. Guinea-Bissau, Liberia and Nigeria have legislation on domestic violence and human trafficking, and a NAP 1325, but do not criminalise marital rape and lack legislation on sexual harassment. The Nigerian Penal Code, however, explicitly excludes marital rape from the definition of rape. Overall, the Western region shows a strong record in laws on human trafficking, in place in all countries, and a high number of countries have adopted a NAP 1325.

Table 5.4. Key legal and policy indicators in Western Africa, GVAW

Country	INDICATORS				
	Legislation on domestic violence	Criminalisation of marital rape	Law on sexual harassment	Law on human trafficking	NAP 1325
Benin	Yes	Yes	Yes	Yes	No
Burkina Faso	Yes	Yes	Yes	Yes	Yes
Cape Verde	PC	Yes	Yes	Yes	No
Côte d'Ivoire	No	No	Yes	Yes	Yes
Gambia	Yes	Yes	Yes	Yes	Yes
Ghana	Yes	Yes	WP	Yes	Yes
Guinea	PC <sup>25</sup>	No	Yes <sup>26</sup>	Yes	Yes
Guinea-Bissau	Yes <sup>27</sup>	-	No	Yes	Yes
Liberia	Yes <sup>28</sup>	-	No	Yes	Yes
Mali	No	No <sup>29</sup>	No	Yes	Yes
Nigeria	Yes	No <sup>30</sup>	No	Yes	Yes
Niger	No <sup>31</sup>	No	Yes	Yes	Yes <sup>32</sup>
Senegal	PC	No	Yes	Yes	Yes
Sierra Leone	Yes	Yes	Yes	Yes	Yes
Togo	No <sup>33</sup>	No	Yes <sup>34</sup>	Yes	Yes

<sup>25</sup> There is no specific legislation on domestic violence; however, women who are victims of domestic violence can appeal to the Penal Code and more specifically to Arts 295 and 303.

<sup>26</sup> A new Labour Code was adopted in February 2014 and prohibits all forms of workplace harassment, including sexual harassment.

<sup>27</sup> There is specific legislation on domestic violence, which was enacted in 2014.

<sup>28</sup> There is specific legislation on domestic violence, which was enacted in 2017 (the 'Domestic Violence Act').

<sup>29</sup> According to the US 2016 Human Rights Report on Mali, no law specifically prohibits spousal rape, but law enforcement officials stated that criminal laws against rape applied to spousal rape. Police and judicial authorities were willing to pursue rape cases but stopped if parties reached an agreement prior to trial. Information on convictions was not available.

<sup>30</sup> 'Under Article 282(2) of the Nigerian Penal Code, "sexual intercourse" by a man with his own wife is not rape if she has attained puberty.'

<sup>31</sup> 'There is no a specific law prohibiting domestic violence, however, a woman can sue her husband for battery. The punishment can go from 2 months in prison and a fine of 10,000CFA to 30 years in prison.'

<sup>32</sup> Niger has adopted a NAP 1325; however, the document has not been accessible to date.

<sup>33</sup> A preliminary draft law of the revised Criminal Code to classify sexual harassment, domestic violence and rape as separate offences and sanctions was validated in 2012 but has not yet been adopted.

<sup>34</sup> The 1984 Presidential Decree prohibits sexual harassment and specifically mentions harassment of female students.

### Trends in legal, policy and institutional reform

**Constitutional provisions:** The constitutions of all countries in Western Africa contain the principle of equality for men and women under the law and protect the fundamental of human rights of all citizens, including their right to be free from torture, slavery, inhuman or degrading treatment and violence.

**Statutory law on GVAW:** Over the years, Western African countries have passed legislation that addresses at least one form of GVAW and some comprehensive legislation to protect women against GBV. Two-thirds of the countries in the region have legislation on *domestic violence*, and this is mostly laid down in specific legislation, and in a few cases in the penal or criminal code. In Guinea, for example, there is no specific legislation on domestic violence but women who are victims of domestic violence can appeal to the Penal Code.<sup>35</sup> <sup>lxii</sup>

Côte d'Ivoire, Guinea, Mali, Niger and Togo are the countries that yet have to enact legislation on domestic violence. These five countries also do not criminalise *marital rape*. Senegal also does not prohibit rape within marriage. Strikingly, Nigeria has specific legislation on domestic violence but the provisions in its Penal Code explicitly exclude marital rape from the definition of rape. Benin, Burkina Faso, Cape Verde, The Gambia, Ghana and Sierra Leone stand out as the five countries that do prohibit spousal rape.

*Sexual harassment* is prohibited in most countries (Guinea-Bissau, Mali, Liberia and Nigeria are exceptions). In Togo, a Presidential Decree was issued in 1984 prohibiting sexual harassment and specifically addressing harassment of female students. Ghana's provisions address only sexual harassment in the workplace (in the Domestic Violence Act 2007 and the Labour Act 2003).

Art. 7 of the Senegalese Constitution protects against physical mutilation. In addition, Art. 22 of Niger Constitution stipulates that 'the State shall take all the measures to fight violence against women and young people in the public and private sphere'. Art. 82 of Cape Verde Constitution, which was amended in 2010, prohibits domestic violence; Art. 74 assures the protection of children against sexual abuse and exploitation; and Art. 48 'prohibits any form of discrimination against women'.

All 15 countries in Western Africa have adopted legislation prohibiting *human trafficking* and some, such as Côte d'Ivoire, The Gambia and Togo, have even gone further to criminalise child trafficking. Nigeria made considerable progress on fighting human trafficking through the 2005 amendment of the Trafficking in Persons (Prohibition) Enforcement and Administration Act of 2003, and established a multidimensional crime-fighting instrument in the form of the National Agency for Prohibition of Traffic in Persons and Other Related Matters (NAPTIP).<sup>36</sup> <sup>lxiii</sup> Since the passage of this Act, NAPTIP has successfully investigated cases, prosecuted criminals and rescued and rehabilitated victims.<sup>lxiv</sup>

None of the countries is meeting the minimum standards on the elimination of trafficking as articulated in the US State Department TIP 2017 report. Guinea, Guinea-Bissau and Mali are not making significant efforts to comply with these standards, whereas the other countries in the Western African region are. Sierra Leone has increased its efforts to investigate and initiate prosecution of trafficking cases. Nine countries are on the watch list: Benin, Burkina Faso, Cape Verde, The Gambia, Ghana, Liberia, Niger, Nigeria and Senegal.<sup>37</sup> <sup>lxv</sup>

**NAP 1325:** Benin and Cape Verde are the only countries in Western Africa that have not yet adopted a NAP on UNSCR 1325. The high number of countries in Western Africa with NAP 1325s is credited to the commitment of ECOWAS to ensuring this, as recommended in the ECOWAS Regional Plan of Action for the Implementation of UNSCR 1325 and 1820 in West Africa, known as the Dakar Declaration (adopted in September 2010 in Dakar). In this, ECOWAS urged all member states to develop a NAP on UNSCR 1325 by December 2010.<sup>lxvi</sup>

**Policy frameworks and institutional mechanisms on GVAW:** Almost all countries have developed national action plans and strategies to end GVAW. Some have gone further to increase access to justice for victims of violence. For example, in Burkina Faso, Art. 39 of Law N. 061-2015/CNT (2015) established an *ad hoc* police bodies for prosecuting SGBV. In Liberia, the National Police established a Women and Child Protection Unit in 2005, and in 2011 a special courtroom was created dedicated to hearing cases of sexual violence. In Sierra Leone, a Special Saturday Court was established in 2012 to try sexual violence cases.

<sup>35</sup> Arts 295 and 303 of the Penal Code.

<sup>36</sup> NAPTIP comprises four specialised units: investigation, prosecution, counselling and rehabilitation and public enlightenment.

<sup>37</sup> Issues hindering anti-trafficking efforts include, among other things, lack of or inadequate funding of key anti-trafficking (government) infrastructures (e.g. Benin, Côte d'Ivoire, The Gambia) or victim support and protection services and activities (e.g. Burkina Faso, Cape Verde, Nigeria, Senegal, Liberia).

Most countries have taken the initiative to establish support centres and/or shelters for victims of violence. The Senegalese government has put in place shelter and accommodation facilities for victims of violence, such as the National Women's Assistance and Training Centre.<sup>lxvii</sup> Burkina Faso has put in place Legal and Social Counselling Centres for victims of violence and The Gambia established a 'one stop centre' for victims of violence in 2012.

In Côte d'Ivoire, GVAW has proven a defining feature of the recent crisis. Women and girls have been direct victims of the country's post-electoral violence, and displaced women and girls are at heightened risk of sexual violence, IPV, abandonment and forced marriage. The country's National Strategy to Combat Gender-based Violence, led by the Ministry of Solidarity, Family, Women and Children, with the support of many partners, over the course of 2009–14, focused on reinforcing a holistic response to GBV.<sup>lxviii</sup> The strategy aimed to tackle key challenges such as community participation, access to justice and access to health services. In 2015, the Ministry of Justice and Public Liberties decreed that a medical certificate was no longer needed to open a rape investigation, thereby removing significant barriers to justice.<sup>lxix</sup>

### Key gaps and contestations

National legal frameworks in Western Africa countries are well developed with respect to human trafficking and having in place a NAP 1325. The picture with respect to domestic violence, marital rape and sexual harassment is more mixed. Violence against women is a serious issue across the region, and one that continues to take place as a result of considerable cultural acceptance.

A first gap concerns the five countries that lack a legal framework for **domestic violence**. A second and related gap is the **lack of criminalisation of marital rape**. Even though more countries in Western Africa than in any other region have outlawed spousal rape, still one in two countries does not prohibit rape within marriage. One country explicitly excludes marital rape from the definition of rape. This lack of criminalisation is critical, considering that spousal rape is still widely tolerated and accepted in most countries in Western Africa. Benin, Burkina Faso, Cape Verde, The Gambia, Ghana and Sierra Leone are the few countries where marital or spousal rape is outlawed.

**Law enforcement** is required in order to successfully implement legislation. GVAW that occurs in the private sphere is rarely considered a matter for police intervention. Rape is often not deemed a matter for the police, therefore many cases go unreported. Stigma and taboo surrounding sexual violence prevent victims from denouncing it and, often, blame is put on the victims. The law to enforce spousal rape is particularly difficult, as many do not consider this a crime. A specific concern is that the infrastructure of most police stations in most countries cannot cope with the demands of investigation, and many citizens settle out of court rather than risk their luck in a system they see as completely corrupt.

While most Western African countries have made attempts to end GVAW through legislation and policies, high numbers of reported cases, as well as high projected numbers of unreported cases, point to a need to tackle the **social and structural barriers** victims face, especially with regard to corruption and stigmatisation. With all countries in the region, except Niger, having ratified the Maputo Protocol, which explicitly prohibits violence against women, countries must take concrete measures to ensure laws are enacted and enforced to protect victims in both private and public.

### 5.3.2 Eastern region

#### Trends, gaps and key contestations

Progress in the legal and policy frameworks on GVAW in the Eastern region is uneven: some countries have multiple laws and policy frameworks regarding GVAW in place, and other countries lack such frameworks. Eritrea, Somalia, South Sudan and Sudan have weak legal and policy frameworks. South Sudan has a NAP 1325 but lacks legislation on domestic violence, marital rape, sexual harassment and human trafficking. Somalia and Sudan have legislation on sexual harassment but not for the other four indicators. Eritrea has a law on human trafficking but lacks legal provisions on domestic violence, marital rape and sexual harassment, and also does not have a NAP 1325. Tanzania's legal and policy framework also does not stand out as particularly strong, considering that it has only a law on human trafficking and a legal provision on sexual harassment. Djibouti has a law on human trafficking, and provisions on domestic in the Penal Code, but scores negatively on the other indicators.

Burundi, Kenya, Rwanda and Uganda stand out as the countries with the more comprehensive legal and policy frameworks on GVAW. Kenya and Rwanda have laws and legal provisions on all indicators. Burundi and Uganda have legislation on domestic violence, sexual harassment and human trafficking, and have adopted a NAP 1325, but have not criminalised marital rape. Ethiopia has a moderate score, with legislation on human trafficking as well as sexual harassment, and Penal Code provisions regarding domestic violence. Within this overall picture of high unevenness and variation across the region, lack of legislation on marital rape stands out as the weakest point: as many as 9 countries have not criminalised rape within marriage.

Table 5.5. Key legal and policy indicators in Eastern Africa, GVAW

Country	INDICATORS				
	Legislation on domestic violence	Criminalisation of marital rape	Law on sexual harassment	Law on human trafficking	NAP 1325
Burundi	Yes <sup>38</sup>	No	Yes	Yes <sup>39</sup>	Yes
Djibouti	PC	No	No	Yes	No
Eritrea	No	No	No	Yes	No
Ethiopia	PC	No <sup>40</sup>	Yes	Yes	No
Kenya	Yes	Yes <sup>41</sup>	Yes	Yes	Yes
Rwanda	Yes <sup>42</sup>	Yes	WP	Yes	Yes
Somalia	No	No	WP	No	No
South Sudan	No	No <sup>43</sup>	No	No	Yes
Sudan	No	No	Yes	No	No
Tanzania	No <sup>44</sup>	No	Yes <sup>45</sup>	Yes	No
Uganda	Yes	No	WP	Yes	Yes

38 Law No. 1/13/2016 on Prevention, Protection of Victims and Expression of GBV.

39 Loi N1/28 du 29 Octobre 2014 portant Prévention et Répression de la Traite des Personnes et la Protection des Victims de la Traite.

40 Explicitly excludes marital rape in defining rape as sexual intercourse 'outside wedlock' (Art. 620 of the Criminal Code).

41 Kenya's Protection Against Domestic Violence Act (2015) includes marital rape in its definition of domestic violence in its provision in Section 3(a)(vi): 'In this Act, "violence" means abuse that includes sexual violence within marriage'. A contradictory provision in the Sexual Offences Act (2006) that had excluded marital rape from the definition of sexual violence (in section 43(5)) however persists. The more recent legislation overrides the application of the former one where there is a contradiction.

42 Law No. 59/2008 on Prevention and Punishment of GBV.

43 The law is explicit that marital rape is not an offence (Art. 247(3) of the 2008 Penal Code).

44 Whereas the Tanzanian Law of Marriage Act provides that corporal punishment may not be inflicted on a spouse, this provision is not backed by a penalty and therefore not criminalised. Corporal punishment, which is undefined, also fails to account for the various ways domestic violence may be inflicted including non-physical forms of violence.

45 Various laws including the Employment and Labour Relations Act, the Penal Code, the Sexual Offences Special Provisions Act and the newly amended Education Act, which includes provisions on sexual harassment in schools.

### Trends in legal, policy and institutional reform

**Constitutional provisions:** The constitutions of all the states in the Eastern region contain broad provisions that are useful with regard to addressing GBV. These cover, among others, the principles of non-discrimination and equality before the law and the right to physical and mental integrity, to freedom from cruel, inhuman and degrading treatment, to freedom from slavery or servitude and to freedom from torture. Some countries have specific provisions on a form of GBV; Somalia's constitution addresses FGM; and the constitutions of Ethiopia and South Sudan speak to trafficking. Moreover, Ethiopia, Somalia, South Sudan and Sudan have specific provisions that allude to addressing harmful practices and traditions, and this may be inferred to have a bearing on GBV, depending on the rights violation in question.

**Statutory law on GVAW:** Virtually all states reviewed (except for South Sudan) have a statutory law that prohibits a form of GBV. Four countries have specific legislation on *domestic violence* (Burundi, Kenya, Rwanda and Uganda), and another two criminalise domestic violence in their Penal Code. Half of the countries in this region lack legislation on domestic violence. The picture with respect to criminalisation of *marital rape* is grim, with only Kenya and Rwanda legally providing that rape within marriage is criminalised. In Kenya, the Protection Against Domestic Violence Act (2015) includes marital rape in its definition of domestic violence where it provides in Section 3(a)(vi) that 'In this Act, "violence" means abuse that includes sexual violence within marriage'. By virtue of this provision, women in Kenya can now rely on the protective and relief provisions in the Act in instances of marital rape. This recent legislation overrides the provision in the 2006 Sexual Offences Act that had excluded marital rape from the definition of sexual violence.

With respect to *sexual harassment*, five countries have specific legislation regarding this in place (Burundi, Ethiopia, Kenya, Sudan and Tanzania). Three others have specific provisions on sexual harassment in the workplace (Rwanda, Somalia and Uganda). Tanzania has legislation specifically addressing sexual harassment in schools. In addition, all of the countries reviewed criminalise rape; the law in Sudan continues to be contested as rape is deemed *zina*, or sex outside marriage, and, while there has since been legal reform, not all of the law's shortcomings have been addressed, as articulated in the gaps below. In five of these countries, legal provisions exist regarding statutory rape<sup>46</sup> (defilement): Kenya, South Sudan, Sudan, Tanzania and Uganda.

Legislation on *human trafficking* is lacking in three countries, but present in Burundi, Djibouti, Eritrea, Ethiopia, Kenya, Rwanda, Tanzania and Uganda. Ethiopia has legal provision regarding forced kidnapping for the purpose of early marriage. None of the countries in the Eastern region meets the minimum standards for the elimination of trafficking. Burundi, Eritrea, South Sudan and Sudan are also not making significant efforts in this direction. On the other hand, Djibouti, Ethiopia, Kenya, Rwanda, Tanzania and Uganda are making significant efforts to comply with these standards. For example, the Tanzanian government has been investigating, prosecuting and convicting more trafficking offenders compared with under the previous reporting period, and has conducted an anti-trafficking awareness-raising campaign. The Ethiopian government has made significant efforts to prevent and raise awareness on TIP and related crimes via media campaigns, its community conversations project and the training of government officials on TIP. Djibouti and Rwanda are on the watch list.<sup>47</sup> Somalia has been labelled a 'special case' for the 15th consecutive year, as the federal government continues to have limited influence outside the capital city Mogadishu.<sup>48</sup> <sup>lx</sup>

**NAP 1325:** Five countries have adopted a National Action Plan 1325: Burundi, Kenya, Rwanda, South Sudan and Uganda. Among the seven countries without a NAP 1325 are some notable ones with a recent history of conflict and insecurity, including Somalia and Sudan.

**Policy frameworks and institutional mechanisms on GVAW:** Each state in the Eastern region has a policy and/ or institutional mechanism in place that addresses GVAW, either broadly or in specific terms. In seven countries (Burundi, Djibouti, Eritrea, Kenya, Tanzania, Rwanda and Uganda), institutional reforms have taken place in the police service or in military personnel efforts. These relate to community policing, gender desks in police stations, special prosecution units and revisions of requisite police forms outlining GBV violations and evidence thereto. Ethiopia has established a Women and Children Trafficking Directorate. Rwanda has established GBV Committees, and has also developed Clinical Guides for Rape Victims. South Sudan has developed Standard Operating Procedures for GBV Prevention and Protection.

<sup>46</sup> Statutory rape, or defilement, defines sexual activity between an adult and a minor as a sexual offence. It pertains to minors, and physically or mentally incapacitated individuals, who are legally incapable of giving consent to the sexual act. (This means that, in statutory rape, overt force or threat is usually not present, and that the law presumes coercion because consent cannot be legally given.)

<sup>47</sup> The anti-trafficking law of Djibouti does not incorporate the definition of trafficking as set in international law, identification of potential victims has remained sporadic and the government has not operationalised its NAP to combat trafficking, among other things.

<sup>48</sup> Areas in South-Central Somalia continue to be occupied by the al-Shabaab terrorist group and this is a main obstacle to the country in addressing human trafficking.

## Key gaps and contestations

In light of these trends, we can observe a number of key gaps and contestations that relate to GBV. A first is that, although most countries have some legal framework or provision on a form of GVAW, the majority lack a comprehensive legal framework. Only one in three of the countries have specific and dedicated laws on domestic violence and/or sexual harassment. Some others have provisions in the penal or labour code but lack dedicated and comprehensive GVAW laws. In addition to that, there is no **holistic** approach to addressing GVAW. Whereas the Maputo Protocol provides for a broad set of measures to address the causes and consequences of violence against women, including not only a comprehensive legal framework that prohibits all forms of GVAW but also the provision of support services to victims and survivors, and the prosecution of perpetrators, the legal, policy and institutional reforms in most Eastern African countries do not live up to these standards.

A second and prominent gap is the failure to legally recognise marital rape. Of the 11 states in the Eastern region, 9 do not have a law that explicitly outlaws/prohibits **marital rape**. Worse still, two countries explicitly exclude marital rape from the definition of rape, and as such actively allow it. The law in South Sudan is explicit that marital rape is not an offence.<sup>49</sup> Ethiopia similarly excludes marital rape, in defining rape as sexual intercourse 'outside wedlock'.<sup>50</sup> Another worrisome example is from Tanzania, which not only does not address the criminalisation of marital rape but also expressly exempts sexual intercourse with 'married girls' above the age of 15 years from the definition of rape, whereas rape of girls is sanctioned.<sup>51</sup> This is not only a problematic inconsistency but also contrary to Tanzania's own definition of a child as being below 18. In Kenya, the 2015 Protection Against Domestic Violence Act (2015) includes marital rape in its definition of domestic violence; the older Sexual Offences Act (2006) however contains a contradictory provision, and had excluded rape from applying to 'persons who are lawfully married to each other' (section 43(5)). The more recent legislation overrides the application of the former one where there is a contradiction. It is nonetheless desirable for the laws to be harmonised through the repeal of the offending provision in the Sexual Offences Act.

A third key gap concerns **retrogressive legal provisions** that perpetuate violations. Sudan is a case in point here, where, prior to reform in 2015, the crime of rape was linked to and conflated with that of adultery (*zina*),<sup>52</sup> and coupled with an onerous burden to prove lack of consent. This often meant that a victim who failed to prove rape was tried for *zina*, whose punishment with respect to an unmarried woman is 100 lashes, while the sanction for a married woman is death. In 2015, new definitions were proposed and a legal reform took place, but this has not solved all shortcomings of the previous law. For instance, punishment for rape remains unchanged and still makes reference to rape in relation to adultery. A further contestation is that women and girls can be blamed and sanctioned for instances of rape and sexual harassment. The 2015 reforms to the criminal legislation contain a problematic definition of sexual harassment, which breeds ambiguity between the victim and the perpetrator through an undue imposition on the victim as inviting the harassment.

<sup>49</sup> Art. 247(3) of the 2008 Penal Code.

<sup>50</sup> Art. 620 of the Criminal Code.

<sup>51</sup> Section 130(2) of the Penal Code.

<sup>52</sup> Art. 149 of the Penal Code previously read (1) There shall be deemed to commit the offence of rape, whoever makes sexual intercourse, by way of adultery, or sodomy with any person without his consent. (2) Consent shall not be recognized, where the offender has custody, or authority over the victim. (3) Whoever commits the offence of rape, shall be punished, with whipping a hundred lashes, and with imprisonment, for a term, not exceeding ten years, unless rape constitutes the offence of adultery, or sodomy, punishable with death.

### 5.3.4 Central region

#### Trends, gaps and contestations

National legal and policy frameworks on GVAW in the Central region show a mixed picture, with considerable variation on the five indicators in the profiles of the eleven countries. Cameroon, Chad, DRC and Gabon score positively on three of the five indicators. Congo Republic and Equatorial Guinea have only one positive score, on sexual harassment and domestic violence, respectively. Angola, as in the Southern regional analysis, has a weak profile, with only two positive scores, and lacks legislation on marital rape and sexual harassment and a NAP 1325. As already noted in the Eastern region, Rwanda stands out with a positive score on all five indicators. About half of the countries in the region have a NAP 1325. On the other four indicators on GVAW frameworks, Chad, CAR and Gabon have legislation on domestic violence, sexual harassment and human trafficking but all fail to outlaw marital rape. São Tomé and Príncipe has a positive score on all these four indicators. The legal and policy framework of CAR also scores positively on four out of the five selected indicators.

Table 5.6. Key legal and policy indicators in Central Africa, GVAW

Country	INDICATORS				
	Legislation on domestic violence	Criminalisation of marital rape	Law on sexual harassment	Law on human trafficking	NAP 1325
Angola	Yes	No <sup>53</sup>	No <sup>54</sup>	Yes <sup>55</sup>	No <sup>56</sup>
Burundi	Yes <sup>57</sup>	No	Yes	Yes <sup>58</sup>	Yes
Cameroon	No	No	Yes	Yes	Yes
CAR	Yes	No	Yes	Yes	Yes
Chad	PC <sup>59</sup>	No <sup>60</sup>	Yes <sup>61</sup>	Yes	No
Congo Republic	No	No	Yes	No	No
DRC	No	No	Yes <sup>62</sup>	Yes	Yes
Equatorial Guinea	PC <sup>63</sup>	No	No	No <sup>64</sup>	No
Gabon	Yes	No	WP	Yes	No
Rwanda	Yes <sup>65</sup>	Yes	WP	Yes	Yes
São Tomé and Príncipe	Yes	Yes	Yes	Yes	No

53 Isis-WICCE. (2014). 'Towards an Anti-Sexual and Gender-Based Violence Norm in the Great Lakes Region of Africa: A Civil Society Review of the Implementation of the 2011 ICGLR Kampala Declaration'.

54 Some offences can be prosecuted under assault.

55 Trafficking prohibited under the Prevention of Organised Crime Act 2009.

56 Drafted a NAP to increase women's participation in conflict prevention but does not have release date.

57 Law No.1/13/2016 on Prevention, Protection of Victims and Expression of GBV.

58 Loi N1/28 du 29 Octobre 2014 portant Prevention et Repression de la Traite des Personnes et la Protection des Victims de la Traite.

59 Domestic violence is criminalised in two acts. The Reproductive Health Act (2002) criminalises domestic violence in Arts 9 and 18. The Penal Code (2017) criminalises domestic violence in Art. 342.

60 Rape is criminalised in the Penal Code (2017) (Art. 349). Art. 350 defines punishments for specific situations (minors, vulnerable people, rape on the basis of sexual orientation) but spouses or partners are not mentioned.

61 Penal Code (2017) Harcèlement sexuel et traitements dégradants (Art. 341).

62 Contained in the Sexual Violence Law and Labour Code.

63 Only in the Criminal Code referring to personal injuries or abuse in general. No specific legislation found on violence against women. A law is under review since 2004.

64 This is a serious issue in Guinea but unfortunately since 2004 a law on child trafficking has been presented only as a project; but no official law has been found.

65 Law No. 59/2008 on Prevention and Punishment of GBV.

### Trends in legal, policy and institutional reform

**Constitutional provisions:** All states have general provisions that may be utilised to address GVAW. These focus on the principles of right to life, physical integrity, humane treatment, freedom and security, personal safety, non-discrimination and equality before the law. All constitutions have provisions on the right to protection from torture, inhuman, cruel and degrading treatment, and most have included the obligation of the state to protect women, youth and families. Burundi has an explicit provision on women's right to protection of their physical and mental integrity.

The Constitution of DRC is the only one that refers explicitly to all forms of GVAW: it stipulates that the state must ensure the elimination of all forms of GVAW. Art. 15 states that the public authorities must ensure the elimination of sexual violence used as a weapon for the destabilisation or the dislocation of the family.<sup>lxix</sup> This is of particular importance in view of the endemic sexual violence in Eastern Congo. Some constitutions explicitly address specific forms of violence, albeit often in gender-neutral terms. The Constitution of CAR includes protection from rape and abuse; the Constitution of Chad prohibits slavery or servitude and Angola prohibits trafficking.

**Statutory law on GVAW:** Most countries have a penal code that criminalises violence in a broad sense (intentional assault, injuries) without referring to women, although some have provisions on violence in general against children. CAR (2006), Rwanda (2008), Angola (2011) and Burundi (2016) have introduced specific laws for the *prevention and punishment of different forms of GVAW*. Each law has a specific focus or leaves out particular issues, which illustrates the range of definitions used in the area of GVAW. The laws include provisions on physical violence and injuries (rape (CAR)), domestic violence (Angola), sexual abuse (Angola), marital rape (Rwanda), spousal abuse (Burundi), paedophilia and incest (CAR), sexual harassment (Burundi, CAR), and early marriage (Angola). The countries are signatories to the Kampala Declaration to prevent SBGV, punish perpetrators and support survivors (2011), which reaffirms their commitment to further implementation of policies on GVAW (see Case study 4 in this chapter). Countries that have a less comprehensive legal framework on GVAW, because of a narrow definition of GVAW or because they cover elements of GVAW only in the Penal Code, are Cameroon, Chad, Congo, DRC, Equatorial Guinea, Gabon and São Tomé and Príncipe.

Six out of eleven countries have legislation on *domestic violence* beyond the Penal Code. Angola, Rwanda and São Tomé and Príncipe have separate domestic violence laws that cover all four types of violence and set clear criminal penalties for transgressions. Chad has a reproductive health act that prohibits domestic and sexual violence, and the new Penal Code speaks of IPV. DRC has a sexual violence act and a separate law on human trafficking focusing on women and girls.

All penal codes penalise (attempted) rape, but *marital rape* is criminalised in only two states. In Equatorial Guinea, rape is not criminalised unless the woman is unconscious or under age 12, or when the perpetrator uses force. In Gabon, perpetrators who were 'driven by a force that they were not able to resist' are excused. Chad provides a range of aggravated punishments for specific cases, such as the rape of persons under age 18, for rape of pregnant women, for rape because of sexual orientation and for rape in the context of cybersex. Rape committed by persons in authority or by intimate relatives and rape of pregnant or vulnerable women are punished with forced labour in perpetuity in CAR. Cameroon's Penal Code specifies that rape followed by marriage does not affect prosecution.

Seven states have legislation regarding *sexual harassment*, mostly covered in sexual violence acts (e.g. DRC) or penal codes. The penal codes of Burundi, Cameroon, Chad, Congo and Gabon, for example, have chapters on indecent assault (*atteinte à la pudeur*), sexual offences (*attentats aux mœurs*) and offences against public morality (*outrages publics aux bonnes mœurs*). The articles related to these offences often include maximum penalties if committed against children (e.g. under 13 in Congo, under 18 in Burundi and Chad, minor in Cameroon) or vulnerable people, including pregnant women and widows in the context of widowhood rituals (e.g. CAR, Chad). Although most provisions are formulated in gender-neutral terms, they can be used to prosecute harassment of and assaults against women and girls. Whereas some legislation defines sexual harassment as something that has to occur repeatedly (e.g. CAR), some laws state explicitly that even one act is punishable (e.g. Chad).

Nine countries have a law on *human trafficking* or provisions in the Penal Code criminalising (attempted) human trafficking and abduction. Some states maximise punishments for cases of abduction of minors (CAR), and of adolescent girls in particular (Equatorial Guinea), or for trafficking for reasons of sexual exploitation of prostitution, slavery or servitude (CAR). Sexual slavery, forced prostitution, forced pregnancy and systematic acts of sexual violence are considered crimes against humanity in Burundi. Most legislation related to human trafficking focuses on child trafficking. For example, the anti-trafficking law of Gabon does not cover trafficking in persons above the age of 18.

None of the Central African region countries<sup>66</sup> meets the minimum standards for the elimination of trafficking. A few countries across Central Africa (e.g. Cameroon, Chad and Gabon) make significant efforts to comply, but these countries remain on the watch list. No efforts are being made to meet the minimum standards in Burundi, CAR, Congo Republic, DRC and Equatorial Guinea. Specifically, anti-trafficking efforts have been hindered as a result of harassment by public officials and corruption in CAR, Congo Republic and DRC, among other issues.<sup>lxixii</sup> States in the Central region (member states of ECCAS) are cooperating with West African states (member states of ECOWAS) through a bi-regional action plan to address trafficking flows between the two sub-regions. The joint plan of action emphasises the need for protection of women and children against trafficking in West and Central Africa, focusing on the legal framework and on policy development.

**NAP 1325:** Fewer than half of the states in the region have adopted **National Action Plans on UNSCR 1325**. These are, in the main, those in the Great Lakes Region and signatories of the Kampala Declaration (Burundi, CAR, DRC, Rwanda) but also Cameroon, which has been affected by the spill-over effects of the protracted crisis in CAR.

**Policy frameworks and institutional reforms on GVAW:** Countries have for the most part put in place **national structures for GVAW**, including national committees on women's affairs, committees specifically responsible for the integration of gender and GVAW in different ministries and gender desks in ministries. Whereas in most countries ministries of gender and family affairs are responsible for policy implementation, some countries have established special inter-ministerial implementation institutes (e.g. DRC, São Tomé and Príncipe). Most countries have instituted **national programmes** to combat GVAW. They have also established **gender policies**, although not all gender strategies address GVAW in a comprehensive manner.

Burundi, DRC, Rwanda and São Tomé and Príncipe have either **special courts or procedures to deal with domestic and sexual violence**.<sup>lxixiii</sup> As a response to increasing numbers of cases of rape and sexual violence, CAR established a special rapid response intervention unit to address sexual violence in 2015, but this is not yet operational.

Most countries have launched zero tolerance for GVAW campaigns (Angola, Burundi, Congo Republic) since the launch of the International Conference of the Great Lakes Region Zero Tolerance Campaign in 2012. Some states organise other **advocacy campaigns around GVAW**, for example around the 16 Days of Activism against GBV or around International Women's Day (e.g. Equatorial Guinea), often lead by Heads of State (e.g. Cameroon) or First Ladies (e.g. Chad, DRC). In most countries, such campaigns are largely implemented and supported by CSOs. There have also been efforts to establish multi-sectoral cooperation and to sensitise and train judicial officers, police officers, health professionals, social workers, public officials, politicians and NGOs on women's rights and strategies to handle GVAW.

At the **decentralised level**, countries have established victim support centres, counselling centres and paralegal support units. Many governments rely on support from NGOs and CSOs to take the lead in organising public education campaigns, paralegal clinics, *centres d'écoute* and victim support. Cameroon, for example, has signed an agreement with a group of NGOs to address GVAW nationwide, including trafficking, training of police and reintegration of victims.

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<sup>66</sup> São Tomé and Príncipe is not analysed by the US State Department TIP Report of 2017 and a country narrative is lacking.

## Key gaps and contestations

The first main gap that can be observed regarding the legal framework on GVAW in the Central African region is the **lack of legal protection against marital rape**. Only two states criminalise marital rape, which is below the average for Sub-Saharan Africa.

A second gap is that seven out of eleven countries in the region have not yet established **special courts to deal with GVAW**; survivors of SGBV then depend on general courts of appeal and support from mediation structures to access justice. In countries such as CAR, there are few operational courts and a lack of judicial officers, leading to lengthy processes or rapid ‘corrections’ of perpetrators. Even where special courts (or victim support centres or paralegal clinics) are set up, they are often located in urban areas, with rural women having sparse access to justice.

Regarding the policy framework, a third challenge is the narrow focus of GVAW policies, which heavily emphasise redress and support for survivors of GVAW, including large-scale training programmes for judicial and police officers. There is **limited focus on prevention strategies and actions**, including the prosecution and rehabilitation of perpetrators and protection against repeat offending. In Equatorial Guinea, this bias is also reflected in the legal framework: the country has weak criminal law regarding GVAW but a strong victim protection and support law, allowing for low prosecution of GVAW.

A fourth gap concerns the **poor quality of prosecution and protection support**. Despite the implementation of large-scale training programmes on GVAW for the judiciary, police and medical officers, reports emphasise the lack of capacity, equipment and gender sensitivity of those supposed to provide services to GVAW victims.<sup>lxiv</sup>

Fifth, there is a **lack of attention to different categories of women**; few legal and policy frameworks differentiate between challenges faced by, for example, indigenous women, female sex workers and adolescent girls. When such attention exists, it is in separate policies and programmes, which could lead to coordination, efficiency and effectiveness problems.

A sixth gap concern obstacles to the reporting and protection of domestic violence. Although important steps have been made to criminalise domestic violence, **reporting of domestic violence and spousal abuse remains a challenge**. As discussed with regard to the other regions of the continent, domestic violence remains underreported as a result of gender norms and fear of social stigma. **Gender norms are often reproduced in legislation**; for example, the Penal Code of Gabon is silent on violence against women (except for the category of pregnant women) but explicit on violence against fathers. Similarly, the Family Code in DRC maintains that a man is the head of the household, with authority over all other members of the household including his wife, legitimising men’s control over women and strengthening gender norms that state that GVAW is allowed in marriage. These provisions strongly contradict DRC’s commitment expressed in the Constitution and laws to combat sexual violence and GVAW. Gender bias in legislation and social gender norms contribute to **low levels of prosecution** of domestic violence. Most cases, if reported at all, are settled within families. In order to respond to this challenge, Angola, in its specific law (2011) categorises domestic violence as a ‘public crime’ that can be reported by a third party. Gender norms are also exacerbated in **programmes and projects** such as those focusing on women’s economic empowerment and education. In Cameroon, for example, Women’s and Family Promotion Centres provide education to women to sensitise them on how to avoid exposure to GVAW and prostitution, thus attributing responsibility for GVAW to women.

A final issue is the **volatile political and social situation in some countries**, undermining efforts to implement progressive legislation and policies. In countries such as Burundi, Cameroon, CAR and DRC, conflict and instability generate heightened levels of GVAW. For example, continued postponement of elections as well as reprisals against peaceful protests, including against women human rights defenders, have provided obstacles to the protection and promotion of women’s rights and initiatives to tackle GVAW in DRC, despite the country’s commitments expressed in its NAP 1325.<sup>lxv</sup>

### 5.3.4 Southern region

#### *Trends, gaps and contestations*

In the regional picture, legal and policy frameworks in Southern Africa seem fairly strong, and are also quite homogenous. Seven of the sixteen countries have a similar profile, with legislation on domestic violence, sexual harassment and human trafficking in place but no criminalisation of marital rape and also no NAP 1325 (Botswana, Madagascar, Malawi, Mauritius, Mozambique, Seychelles and Zambia). Comoros has three positive scores on legislation on domestic violence, marital rape and sexual harassment. Comoran law does however not prohibit all forms of human trafficking and Comoros has no NAP 1325. DRC also has three positive scores, on legislation on sexual harassment and on human trafficking, and for a NAP 1325; DRC lacks legislation on domestic violence as well as on the outlawing of marital rape. DRC stands out as the only country in the region that has a NAP 1325. Lesotho also scores positive on three indicators, and does criminalise marital rape, but does not have legislation on domestic violence: a bill on domestic violence has been drafted but has never been passed. Namibia, South Africa and Zimbabwe have a stronger profile, scoring positively on all indicators except NAP 1325. Angola, Swaziland and Tanzania's national legal and policy frameworks are weaker than those of most other countries in the region. Angola has legislation on domestic violence and human trafficking but does not achieve the other indicators. Tanzania has legislation with respect to sexual harassment and human trafficking. Swaziland scores positively only on legislation on human trafficking, and otherwise lacks a legal and policy framework regarding domestic violence, marital rape, sexual harassment and the NAP 1325.

The **SADC Protocol on Gender and Development** contains specific provisions regarding GVAW. Arts 20–25 call on state parties to legislate against sexual violence, sexual harassment and other forms of GVAW and for support services, treatment and care of survivors of sexual violence and GVAW.<sup>67</sup> Art. 7 provides for equality in accessing justice. The Protocol targets focus emphatically on preventing and combating trafficking in women and girls, and this is strengthened by the **SADC Strategic Plan of Action on Combating Trafficking in Persons, especially Women and Children**, driven by the SADC Gender Unit.

The SADC Gender Secretariat and SADC Gender and Development Protocol Alliance, using the SADC GVAW frameworks, have been a strong factor in creating convergence towards gender-responsive frameworks to promote gender equality in SADC countries. The presence of critical regional civil society networks such as the SADC Gender Protocol Alliance and NGOs like Gender Links has led to heightened monitoring at national level. The Gender Links' *Violence against Women Baseline Studies* (2010–16) gather data from sources from household level to the institutional level, extending to police stations, courts, health services and shelters, and carry out media monitoring too.<sup>lxvii</sup> Such studies have been undertaken in seven countries: Botswana, Lesotho, Mauritius, Seychelles, South Africa, Zambia and Zimbabwe.

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<sup>67</sup> Part VI of the SADC Protocol on Gender and Development addresses GBV. It contains six articles with specific provisions: Art. 20 (on legal aspects), Art. 21 (on social, economic, cultural and political practices), Art. 22 (on sexual harassment), Art. 23 (on support services), Art. 24 (on training of service providers) and Art. 25 (on integrated approaches).

Table 5.7. Key legal and policy indicators in Southern Africa, GVAW

Country	INDICATORS	Legislation on domestic violence	Criminalisation of marital rape	Law on sexual harassment	Law on human trafficking	NAP 1325
Angola	Yes	No <sup>68</sup>	No <sup>69</sup>	Yes <sup>70</sup>	No <sup>71</sup>	No
Botswana	Yes	No	WP	Yes	No	No
Comoros	Yes <sup>72</sup>	Yes <sup>73</sup>	Yes <sup>74</sup>	No	No	No
DRC	No	No	Yes <sup>75</sup>	Yes	No	No
Lesotho	No <sup>76</sup>	Yes	WP	Yes	No	No
Madagascar	PC <sup>77</sup>	No	WP	Yes	No	No
Malawi	Yes	No	Yes	Yes	No	No
Mauritius	Yes	No	Yes <sup>78</sup>	Yes	No	No
Mozambique	Yes	No	WP	Yes	No	No
Namibia	Yes	Yes	WP	Yes	No	No
Seychelles	Yes	No	WP	Yes	No	No
South Africa	Yes	Yes	Yes	Yes	No	No
Swaziland	No	No	No	Yes	No	No
Tanzania	No <sup>79</sup>	No	Yes <sup>80</sup>	Yes	No	No
Zambia	Yes <sup>81</sup>	No	Yes	Yes	No	No
Zimbabwe	Yes	Yes	WP	Yes	No	No

### Trends in legal, policy and institutional reform

**Constitutional provisions:** Constitutional reforms have been undertaken to ensure that countries align their frameworks more closely with the SADC Gender and Development Protocol. All SADC countries forbid discrimination based on sex and other factors. Thirteen countries have constitutional provisions on gender equality (Angola, Comoros, DRC, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Tanzania and Zimbabwe).<sup>lxvii</sup>

**Statutory law on GVAW:** The majority of the countries (12 out of 16) have legislation on *domestic violence*, and Madagascar has sanctions in the Penal Code regarding violence against women and children. Only DRC, Lesotho and Tanzania lack specific legal provisions on GVAW, but even these have general criminal or penal codes that can address certain forms of domestic violence—namely, assaults and neglect of children. All countries have legislation criminalising *rape*. However, only five out of sixteen countries have passed laws on *marital rape* (Comoros, Lesotho, Namibia, South Africa and Zimbabwe). This could be a result of conservative or patriarchal societal forces that are reluctant to extend protection to women facing IPV. The Girls' and Women's Protection Act 39 of 1920 of Swaziland relating to sexual abuse of girls under 16 excludes marital rape in circumstances where a man is married to a girl.<sup>lxviii</sup>

68 Isis-WICCE. (2014). 'Towards an Anti-Sexual and Gender-Based Violence Norm in the Great Lakes Region of Africa: A Civil Society Review of the Implementation of the 2011 ICGLR Kampala Declaration'.

69 Some offences can be prosecuted under assault.

70 Trafficking prohibited under the Prevention of Organised Crime Act 2009.

71 Drafted a NAP to increase women's participation in conflict prevention but does not have release date.

72 Original text could not be found, determined from secondary sources. A news article mentions the launch of a law on violence against women: <http://www.linfo.re/ocean-indien/les-comores/670664-comores-promulgation-de-la-loi-contre-les-violences-faites-aux-femmes>. Law on domestic violence also mentioned in the 2017 US State Department Human Rights Report of Comoros: <https://www.state.gov/documents/organization/265452.pdf>

73 The original text could not be found, determined from secondary sources. Mentioned in the 2017 US State Department Human Rights report of Comoros: <https://www.state.gov/documents/organization/265452.pdf>. Also indicated in World Bank Data: [https://datacatalog.worldbank.org/search?search\\_api\\_views\\_fulltext\\_op=AND&query=marital+rape&sort\\_by=search\\_api\\_relevance&sort\\_by=search\\_api\\_relevance](https://datacatalog.worldbank.org/search?search_api_views_fulltext_op=AND&query=marital+rape&sort_by=search_api_relevance&sort_by=search_api_relevance)

74 The Penal Code criminalises sexual assault. [http://www.wipo.int/wipolex/fr/text.jsp?file\\_id=208475#LinkTarget\\_7843](http://www.wipo.int/wipolex/fr/text.jsp?file_id=208475#LinkTarget_7843). Law on Sexual harassment also mentioned in secondary source, the 2017 US State Department Human Rights Report of Comoros: <https://www.state.gov/documents/organization/265452.pdf>

75 Contained in the Sexual Violence Law and Labour Code.

76 A Domestic Violence Bill as drafted in 2000, but has not been passed ([www.lesotimes.com/call-to-harmonise-laws/](http://www.lesotimes.com/call-to-harmonise-laws/)). The Sexual Offences Act of 2003 has stipulated that sexual abuse can take place within marriage (<http://genderlinks.org.za/news/lesotho-demanding-zero-tolerance-for-violence-against-women-2015-11-25/>).

77 The Malagasy Penal Code Update on Sanctions for Violence Against Women and Children 2005 includes domestic violence but there is no standalone legislation on domestic violence.

78 The Equal Opportunities Act 2008 covers sexual harassment in all respects of life.

79 Whereas the Tanzanian Law of Marriage Act provides that corporal punishment may not be inflicted on a spouse, this provision is not backed by a penalty and therefore not criminalised. Corporal punishment, which is undefined, also fails to account for the various ways domestic violence may be inflicted including non-physical forms of violence.

80 Various laws including the Employment and Labour Relations Act, the Penal Code, the Sexual Offences Special Provisions Act and the newly amended Education Act, which includes provisions on sexual harassment in schools.

81 Zambia has a comprehensive law named the Anti-SGBV Act.

Sexual violence in the public sphere is legislated against in the majority of the countries in the Southern region. Out of 16 countries in Southern Africa, 14 have passed legislation with respect to *sexual harassment* in different forms; only Angola and Swaziland lack such a law. In seven countries, such legislation is largely applicable to the public services employment sector, leaving out the private sector and educational institutions. In these cases, provisions are contained in labour or employment laws, mostly limited to the public service. Mauritius stands out in this regard, with an expansive definition that protects a wider range of women in the public and private arena. The Equal Opportunities Act 2008, in forbidding sexual harassment, refers specifically to a range of actors in employment, company and educational settings.<sup>82</sup> For other situations, sexual harassment is criminalised in the Penal Code. In Zambia, sexual harassment comes under the Anti-SGBV Law.

*Human trafficking* is prohibited in 15 out of 16 countries in the region, and in 14 of these, this is done in specific legislation on trafficking in persons. Namibia prosecutes acts of trafficking under the Prevention of Organised Crime Act. The law of Comoros does not prohibit all forms of trafficking.<sup>boxix</sup> Even though none of the countries in the Southern region is meeting minimum standards for the elimination of trafficking, all countries except DRC are making significant efforts to comply with these standards. The government of DRC has continued to arrest and detain trafficking victims (including some child soldiers, who have also reportedly been executed by the National Police and the National Army). The main issues hindering anti-trafficking efforts in DRC are lack of an anti-trafficking framework, capacity and funding and widespread corruption.<sup>boxx</sup>

**NAP 1325:** SADC is yet to adopt a Regional Action Plan on UNSCR 1325 or to incorporate the women, peace and security agenda in its protocols.<sup>boxxi</sup> DRC is the only country in the Southern region with a National Action Plan on UNSCR 1325. Namibia is due to formalise one and Angola, Madagascar, South Africa, Tanzania and Zimbabwe are undertaking processes in this regard.<sup>boxxii</sup> Art. 28 of the SADC Gender Protocol integrates peace-keeping, in accordance with UNSCR 1325. In December 2016, the SADC Secretariat and member states moved to develop a Regional Framework for the Implementation of Resolution 1325.<sup>boxxiii</sup>

**Policy frameworks and institutional reforms on GVAW:** Access to justice for survivors of GVAW is a critical component of women's human rights. Many countries in the region have institutional reforms to improve this and provide different types of support services. All countries offer various affordable and specialised services, including legal aid and shelters, to survivors of GVAW.<sup>boxxiv</sup> Service providers in government are increasingly working with NGOs to plug capacity and outreach gaps. Most countries by policy offer comprehensive treatment including post-exposure prophylaxis to survivors of sexual violence, although there is no specific legislation on this for the most part.

There has been a notable increase across the region of **one-stop centres** for survivors of GVAW, especially rape survivors. These centres bring together the police and legal and medical practitioners as well as social welfare services to offer comprehensive support to survivors of sexual violence. This model has been most successfully implemented in South Africa with the Thuthuzela Care Centres—a world-renowned model that was initiated by the National Prosecuting Agency to provide victim-friendly services to survivors of GVAW.

Police departments in most of the countries have created *specialised units* that aim to address domestic violence cases in sensitive ways. For example, Swaziland established the Domestic Violence, Child Protection and Sexual Offences Unit in 2002. In 2013, Malawi established Victim Support Units in police stations and support units in traditional authority institutions. In Botswana, each police station has a police officer trained on GVAW and other gender-related matters. South Africa has established Victim Empowerment Centres in the police department in which police officers are trained to handle GVAW survivors with sensitivity. There are also institutional reforms in the courts. Zambia has two user-friendly *fast track courts* to specifically expedite GVAW cases, and South Africa has sexual offences courts specifically to dispense justice for victims of GVAW. DRC initiated mobile courts or special circuits from 2009, focusing on only SGBV, to combat rape and impunity for such crimes in the Eastern region in particular.

In addition, quite a few countries have made attempts to develop **data** around gender issues and this effort often covers GVAW. Many countries conduct periodic DHS that include indicators on GVAW and provide much-needed data for planning, service delivery and advocacy purposes.

<sup>82</sup> The Equal Opportunities Act 2008, in forbidding sexual harassment, refers to employers or their agents in general; job contractors; persons employing accommodation or disposing of immovable property; members of a partnership or company or persons who provide goods, services or facilities; and students or member of staff of educational institutions.

### Key gaps and contestations

GVAW in Southern Africa continues to be prevalent in both the private and the public spheres, despite efforts at national and regional level to combat the diverse manifestations and impacts. GVAW is perpetuated by **patriarchal norms** that sustain unequal power relations between men and women and is entrenched as a result of cultural and societal acceptance of gender inequalities. This leads to environments in which GVAW is normalised and accepted in certain circumstances, at communal and family level, including practices such as marital rape, domestic violence and sexual harassment.

Countries have resisted making laws on **marital rape** as a result of cultural and religious norms that view women's consent at the time of marriage as unconditional and absolute. Major progress has been noted in legal reforms around sexual violence, domestic violence and trafficking in women and girls in particular, though less success has been evidenced concerning marital rape. Although none of the countries explicitly excludes marital rape from the definition of rape, more than two-thirds fall short of outlawing it in their legal frameworks.

Many countries in the region have made progress in terms of improving *access to justice* for GVAW survivors, to ensure accountability. There have also been steps forward in the provision of *support services*, especially counselling, legal aid and adoption of victim-friendly procedures to ensure more reporting by victims. Yet the resources for these support services are often limited in their scope, meaning the implementation of measures is challenged by lack of financial as well as human capacity. This also affects the expeditious handling of cases in courts. Other challenges that affect the provision of services to GVAW survivors include low legal literacy among survivors, long distances to courts and low representation of women in adjudicatory positions.<sup>lxvii</sup> In addition to this, progressive initiatives for reforms in courts, in DRC, South Africa and Zambia, are constrained by lack of adequate human and financial resources, and also require more training of male and female personnel to enable them to obtain gender-friendly and responsive orientation. Lack of funding for training legal and health stakeholders on GVAW is a critical constraint.

### 5.3.5 Northern region

#### Trends, gaps and contestations

The profile on legal and policy indicators regarding GVAW for the Northern region looks fairly bleak. None of the countries scores positively on four or five indicators; none of the countries criminalises marital rape; and none of the countries has a NAP 1325. Libya has the weakest framework, with only a law on human trafficking in place. Mauritania and Morocco score positively on legislation on sexual harassment and on human trafficking but lack legislation on domestic violence and the criminalisation of marital rape. Egypt and Tunisia have three positive scores, on legislation on domestic violence, sexual harassment and human trafficking.

Table 5.8. Key legal and policy indicators in Northern Africa, GVAW

Country	INDICATORS				
	Legislation on domestic violence	Criminalisation of marital rape	Law on sexual harassment	Law on human trafficking	NAP 1325
Algeria	PC	No	Yes	Yes	No
Libya	No	No	No	Yes <sup>83</sup>	No
Egypt	PC	No	Yes	Yes	No
Tunisia	Yes <sup>84</sup>	No	Yes	Yes	No
Mauritania	No	No <sup>85</sup>	Yes <sup>86</sup>	Yes	No
Morocco	No <sup>87</sup>	No <sup>88</sup>	Yes <sup>89</sup>	Yes	No
Western Sahara	-	-	-	-	-

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

**Constitutional provisions:** All of the states reviewed have constitutional provisions, which are considered essential in relation to protection from GVAW. Most of the states expressly proscribe violence in their constitutions. For example, Algeria prohibits all forms of physical or psychological violence or indignity and Egypt guarantees the equality of women in all spheres and the protection of women from all forms of violence. Children (girls) are also protected from violence and sexual exploitation. Egypt's Constitution additionally prohibits trafficking. Morocco prohibits incitement to violence. Tunisia's Constitution also includes a commitment to eradicate violence against women. All the states reviewed also have provisions on equality and non-discrimination on the basis of sex or gender, which also provide a key foundation for women's protection from violence.

**Statutory law on GVAW:** Of the states reviewed, only Morocco and Tunisia have specific law on GVAW. Some of the other states reviewed have provisions within their penal codes criminalising *domestic violence* (Algeria, Egypt); others do not have clear provisions criminalising domestic violence (e.g. Mauritania). All of the Northern African states except for Libya have laws on *sexual harassment*. None of the states reviewed proscribes *marital rape*.

In Tunisia, the new law passed in 2017 reinforces the country's place as a leader in the Middle East and North Africa in setting human rights standards. This law expansively defines GVAW to include physical, moral, sexual or economic aggression, and recognises that GVAW or the threat of it can occur in private and public spaces. Most importantly, this law provides for help to victims of domestic violence and removes a controversial article that allows rapists to escape punishment if they marry their victim.

Similarly, in 2014 the Moroccan Parliament unanimously amended Section 475(2) of the Penal Code, which stated that 'when a marriageable minor thus removed or divorced has married his kidnapper, he can only be prosecuted on the complaint of the persons having the right to request the annulment of the marriage and cannot be condemned until after this marriage annulment has been pronounced'.<sup>83</sup> GVAW is widespread throughout the country and, after a decade of advocacy by women's groups, the Moroccan Parliament finally adopted a law in February 2018 to combat it, two years after the law was introduced in 2016.

<sup>83</sup> Criminalised in the Penal Code rather than in a standalone law.

<sup>84</sup> Within the general Law on Eliminating Violence against Women.

<sup>85</sup> Arts 309 and 310 of the Criminal Code prohibit rape but do not define it to include marital rape ('Quiconque aura commis le crime de viol sera puni des travaux forcés à temps sans préjudice, le cas échéant, des peines de Had et de la flagellation si le coupable est célibataire. S'il est marié, seule la peine capitale sera prononcée').

<sup>86</sup> The Mauritanian Labour Law (Arts 306, 309 and 310) clearly stipulates that any act of sexual harassment against women at workplace or elsewhere is a crime.

<sup>87</sup> A law to combat violence against women legislation was adopted in February 2018, five years after it was first drafted: Law no. 103-13 on Combating Violence against Women prohibits 'any act based on gender discrimination that entails physical, psychological, sexual, or economic harm to a woman'. However, the new law does not explicitly address or give a clear definition of domestic violence.

<sup>88</sup> The new law on violence against women does not criminalise marital rape.

<sup>89</sup> Under Art. 40 of the Labour Code, sexual harassment of an employee by his or her employer and incitement to debauchery are serious offences. The new law to combat violence against women goes even further, to criminalise sexual harassment via social media.

Algeria in 2016 passed significant amendments to the Penal Code in the area of sexual violence. Before that, the Penal Code had been amended in 2004 to Law No. 04-15 to create the offence of sexual harassment in public places, but this was viewed to have a narrow application. The 2016 amendment extends the definition of sexual harassment to any person who abuses power in order to give orders to, threaten or impose constraints/exercise pressure on another person to obtain sexual favours. <sup>lxxxvii</sup>

All of the states in the Northern region have laws proscribing *trafficking in persons*. However, none of the countries<sup>90</sup> is meeting the minimum standards for the elimination of trafficking in persons. Egypt, Morocco and Tunisia are however making significant efforts to do so through, for example, new legislation that limits child domestic work; extending protection and services (both legal and social) to migrants (Morocco); creating specialised courts to prosecute human trafficking cases (Egypt); enacting new anti-trafficking legislation and training officials (Tunisia); and conducting awareness-raising campaigns (Egypt and Tunisia), among other things. Mauritania is the only country that has not made significant efforts to comply with minimum standards. Lastly, Libya is being considered a 'special case' for the second consecutive year, as the government's priority lies in securing its territory and counter violence by extremist groups.<sup>91</sup>

**Policy frameworks and institutional mechanisms on GVAW:** Each state reviewed has both policy and institutional mechanisms in place that address GVAW, either broadly or in specific terms, with the exception of Libya, which does not have policy measures on the issue. On policy, most countries have national strategies specific to GVAW (Algeria, Egypt, Mauritania, Morocco, Tunisia). In terms of institutional measures, some have specific organs or committees mandated with addressing GVAW (Algeria, Egypt, Libya). Morocco's institutional measure is in the form of a Domestic Violence Unit within the Criminal Investigation Directorate, tasked with gathering statistics on GVAW. In addition, Egypt and Tunisia have bodies dedicated to addressing trafficking in persons.

**NAP 1325:** None of the countries has adopted a National Action Plan 1325.

### Key gaps and contestations

**Non-criminalisation of forms of GVAW:** Libya, Mauritania and Morocco have not criminalised domestic violence. Despite this being a serious issue in Mauritania, there is no specific law prohibiting it, and it does not appear in any other legislation. Under Art. 309 of the Criminal Code, rape is a criminal offence; however, the Code does not give an explicit definition of rape.

**Pluralism of laws and the influence of religion and culture:** In general, most of the countries apply old laws predating the Maputo Protocol on matters of personal status. The Libyan Penal Code frames sexual offences as attacks on honour rather than as a human rights issue (i.e. related to the right to bodily integrity); this may cast the spotlight on the woman's history rather than on the act of sexual violence and the perpetrator. <sup>lxxxviii</sup> This is aggravated by the giving of sentences for criminal acts that are influenced by the preservation of honour that are lower than those for crimes committed without honour considerations. In a positive move, though, the Libyan Council of Ministers has adopted a decision recognising female victims of violence or those raped in the war of independence as war victims. <sup>lxxxix</sup>

In most Middle Eastern and North African countries, women's right to divorce is restricted owing to **cultural and religious norms**, which can have the effect of keeping women in violent marriages, as has been observed in, for instance, Algeria and Egypt.<sup>92</sup> With respect to Algeria, the UN Special Rapporteur has referred to contradictions between the interpretation of the Family Code of 2005 and the spirit of the law regarding marriage, polygamy and divorce. The offence of rape and sexual assault is not defined in the Penal Code and marital rape is not expressly prohibited. There are loopholes that allow for marriage of victims of sexual violence to their perpetrators.<sup>93</sup> In Mauritania, an Islamic country governed by *sharia* law mixed with a French colonial legal system, women have difficulties accessing justice in cases of sexual violence. For instance, women who are victims of rape find themselves accused of *zina*, which refers to sex outside the marriage between unmarried couple.<sup>94 xc</sup>

<sup>90</sup> Western Sahara is not analysed by the US State Department TIP report of 2017 and a country narrative is lacking.

<sup>91</sup> Libya is afflicted by widespread violence by militant groups, civil unrest and increased lawlessness, as a result of its dysfunctional judicial system, which has not been operational since 2014. Most diplomatic missions, NGOs and international organisations withdrew from the country in 2014.

<sup>92</sup> Attempting to remedy this and failing, a law was introduced in Egypt in 2000, called the Khula Law, whereby a woman can file for divorce on no grounds, but then she has to forfeit her financial rights and reimburse her husband the dowry (and any gifts) paid when contracting the marriage. This effectively makes the right hard or expensive to implement in practice ([www.juancole.com/2015/02/itself-womens-rights.html](http://www.juancole.com/2015/02/itself-womens-rights.html)).

<sup>93</sup> Victims of rape may also face pressure to be married to the perpetrator, at his request or the request of either of the respective families. Further, Section 26 of the Algerian Penal Code provides that a person who 'abducts or corrupts' a child under 18 years without using violence, threats or deception or attempts to do so may be imprisoned for one to five years but can avoid this penalty if he marries the child.

<sup>94</sup> In Mauritania, both perpetrators and victims are culpable under *zina*. In 2013, a report found that around 60% of victims of rape were accused of *zina* and were thus in danger of being put in prison. This makes it harder for women who have been raped to fill a complaint, who will fear being imprisoned.

This plurality in legal systems may also explain the **failure to legally recognise marital rape**. None of the countries reviewed legally recognises marital rape, despite the reality and prevalence of the practice. In Tunisia, Art. 23 of the Personal Status Code requires spouses to 'fulfil their conjugal duties according to practice and customs', a provision that is, as Amnesty International points out, 'generally understood to mean that sexual relations constitute a marital obligation'.<sup>xci,xcii</sup> In Egypt, some abusers have erroneously used religion (Islam) to justify their violent behaviour, but this has been disputed among Islam clerics.<sup>xciii</sup>

**Retrogressive provisions and half-measures:** In Morocco, women's rights groups heralded the adoption of the new law criminalising violence against women but are also calling it a 'bittersweet victory'. The new law has a number of key gaps. First, it lacks a clear definition of domestic violence and does not directly criminalise marital rape. Second, it is difficult for women to obtain a protection order (to do so, they need to file criminal charges). Meanwhile, the law does not address the issue of financial support and emergency and long-term facilities for survivors of violence, while access to the few available shelters run by NGOs is very limited as a result of scarce resources. The government needs to ensure it fully enforces the legislation to ensure that perpetrators of violence are brought to justice and also resources are available for survivors of violence.<sup>xciv</sup>

In Libya, access to justice for victims is problematic, characterised by few incidences of reporting violence; cases that are lodged are usually withdrawn. This is mostly related to the difficulty for victims in reporting sexual violence, as a result of penalties imposed on sexual intercourse between an unmarried man and women.<sup>95</sup> Another challenge is that, in some circumstances, rapists can have their trial suspended if they marry their victim, as has also been noted in Algeria.

**Implementation challenges:** Despite the presence an enabling framework, underreporting of sexual violence cases such as sexual harassment is characteristic, caused by fear of accusations of victim-blaming for having incited the perpetrator's advances or lack of protection for victims and witnesses of sexual harassment.<sup>xcv</sup> Victims of GVAW are trivialised by law enforcement agents, who consider such matters domestic issues. In Algeria, there is also a 'lack of specific rehabilitation measures for victims, difficulties faced in obtaining compensation and insufficient information on the investigation and prosecution of perpetrators of sexual violence'.<sup>xcvi</sup>

**Slavery in Mauritania:** Mauritania is one of the few countries where slavery is still practised. Slavery was the last country to officially abolish slavery, in 1981. In 2007, the country adopted an anti-slavery law, which was later amended in 2015 by labelling slavery a 'crime against humanity' and making it a criminal act (it was considered an 'offence' in the previous law) with a jail sentence up to 15 years for offenders. Nevertheless, slavery is widely practised in the country, and the 'status of slave is still passed down from mother to infant'<sup>xcvii</sup> owing to a lack of law enforcement.

<sup>95</sup> Law No. 70 (1973) and the Libyan Penal Code establish the Hadd penalty on sexual intercourse between a non-married man and a non-married woman, which is punishable by flogging. This is problematic in that women who have had non-consensual sex but without proof may be flogged if they fail to prove their case, which thus discourages reporting.

## 5.4 Case studies

This section presents seven case studies on strategies to promote and realise women and girls' rights regarding GVAW. They speak to multiple forms of GVAW, ranging from sexual violence and rape to verbal abuse, physical abuse, sexual harassment and image-based sexual violence. This violence is experienced by women as well as girls at the hands of intimate partners, as well as parents, grandparents and relatives; by teachers, public transport drivers, neighbours and landlords; and by law enforcement officers who are actually supposed to protect and promote women and girls' rights. The case studies address GVAW experienced by women and girls in private as well as public settings, and also in contexts of armed conflict and crisis.

Each case study presents a strategy used by an actor or group of actors to promote and realise women and girls' rights in GVAW. These strategies are diverse and cover different levels. The ECOWAS Court case and the Kampala Declaration of the ICGLR are two examples at the regional level, and point to the importance and added value of regional coordination and monitoring of commitments on gender equality and women and girls' rights. The other cases document strategies at national or subnational level. They point to strategies pursued to promote and realise legal and/or policy reform, as with the work on image-based sexual violence in Zimbabwe by Katswe Sistahood.

Several case studies shed light on the efforts needed to actually implement existing legal and police frameworks. Both the Shukumisa campaign case study and the study on cross-sector coordination on Kenya's Sexual Offences Act illustrate the efforts required to translate legal provisions into practice on the ground to make a difference to women and girls' lived realities. The cross-sector coordination initiative has improved coordination and collaboration among the many actors and stakeholders involved in legal and medical support to survivors of sexual violence. The Shukumisa campaign points to the importance of continued monitoring of implementation, to further advance practice and tackle barriers. The 160 Girls project in Kenya points to the effect of public interest litigation to realise access to justice for survivors of sexual violence. The case study on the Safe Ride campaign highlights that realising women and girls' rights does not end in the formulation of legal, policy and institutional frameworks; also required is social norm change that transforms patriarchal mores and institutions that perpetuate GVAW.

Some insights that can be drawn from these seven case studies on strategies for women and girls' rights regarding GVAW are as follows:

- **Civil society and women and girls' rights organisations** are critical actors in promoting and monitoring legal, policy and institutional reform on GVAW at regional, national and subnational levels.
- **Collaboration and coordination** between stakeholders, and between government and CSOs, is critical at all levels, to avoid second traumatisation of GVAW survivors. Cross-sector collaboration along the long chain of legal and medical support to survivors of GVAW is key to realising women and girls' rights to protection from GVAW and their access to justice.
- Collaboration and coordination is also needed at **community level and with informal justice actors**, and in the linkages between these and formal justice and health systems.
- Strategies are needed to engage **men and boys** as change agents in ending GVAW.
- **Training** of legal and health professionals and officers on GVAW, its manifestations and women and girls' rights is key to the translation of legal and policy frameworks into women and girls' lived realities.

### Case study 1. State accountability for sexual violence in Kenya: the 160 Girls project

The 160 Girls project is a legal advocacy initiative that successfully secured enforcement of the law in Kenya to protect girls from sexual violence. The initiative entailed a public interest court case, and the favourable court decision that ensured forced the police to investigate and prosecute the neglected rape cases in question. This led to a training programme for police officers, later rolled out across Kenya.

Girls are particularly vulnerable and disproportionately affected by sexual violence, owing to factors such as sex, gender, age and low socioeconomic status, among others. Meanwhile, lack of perpetrator prosecution and accountability perpetuates the occurrence and social acceptance of sexual violence. This was the case in Meru county in eastern Kenya, where 160 girls, all between the ages of 3 and 17 years old, had all been victims of rape and in other cases repeated rapes. The girls were identified through Tumaini Girls Rescue Centre/Ripples International in Meru. Most had been raped by people known to them, including parents, grandparents, relatives, teachers, neighbours, landlords and a police officer. Since the perpetrators were known, this should ideally have resulted in more effective investigations and prosecutions. However, none of the 160 girls had received justice, with the police neglecting or refusing to pursue the reports.

In response to this systemic and perverse lack of access to justice, Tumaini Girls Rescue Centre/Ripples International approached the Equality Effect to co-develop a legal advocacy solution to the problem. This led to the 160 Girls project—a legal initiative that aims to achieve justice and protect girls in Kenya from rape. The partners began by initiating litigation on behalf of the girls to secure legal remedies ordering the state to enforce existing laws to investigate and prosecute the cases and hold the rapists accountable as well as to secure protection from sexual violence for girls in Kenya. In a bold and innovative legal move, the girls sought to make a case that failure by the police to enforce existing laws amounted to violation of domestic, regional and international human rights law.

The initiative took on the nature of a public interest case, when means the remedies requested sought to benefit the specified girls' cases as well as to secure legal protection from sexual violence for all girls in Kenya by targeting policy reform and the implementation of existing laws.

Various strategies were utilised in developing the court case. The project partners undertook fundraising and built collaborative networks with other organisations such as the Federation of Women Lawyers (Kenya) and the Kenya National Commission on Human Rights, which were also enjoined in the court case as interested parties. The research and collection of evidence itself took almost two years and was the product of rigorous legal strategy development and consultation drawing on the expertise of Canadian and Kenyan human rights lawyers and advocates.

The results of the initiative were successful on various fronts. In 2013, a Kenyan High Court decision (*C.K. (a child through Ripples International as her guardian and next friend) & 11 others v Commissioner of Police/Inspector General of the National Police Service & 3 others* [2013] eKLR) made legal history by finding that 'The neglect, omission, refusal and/or failure of the police to conduct prompt, effective, proper and professional investigations into the first eleven petitioners' complaints of defilement violates the first eleven petitioner's fundamental rights and freedoms.' The Court then went on to list the various rights that had been violated in the Kenyan Constitution as well as rights in the UDHR, the UN CRC, the ACRWC and the African Charter.

The Court ordered the police to undertake prompt and effective investigations into the rape cases of the girls. It further linked the failure of the police to ensure justice in rape cases as contrary to their constitutional obligation to comply with standards on human rights and fundamental freedoms. The decision has had a direct legal impact, with most of the rape cases that had been neglected or purposefully obstructed investigated and prosecuted, and about 80% have seen a positive outcome.

160 Girls is a long-term initiative and work continues to address perpetrator accountability as well as the root causes of the systemic and epidemic sexual violence experienced by girls. The initiative has had significant policy, institutional and societal impact. For instance, Tumaini Girls Rescue Centre/Ripples International reports that there is increased reporting of rape cases in Meru county, and this is putatively linked to the Court's decision and is a possible indicator of the dwindling social acceptability of sexual violence. The project partners have also established justice clubs in schools through which they sensitise children on child rights and protection.

From an institutional perspective, Tumaini Girls Rescue Centre/Ripples International reports that the decision was well received by the National Police Service, which in fact contacted the Centre on its own initiative seeking details on the rape cases. In an unprecedented development, the Kenya National Police Service approached the Equality Effect to establish a partnership to achieve implementation of the 160 Girls High Court decision. The Equality Effect is now developing and executing the 160 Girls police defilement investigation programme, which was piloted in four counties in Kenya. The pilot proved a success,<sup>xviii</sup> and the training, incorporating international best practices and infused throughout with human rights law, is now being rolled out across Kenya. In 2017, the UN recognised 160 Girls as an international best practice in advancing women's rights and empowerment. These legal, societal, attitudinal, policy and institutional changes are likely to have a deterrent effect on sexual violence against girls as well as easing access to justice should they occur.

## Case study 2. Revenge porn in Zimbabwe: image-based sexual violence and social media

This case study looks at the growing phenomenon of non-consensual leakages of sexually explicit images seeking to shame and distress women publicly. Katswe Sistahood, a Zimbabwe-based organisation, used various strategies to successfully combat this type of GVAW, including a petition to Parliament to generate a responsive law to the particular crime of releasing sexually explicit materials.

Activists in Zimbabwe have decried the growing use of social media platforms for image-based sexual violence. This entails the posting pictures and videos of sexually explicit content that is deemed pornographic by Zimbabwean law, in some countries dubbed the 'snap of shame'.<sup>96</sup> This has become a common practice in Zimbabwe with the advent of social media, affecting women who are public figures and young women in universities, particularly Midlands State University. <sup>xcix</sup> A number of local celebrities in Zimbabwe have fallen victim to revenge porn over the past few years.<sup>96</sup> Other women have also suffered from the dissemination of such content. In one instance, a university student was expelled after sexually explicit images were disseminated.<sup>ci</sup>

Such image-based sexual violence not only violates the rights of women to express themselves in circumstances of privacy but also offends their inherent dignity. It is a form of violence against women that results in mental, physical and even economic violence. Often, the knee-jerk reaction of the public court of opinion in Zimbabwe, set in a highly patriarchal society that frames women's sexuality within rigid parameters, is to condemn, shame and stigmatise the woman in the pictures or video. Given the societal backlash that follows the dissemination of such images, the risk of mental and psychological torture for the victims is real and can have repercussions for her education and employment and in social terms at both family and community level. There is also the risk of further victimisation caused by unwanted sexual advances and harassment by strangers who may think such women and girls are inviting them by 'releasing' the images.

Director of Katswe Sistahood, Talent Jumo, in describing the gender implications of the crime, observed that, 'When a sex tape is leaked, society will slut-shame and even ostracise the woman while the man is praised for his virility.' Katswe Sistahood, a movement of young women fighting for the full attainment of SRHR in Zimbabwe, undertook decisive and strategic action against this form of sexual violence. The absence of a specific criminal law in Zimbabwe to prohibit this growing trend is depriving its victims of justice. Katswe Sistahood prepared a petition to ban this type of GVAW.

In many countries this crime is labelled 'revenge porn', but legally it does not amount to pornography, and the term itself is a misnomer. Image-based sexual violence is not pornography, but a form of GVAW; it also leads to victim-blaming and distracts attention from the perpetrators.<sup>97</sup> Globally, some countries now have revenge porn laws;<sup>98</sup> in Africa, though, for the larger part, countries are yet to specifically recognise revenge porn. In Zimbabwe, while Section 26 of the Censorship and Entertainment Control Act criminalises possession of indecent, obscene or prohibited articles, it does not cover materials released to cause harm or distress. Prosecutors across the continent have to rely on laws prohibiting the broadcasting and distribution of regular pornography, anti-harassment laws, the use of mobile phones to send harassing messages (under the Telecoms Act in Zimbabwe), anti-extortion laws or pornography or anti-obscenity provisions in the law, which are not victim-centred. Katswe Sistahood has found serious gaps in these laws, which do not respond to the specific circumstances of perpetrators and victims of revenge porn.<sup>cii</sup>

In preparing its petition, Katswe Sistahood undertook consultations with the public. In 2016, it conducted an online survey and focus group discussions on the criminalisation of non-consensual distribution of explicit and intimate images. The survey revealed that 66% of the sample considered this to be a criminal offence. Armed with these public perceptions and statistics in support of its cause, Katswe Sistahood petitioned the Parliamentary Portfolio Committee on Justice, Legal and Parliamentary Affairs to ban 'revenge pornography' specifically.<sup>99</sup> Katswe Sistahood's petition argued that the growing non-consensual use of explicit images and film footage was intended to 'humiliate, intimidate, dehumanise and degrade people's lives in general and women's lives and livelihoods in particular'. The petitioners also decried the lack of a criminal law protecting the privacy of private communications involving sexual expression from publication without a subject's consent.

<sup>96</sup> A sex tape of popular socialite and Zimbabwe's former Big Brother housemate Pokello Nare with musician Desmond Chideme, popularly known as Stunner, was leaked. Former TV personality Tinopona Katsande also complained that sex tapes had been leaked. Another victim is former Miss Zimbabwe Emily Kachote, who in 2015 was dethroned after nude pictures were reportedly leaked. In 2014, Thabiso Phiri had resigned from the Miss Zimbabwe position three days after pictures were leaked.

<sup>97</sup> 'Revenge porn' is a term used to refer to a partner or ex-partner purposefully publishing privately captured and sexually explicit content without the subject's consent, as an act of spite or vengeance. The victim may have initially consented to the image creation but without ever intending it to be made public. However, the term has been decried as a misnomer: the act should not fall under the crime of pornography since the victim does not intend to have his or her private acts with an intimate partner exposed to the public. Use of the term can thus lead to victim-blaming of the person in the images rather than blaming the perpetrator who wrongfully circulates such pictures.

<sup>98</sup> Countries with so-called revenge porn laws include the Philippines, the UK, the US (some states), Australia and Canada, among others. In the UK, for example, the government has created a new criminal offence to ensure this behaviour is fully captured under criminal law. Section 33 of the Criminal Justice and Courts Act 2015 covers the offence of disclosing private sexual photographs or films without the consent of an individual who appears in them and with intent to cause that individual distress.

<sup>99</sup> Katswe Sistahood relied on the Constitution provision under Section 149 that grants every citizen and permanent resident of Zimbabwe a right to petition Parliament to consider any matter within its authority, including the enactment, amendment or repeal of legislation.

Rather fortuitously, in 2016 Zimbabwe was in the process of enacting a Computer Crime and Cyber Crime Bill that already contained sections on criminalising pornography and child pornography. Katswe Sistahood seized the opportunity to participate in the process and to influence the law to ensure it responded to the concerns of women with regard to the release of sexually explicit content in violation of intimate partner and trust relations. Following the petition, the Cyber Crime and Cyber Security Bill, as it had come to be known, which was under development by the Attorney-General's Office, included provisions to criminalise the leaking of nude pictures of former lovers on social media or online. These amendments were made to the proposed law after public consultations. The Bill contains a provision on revenge pornography that reads as follows:

Section 14: Any person who, with the intent to cause harm or distress or realising that there is a real risk or possibility to cause harm or distress, discloses private sexual or nude photographs and/or films without the person's permission shall be guilty of an offence and liable to a level six fine or imprisonment not exceeding six months or both such imprisonment and fine. It shall be an aggravating circumstance if the photographs and/or film are of a minor.

Katswe Sistahood continues to campaign for an end to the non-consensual distribution of sexually explicit images and for the criminalisation of such acts using social and mainstream media in Zimbabwe.

### Case study 3. ECOWAS Court makes first judgment on Maputo Protocol in favour of four Nigerian women

This case study describes the case of violations of the women's human rights of four Nigerian women, which was taken to the ECOWAS Court. This was the first time an African court had ruled on violations of the Maputo Protocol. The case concerns the arbitrary arrest and detention and the verbal, physical and sexual abuse that the four women suffered at the hands of Nigerian law enforcement officials.

The ECOWAS Community Court of Justice was set up following the provisions of the ECOWAS Revised Treaty in its Arts 6 and 15 in 1991. However, the Court came into operation only in August 2002 and the first case was brought in 2004. The Court is based in Lagos, Nigeria, and comprises seven judges appointed by the authority of Heads of State from among citizens of member states for a four-year term. The mandate of the ECOWAS Community Court of Justice is to observe the law and the interpretation and application of the provisions of the Revised Treaty, as well as other legal instruments, including treaties adopted and ratified by ECOWAS states.<sup>ciii</sup>

On 12 October 2017 the ECOWAS Court ruled in favour of four women, Dorothy Njemanze, Edu Ene Okoro, Justina Etim and Amarachi Jessyforth, against the Federal Republic of Nigeria. The case centred on the violation of the plaintiffs' human rights following physical, sexual and psychological violence perpetrated by law enforcement agents in Abuja state, Nigeria. This is the first time an African court has ruled in breach of the Maputo Protocol.

In 2009, the Abuja Environmental Protection Board (AEPB), a government agency in charge of the sanitation of the city of Abuja, started raiding at night with the aim of removing prostitutes, with the help of the police and law enforcement agents.<sup>civ</sup> Four women were unlawfully arrested, and detained by the AEPB, the police and the military. Between January 2011 and March 2013, the plaintiffs were arrested several times and accused of being prostitutes by the government security forces. During these encounters, the women suffered verbal, physical and sexual abuse and were labelled as prostitutes for the simple reason that they had been found on the streets at night.<sup>100 cv</sup>

On 17 September 2014, the four women, with the Institute for Human Rights and Development in Africa (IHRDA), Alliances for Africa, Nigerian Women Trust Fund and the law firm SPA Ajibade, filed a case before the ECOWAS Court (suit no. ECW/CCJ/APP/17/14),<sup>cvi</sup> with support from Open Society Initiative for West Africa (OSIWA). The women asked for 100 million naira in damages for pain, suffering and harm to their dignity, including physical, mental and emotional trauma, following their arbitrary arrest and detention by agents of the state in Abuja.

The plaintiffs did not file a case at a domestic court in Nigeria; instead, they went straight to ECOWAS, since they did not need to exhaust local remedies to do this. They opted for the ECOWAS Court first because the Maputo Protocol is ratified by Nigeria but not yet domesticated; this would make it difficult (or almost impossible) to get a court in Nigeria to directly apply its provisions: 'We lost two cases in Nigeria (one on citizenship-related discrimination and the other on forced evictions). The courts in both cases held that the rights we argued were violated were not justiciable in that they are not provided in Chapter 4 of Nigeria's constitution.'<sup>cvi</sup> Second, the plaintiffs felt the ECOWAS Court would be more progressive and open to arguments made related to the duty of states to investigate human rights violations.

In its deliberation, the ECOWAS Court stated that the Nigerian government had failed to acknowledge and protect the rights of the plaintiffs and had violated the following:<sup>cviii</sup>

- Arts 1, 2, 3, 5, and 18 (3) of the African Charter on Human and Peoples' Rights
- Arts 1, 2, 3, 4(1 and 2), 5, 8 and 25 of the Maputo Protocol
- Arts 2, 3, 5(a) and 15(1) of the Convention on the Elimination of All Forms of Discrimination Against Women
- Arts 2(1), 3, 7 and 26 of the International Covenant on Civil and Political Rights
- Arts 10, 12, 13 and 16 of the Convention against Torture and
- Arts 1, 2, 5, 7 and 8 of the Universal Declaration of Human Rights

The Court found that the Nigerian government had failed to carry out an investigation to ensure that those responsible for the infractions were prosecuted. It also found that the ill-treatment of the plaintiffs in the hands of the AEPB, the Nigerian police and the Nigerian military counted as gender-based discrimination and constituted a violation of the various human rights instruments cited above. Furthermore, the Court found that the government forces' conduct towards the plaintiffs counted as 'cruel, inhuman and degrading discriminatory treatment'.<sup>cix</sup> The Court also found that the defendants had put forward no evidence to support the claim that the plaintiffs were indeed prostitutes.<sup>cx</sup>

Following this favourable ruling, three of the plaintiffs were each awarded a sum of 6 million naira. One plaintiff's claim was dismissed for being statute-barred under the Protocol creating the Court.<sup>cxii</sup> Meanwhile, the Court ruling remained mute on the request to order Nigeria to provide structural remedies, including to support services for victims of GVAW and to provide training for judges and law enforcement on prohibition of GVAW.

<sup>100</sup> For more information on the background of the case, see [www.courtecawas.org/site2012/pdf\\_files/decisions/judgements/2017/ECW\\_CCJ\\_JUD\\_08\\_17.pdf](http://www.courtecawas.org/site2012/pdf_files/decisions/judgements/2017/ECW_CCJ_JUD_08_17.pdf)

#### Case study 4. Great Lakes region civil society initiative to garner sub-regional political commitment to addressing GVAW

This case study highlights the so-called Kampala Declaration adopted by the International Conference of the Great Lakes Region, which has been celebrated for providing a strong regional framework on GVAW. Mobilisation, advocacy and engagement of civil society and women's rights organisations, under the leadership of Akina Mama wa Afrika, have been critical in its adoption, and also in pushing for actions needs to further its implementation.

The International Conference of the Great Lakes Region (ICGLR) was established mainly in response to the protracted war in DRC in the 1990s, and regional political instability and conflicts that constituted a major threat to international peace and security.<sup>101</sup> It has since evolved and institutionalised into a forum for the promotion of peace, security and development in the Great Lakes region.<sup>cxii</sup> An initiative of the ICGLR-based CSOs resulted in the *Goma Declaration on Eradicating Sexual Violence and Ending Impunity in the Great Lakes Region* in 2008.<sup>cxiii</sup> In 2010, an ICGLR Regional Women's Forum was established, with a mandate on GVAW, among other areas.

One critical concern relates to violence against women being utilised as a weapon of war, resulting in women and girls being disproportionately affected by conflict. In response, Akina Mama wa Afrika, the ICGLR Women's Platform and the ICGLR Regional CSO Forum<sup>102</sup> came together to advocate for a special session of the ICGLR Summit of 2011 (to be held in Kampala, Uganda). This special session was to be dedicated to addressing issues of GVAW in the region. From June 2011, under the leadership of Akina Mama Wa Afrika, CSOs in the Great Lakes region, comprising national, regional and international NGOs and human rights organisations,<sup>103</sup> spearheaded a regional process to mobilise civil society in the region to participate in deliberations leading up to the fourth Ordinary Summit of Heads of State of ICGLR Member States and Special Summit on SGBV. The aim of this advocacy initiative was to achieve concrete commitments on the part of member states towards addressing GVAW in the region. An interesting element of the strategy was that a session of the Heads of States had never previously been dedicated to such a woman-centric theme.

The International Conference of the Great Lakes Region is an intergovernmental organisation composed of 12 member states: Angola, Burundi, CAR, DRC, Congo Republic, Kenya, Rwanda, South Sudan, Sudan, Tanzania, Uganda and Zambia.

This session resulted in the adoption of the *Declaration of the Heads of States and Government of the Member States of the International Conference on the Great Lakes Region* (popularly referred to as the Kampala Declaration). This has been celebrated as providing one of the strongest sub-regional frameworks on GVAW. It focuses on prevention, ending impunity and providing support to victims/survivors. It is a far-reaching instrument that touches on the following areas:

- Increasing financial and technical support for judicial sector reform on women's rights and GVAW eradication, to build institutional capacity and accountability
- Facilitating reporting and documentation of cases
- Fast-tracking prosecution of perpetrators for swift and effective justice
- Integrating GVAW into national planning frameworks and allocating budget lines for prevention and response to ministries of gender, justice, defence and others
- Empowerment of professional bodies and CSOs such as the regional FIDAs to provide support to victims/survivors

The Regional Training Facility (RTF) was set up under the ICGLR *Protocol on the Prevention and Suppression of Sexual Violence against Women and Children* (2006) and the Kampala Declaration. Its mandate is to train and sensitise those who handle cases of sexual violence in the region as provided for under the ICGLR Protocol on Prevention and Suppression of Sexual Violence in the Great Lakes Region.<sup>104</sup> The RTF became operational in 2014 and has conducted a series of trainings for judges, prosecutors, police officers and military personnel, forensic experts and CSOs working on GVAW.

<sup>101</sup> The ICGLR emerged out of the conflicts that engulfed the region in the 1990s, including the 1994 genocide in Rwanda and the protracted conflict, instability and war in eastern parts of DRC. The UN Security Council, in Resolutions 1291 and 1304 of 2000, called for an International Conference on Peace, Security, Democracy and Development in the Great Lakes Region, whose outcome was the establishment of the Secretariat in Nairobi under the auspices of the UN and the OAU/AU.

<sup>102</sup> CSO mobilisation comes under the mandate of the Regional Civil Society Forum (RCSF), a space for open and constructive dialogue permitting the identification of common interests and the search for solutions through consultation and cooperation. The RCSF provides for organising regional or thematic meetings around the issues at stake in the International Conference.

<sup>103</sup> ACFODE, ACORD Uganda, Action Aid Uganda, African Women's Development and Communication Network (FEMNET), Akina Mama wa Afrika, (AMwA), CARE International Uganda, Centre for Citizens Participation in the African Union, (CCP-AU), EASSI, Isis-WICCE, NAWOU, Regional Associates for Community Initiatives, (RACI), International Refugee Rights Initiative (IRRI) EASSI and UWONET.

<sup>104</sup> The ICGLR has developed a number of highly relevant and substantive legal instruments to guide the work of the RTF. These include (1) the Pact on Security Stability and Development in the Great Lakes Region (2006), (2) the Dar es Salaam Declaration on Security, Stability and Development in the Great Lakes Region (2004), (3) the Protocol on the Prevention and Suppression of Sexual Violence against Women and Children (2006), (4) the ICGLR Protocol on Judicial Cooperation (2006), (5) the ICGLR Protocol on Non-Aggression and Mutual Defence (2006), (6) the Protocol on Prevention and Punishment of the Crime of Genocide, War Crime and Crime against Humanity and All Forms of Discrimination, (7) the Goma Declaration (2008) and (8) the Kampala Declaration (2011).

While the Kampala Declaration intends to encourage great reform in addressing GVAW in the region, in practice states are yet to fully implement their commitments. Implementation is important particularly for countries such as Burundi and Sudan that have not ratified the Maputo Protocol and are therefore outside of its norms on GVAW.

Akina Mama wa Afrika has continued to lead civil society in highlighting the Declaration and the actions that need to be undertaken for its implementation. In a convening in 2016 on ways to accelerate implementation of the Kampala Declaration, Akina Mama wa Afrika together with others identified called on governments of the region to undertake the following actions:

- Increase budget allocations to the one-stop centres and ensure they comprehensively support survivors
- Strengthen partnerships between government, CSOs and other actors including the private sector to collectively address GVAW in the region
- Launch and implement a zero tolerance campaign in all member states
- Provide assistance to survivors by liberating and rehabilitating them from trauma and providing conditions favourable for the reconstruction of their lives
- End impunity and bring to book the perpetrators of GVAW

While some states have made progress, as illustrated elsewhere in this report, overall this falls short when compared with the commitments made and the fair amount of time that has lapsed since adoption of the Kampala Declaration.

## Case study 5. Shukumisa Campaign: Sonke Gender Justice Advocates for state accountability for sexual violence in South Africa

The Shukumisa campaign is a civil society initiative to track the implementation of South Africa's Sexual Offences Act. The consortium monitors the victim-friendly approaches of hospitals, police stations and courts, to avoid secondary traumatising of GVAW survivors. Sonke Gender Justice engages in monitoring throughout the service delivery chain, and also works at community level and with victims and their families to ensure substantive justice for victims and survivors of sexual violence.

The prevalence of sexual violence in South Africa has been a source of great concern in the country and regionally. The Criminal Law (Sexual Offences and Related Matters) Amendment Act (Act No. 32 of 2007), also known as the Sexual Offences Act, was passed in recognition of the many forms of GVAW in South Africa, including sexual, physical and psychological violence. South Africa has also established special sexual offences courts and is well known for its one-stop centres for GVAW survivors, the Thuthuzela Care Centres.

Despite this law and these institutional innovations, which have contributed to a rise in conviction rates, victims of GVAW continue to abandon cases because of the systemic challenges they face within the justice system. When this happens repeatedly, it leads to underreporting of the crime and contributes to a climate of impunity.<sup>cxiv</sup> In a communiqué issued on 18 August 2017, the Commission for Gender Equality voiced its concern around the inconsistencies on systemic issues in the judiciary 'wherein cases of gender based violence take too long to prosecute in the process the victim suffers secondary victimisation'.<sup>cxv</sup> A major challenge noted in the Report of the UN Special Rapporteur on violence against women on South Africa relates to court hearings and procedures that are not conducted in a victim-friendly conduct, as well as secondary traumatising caused by insensitivity to victims through reiteration of gender stereotypes by magistrates.<sup>cxvi</sup> Without appropriate psychosocial support, victims of sexual violence are unlikely to cooperate in processes such as reporting cases to police and facilitating police investigations or court trials. These systemic challenges continue to translate into too low rates of conviction and diminished accountability for sexual violence.<sup>cxvii</sup>

In 2008, a consortium of CSOs formerly working under the National Working Group on Sexual Offences created the Shukumisa (Shake up) Campaign. The campaign seeks to track the implementation of sexual offences policies and laws, including the Sexual Offences Act of 2007 and the attendant National Instructions (3/2008). Since 2009, the Shukumisa Campaign has regularly monitored hospitals, police stations and courthouses, with a view to determining the extent to which they are complying with the legal regime with regard to victim-friendly approaches. Consortium members have monitored the work of the police in 50 stations in the Western Cape. The value added of such a campaign is that CSOs monitor from a comparative advantage perspective in order to deal with the complex, multi-sectoral problem of access to justice for victims. Monitoring findings of the Shukumisa Campaign are submitted to the South African Police Service, the Department of Justice and Constitutional Development and the Department of Health, in a bid to improve their response to victims of sexual violence as mandated under the Sexual Offences Act.

Sonke Gender Justice, one of the consortium members, has actively monitored cases right through the service delivery chain, covering police stations, prosecutors and courts, to ensure conformity with the legal requirements for victim-friendly services. It has also conducted policy scans to identify critical service delivery standards and action points to support the Shukumisa Campaign. Sonke further realised that forensic departments did not capture the details of sexual violence cases well, leading to inconclusive forensic evidence and a low prosecution rate. Consequently, it added forensic departments to its list of monitoring targets.

At the level of communities, the organisation educates community action teams on court processes, and works on raising consciousness around GVAW. Community action teams identify issues and cases at the community level to escalate to Sonke. Sonke thus allows women and victims to tell their stories and open up about sexual violence, which has been very helpful in establishing patterns, wherever an offender has attacked multiple victims.

Sonke also works with the Shukumisa Campaign partners during court hearings to monitor the quality of case investigations. In one example given, a former African National Congress youth leader had beaten his partner to death. Obtaining information in this case was difficult because victims were easily intimidated. Sonke pressured law enforcement agencies to play their role but also assisted the prosecutors in identifying gaps. In their words, 'We met the national prosecuting authority in this case and all were aware that we were monitoring the case as it played out. We asked the judge to recuse himself and we got the right judge for the case.'

With respect to court hearings, Sonke also meets victims and their family members and gives them moral as well as psychosocial support. It then mobilises members of the community to support victims when they report cases or attend hearings in court. Together with Sonke staff, who reinforce victims and give them institutional support, community members attend hearings wearing matching tee-shirts in solidarity. This makes judicial officers aware that a highly visible 'constituency' will be following court processes closely to ensure fair proceedings. Sonke notes that this has been effective in averting procedural injustices in many cases. For example, a corporal punishment case that Sonke was monitoring was on 'Special Assignment' on national TV in 2017, and was one of the most viewed programmes in South Africa. Involvement of the media plays a major role in bringing visibility to issues.

## Case study 6. Cross-sector coordination in the management of sexual violence: Kenya's Sexual Offences Act implementation workshop

This case study highlights the importance of cross-sector coordination in the implementation of Kenya's Sexual Offences Act. It refers to a convening which, for the first time, brought together over 80 government and civil society representatives involved in the provision of legal, medical and other services to survivors of sexual violence. The workshop aided in coordinating among these many actors, and concretely contributed to the adoption of a new and improved Post-Rape Care Form for capturing medical evidence.

Kenya's 2006 Sexual Offences Act revolutionised the issue of accountability for sexual violence against women and girls in Kenya. Before this, the legal and social markers required to address sexual violence were weak (e.g. the requirement of corroboration to prove a sexual offence, which is often carried out in private; wide discretionary sentencing powers, which, when misused, served to minimise the crime and embolden perpetrators). The Act contains critical progress markers such as the categorisation of sexual violence as a crime of violence as opposed to a crime against morality, thereby heightening accountability. The scope of acts that qualify as sexual offences was also expanded. The Act also provides for minimum sentences and envisages the provision of psychosocial support and witness protection, thereby taking a survivor-centric approach.

However, in practice, implementation of the Act was weak, owing to, among other reasons, a lack of cross-sector coordination among the various actors envisaged in the ideal accountability process. Various actors are related to the pre-investigation, investigation, prosecution and trial, and post-trial stages of a sexual offence case: health care providers, lawyers, police, forensic scientists, prosecutors, magistrates, judges and community advocates. In reality, a survivor may encounter many others, such as community members and informal justice actors. All these have a role to play that can either enhance or impede a survivor's access to treatment and justice. Their coordination is critical to ensure that the survivor receives speedy and effective treatment, the right information and evidence are collected at each stage and the survivor is not re-victimised by having to unnecessarily narrate their ordeal to several actors owing to poor documentation or coordination.

In response to this challenges, the Human Rights Center of the University of California, Berkeley, together with the now former Task Force on the Implementation of the Sexual Offences Act, FIDA Kenya, LVCT, COVAW, ICJ Kenya, CREAM, AIDS-Free World and GIZ Kenya, coordinated a convening of relevant stakeholders. This brought together over 80 participants from government and civil society who worked directly or indirectly on sexual violence. The initiative took a collaborative multi-sectoral approach. This was the first time that all the providers and stakeholders a survivor would interact with in seeking treatment and justice had been in the same room in order to diagnose and redress critical breakages and links between the sectors. The direct results of the workshop accordingly included the identification of individual sector as well as linkage challenges and related recommendations.

The workshop also aided in securing critical reforms with regard to a Post-Rape Care (PRC) form to be used in the documentation and presentation of medical evidence of sexual offences in court. Prior to this, medical evidence was captured only on the P3 form, which was utilised by police officers for any crime that results in the need for a medical examination. It is filled first by a police officer then by a police doctor; therefore, it is almost always completed retrospectively as a survivor often presents herself for treatment prior to making a report. The PRC form, on the other hand, is filled out by health care providers when they receive a survivor and is designed to capture various physical and psychosocial information specific to a survivor of sexual violence. In this regard, it enhances the chances of prompt and credible data; this facilitates the presentation of stronger evidence in court and consequently higher rates of prosecution of perpetrators and accountability for violence against women.

It must be noted here that numerous and prior advocacy efforts particularly in the health and medico-legal sector led to the development of the PRC form. The workshop provided a critical impetus by way of discussions with crucial stakeholders such as the Attorney-General that thereafter gazetted the use of the form, thereby giving it legal recognition. This thus exemplifies the intended outcome of the workshop in terms of cross-sector coordination. Documentation of evidence in sexual violence is an aspect that relies on the full coordination and effectiveness of both health providers and legal actors such as the police. Undoubtedly, this development's long-term effect will be to enhance survivors' access to treatment and justice and overall accountability for and the consequently dwindling of sexual offences.

## Case study 7. The Safe Ride Campaign: making travel safe for women and girls in South Africa

The Safe Ride Campaign is about sensitisation and education on sexual violence in the public transport industry in South Africa. Sonke Gender Justice has worked with the national association of drivers to seek strategic engagement with drivers at national and provincial level. Using peer educators, the media and communication tools, the campaign seeks to raise awareness on the negative impact of sexual violence on victims, and make public transport safer for women and girls.

About 15 million passengers use public transport each day in South Africa, and yet many women do not feel safe while using these services, particularly at night. Women experience sexual harassment, such as touching of body parts, coarse language and verbal abuse and worse. Incidents of verbal abuse, physical violence, sexual assault and rape, including gang rape, of girls and women at the hands of public transport drivers and queue marshals have been recorded in many parts of South Africa. Rapes and sexual assaults are carried out in taxis or in premises or bushes close by. Apart from being a violation of the rights of women and girls to security and bodily integrity, this has the result of limiting women's mobility, particularly for those travelling alone or at night.

The control of women's expression and their sexuality is evident, as those who do not conform to societal norms of modest dressing or behaviour face a backlash, including violence, from taxi drivers and marshals. A video of a taxi driver harassing a woman on the way to Sunninghill went viral on social media in November 2015.<sup>cxviii</sup> In another highly publicised incident in 2011, around 50 taxi drivers harassed two teenage girls about their skirt length, taunting and groping them and taking pictures of them with their mobile phones.<sup>cxix</sup>

Sonke Gender Justice created the *Safe Ride Campaign* in order to reduce sexual and gender-based harassment and violence in taxis and at taxi ranks. The campaign's main objective is to strategically engage the South African taxi industry—associations, owners and drivers—and key government departments to promote respectful and non-violent behaviour towards customers. As such, it seeks to contribute to the prevention of GVAW, particularly sexual violence, and promote gender equality and safety of women and children.

On 17 August 2016, Sonke and the South African National Taxi Council launched the 12-month campaign in Gauteng, the Eastern Cape and the Western Cape at high-risk taxi rank sites. Sonke realised it would be near impossible to prevent the harassment of women without engaging men. Campaign strategies involve educating taxi drivers, owners, marshals and associations on human rights and particularly on GVAW. Taxi commuters have also been educated on the forms of sexual violence and appropriate responses.

Buy-in from the South African National Taxi Council was critical. Sonke engaged with the council leadership for over a year just to share the concept with them and to help them understand their role. It was easier to talk to the national body, which suggested a national workshop with provincial leaders. The campaign was launched at a half-day workshop at a taxi park rank. The president of the Taxi Association led the launch, to give legitimacy to Sonke's campaign and increase buy-in. There was positive media support for the campaign, which helped drum up publicity and public discourse on the issues. In the next phase, Sonke intends to reach out to other local taxi associations and work with the lower leadership of taxi associations.

Thereafter, Sonke had help to launch the campaign in other provinces. Seven community dialogues were conducted during the project period: in Soweto, Tembisa, Vosloorus, Ivory Park and Mulberton, involving women commuters, taxi drivers, queue marshals, taxi owners and national, provincial and local government representatives. The organisation conducted dialogues at taxi ranks and had one-on-one talks with drivers, distributing informational pamphlets and tee-shirts. Sonke also developed a video of sexual assault victims talking about their experiences and the impacts they had had on them. This video was used during the community dialogues and was effective in evoking sentiments of regret and a desire to commit to behavioural change.

Sonke also used a positive role model of masculinity to interest the taxi drivers in conversation. One campaign actor was a former professional football player whom taxi drivers recognised and identified with, making it easier to engage them—an ambassador, in a way. In the interactions with the taxi drivers, a number of them have explicitly condemned rape, including gang rape, and negative masculinity behaviours portrayed by some of their fellow taxi operators or queue marshals. Ten Taxi Rank Action Teams have been formed, made up of volunteers who work with the Sonke teams in the taxi ranks as mobilisers and peer educators. This paves the way for a sustainable and sustained campaign to ensure women can travel in environments that respect gender equality and their bodily integrity.<sup>105</sup> Though the work is challenging, Sonke intends to spread its outreach to other taxi associations and lower levels of leadership in a sustained effort to raise drivers' awareness on eliminating violence against women.

<sup>105</sup> The campaign faced a number of challenges. Taxi ranks pay taxes to their municipality, and getting permission from the municipality was a very bureaucratic process and this caused some delays. Some of the drivers approached had a reputation as being very dangerous and were arrogant in their response. Taxi drivers also wanted money to attend the workshop.

## Chapter 5

# ENDNOTES

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- cviII ECOWAS Court. (2017) 'ECOWAS Court Awards 18 Millions in Damages against Nigerian Government for the Violation of the Dignity as well as Physical and Sexual Violence Inflicted ont Three Women'. <http://ow.ly/nL6F30hcdMI>
- cix Ibid.
- cx Ibid.

- cxix** Ibid.
- cxii** <http://icglr.org/index.php/en/background>
- cxliii** International Conference on the Great Lakes Region CSO Handbook.
- cxliv** Smythe, D. (2016). *Rape Unresolved: Policing Sexual Offences in South Africa*. Cape Town: University of Cape Town Press.
- cxlv** CGE. (2017). 'CGE Alarmed Over Heightening State Of Gender Based Violence in South Africa', 18 August.
- cxlvi** UN Human Rights Council. (2016). 'Report of the Special Rapporteur on Violence against Women, Its Causes and Consequences on her Mission to South Africa' (A/HRC/32/42/Add.2).
- cxlvii** Vetten, L. (2014). 'Rape and Other Forms of Sexual Violence in South Africa'. Policy Brief No. 72. Pretoria: ISS.
- cxlviii** [www.enca.com/south-africa/video-taxi-driver-assaults-female-passenger](http://www.enca.com/south-africa/video-taxi-driver-assaults-female-passenger)
- cxlix** [www.polity.org.za/article/launch-of-safe-ride-campaign-2016-08-15](http://www.polity.org.za/article/launch-of-safe-ride-campaign-2016-08-15)

## Chapter 6

# Harmful practices

## 6.1 ISSUE ANALYSIS

### 6.1.1 Defining harmful practices

**Harmful practices** are defined in the Maputo Protocol 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, including child marriage, female genital mutilation (FGM), widow inheritance (levirate), sororate,<sup>1</sup> breast ironing,<sup>2</sup> force-feeding of women and girls, son preference, girls’ as well as boys’ initiation rites, child abduction, lips plates, *trokosi*,<sup>3</sup> widowhood rites, acid attacks, stoning, honour killings, witchcraft rituals and virginity tests.

Harmful practices 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 practices conducted for non-therapeutic purposes.<sup>i</sup>

For this report, we focus on child marriage and FGM, given their high prevalence in African countries. In certain contexts, they are strongly related. Moreover, child marriage and FGM are linked to other harmful practices, including force-feeding, widow inheritance and virginity tests.

**Child marriage** refers to marriages ‘where at least one of the parties is below 18 years of age’ (African Common Position on the AU Campaign to End Child Marriage in Africa 2015).<sup>ii</sup> It has been defined as ‘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 marriage is to be distinguished from forced<sup>4</sup> and early marriage, as these do not necessarily or always involve children. Yet child marriage is a form of forced marriage, because legally a child does not have the ability to give full and free consent to marriage. For this reason, ‘Betrothal and the marriage of a child shall have no legal effect.’<sup>iii</sup> Although child marriage affects both boys and girls, it is less common for boys.<sup>iv</sup> This report looks at the issue mainly from girls and women’s perspective.

- 1 Sororate is a marriage in which a husband engages in sexual relations or marriage with the sister of his wife, usually after her death or her being infertile.
- 2 Breast ironing, also called ‘breast flattening’, involves the use of an object to massage, pound or press the developing breasts of adolescent girls in order to make them stop growing or to flatten them. It is common in Cameroon and also practised in other parts of West Africa
- 3 *Trokosi* is a practice in which virgin girls are sent to shrines to serve as slaves to the gods and the priest, in order to pay for the crimes committed by a relative. *Trokosi* is practised in Benin, Ghana and Togo.
- 4 Forced marriages are marriages in which one of the parties is not permitted to end it or leave. They may include child marriages, exchange or trade-off marriages, servile marriages and levirate marriages (in which a widow is forced to marry a relative of her deceased husband). In some cases, forced marriages occur after a woman or girl has been raped, and the marriage (often with consent of the victim’s family) then allows the rapist to escape criminal sanctions. Forced marriages can be prominent in contexts of migration, as well as during or after armed conflict.

**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'.<sup>v</sup> This includes all interventions of partial or total cutting or injury of a woman's external genitalia or sexual organs for non-therapeutic reasons.<sup>vi</sup> The World Health Organization (WHO) has classified FGM into four major types,<sup>5</sup> with the extent of genital tissue cutting increasing from Type I to III.<sup>vii</sup> FGM is recognised globally as a human right's violation and it involves specific violence against women's physical integrity, affecting other rights such as those to life, dignity, equality and freedom of torture, among others.<sup>6,viii</sup>

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 has 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.<sup>ix</sup> All four types of FGM represent a direct risk to women's health. FGM has long-lasting effects on the reproductive organs of girls and women,<sup>x</sup> and can result in serious complications such as bleeding, incomplete healing and infections such as HIV, among other health risks, and psychological traumas and even death.<sup>xi</sup>

### Box 6.1. Harmful practices, child marriage and female genital mutilation defined

*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, Art. 1).

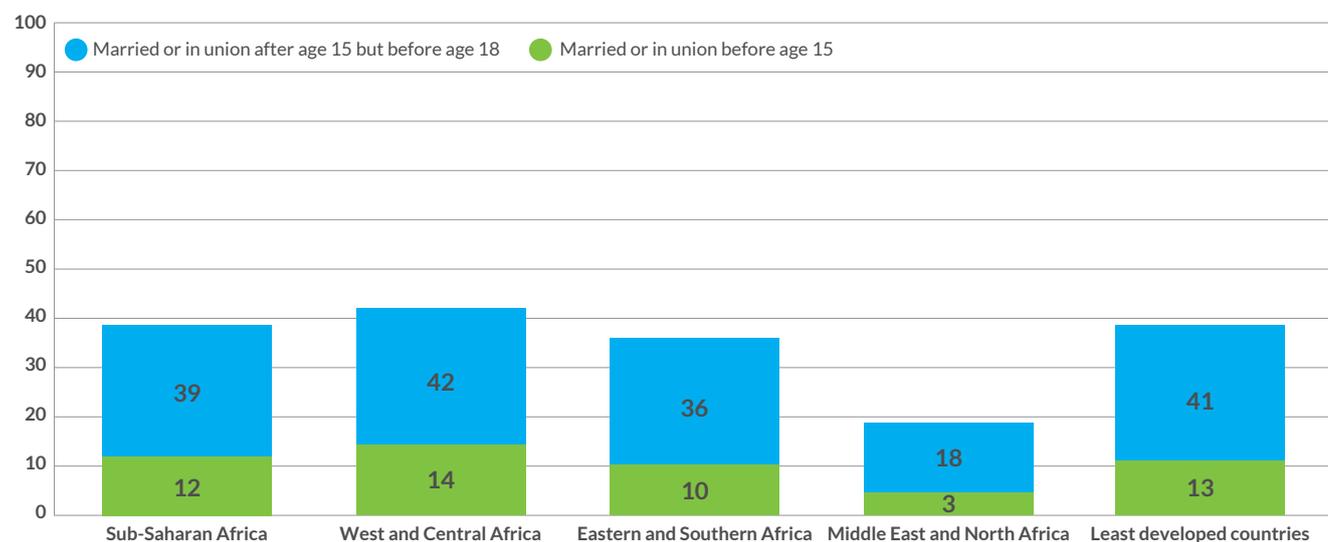
Child marriage refers to 'a marriage in which either one of the parties, or both, is or was under the age of 18 at the time of union' (Joint General Comment ACHPR and ACERWC on Ending Child Marriage, Point 6).

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' (Committees on CEDAW and CRC Joint General Recommendation No. 31/General Comment No. 18 on Harmful Practices 2014, Point 19 (Part VI.A.19, p. 6).

## 6.1.2 Prevalence of child marriage

Child marriage is practised in many regions in the world.<sup>xii</sup> However, rates in the African region are the highest, as Figure 6.1 shows, with 39% of women and girls in Sub-Saharan Africa married before 18 years old. Prevalence of child marriage is highest in West and Central Africa, where 15% of the girls are married before the age of 15 and 42% by the time they turn 18. Prevalence rates in East and Southern Africa are only slightly lower, with respectively 12% and 39% of women and girls married.<sup>xiii</sup>

Figure 6.1. Percentage of women and girls married before the age of 15 and 18<sup>xiv</sup>



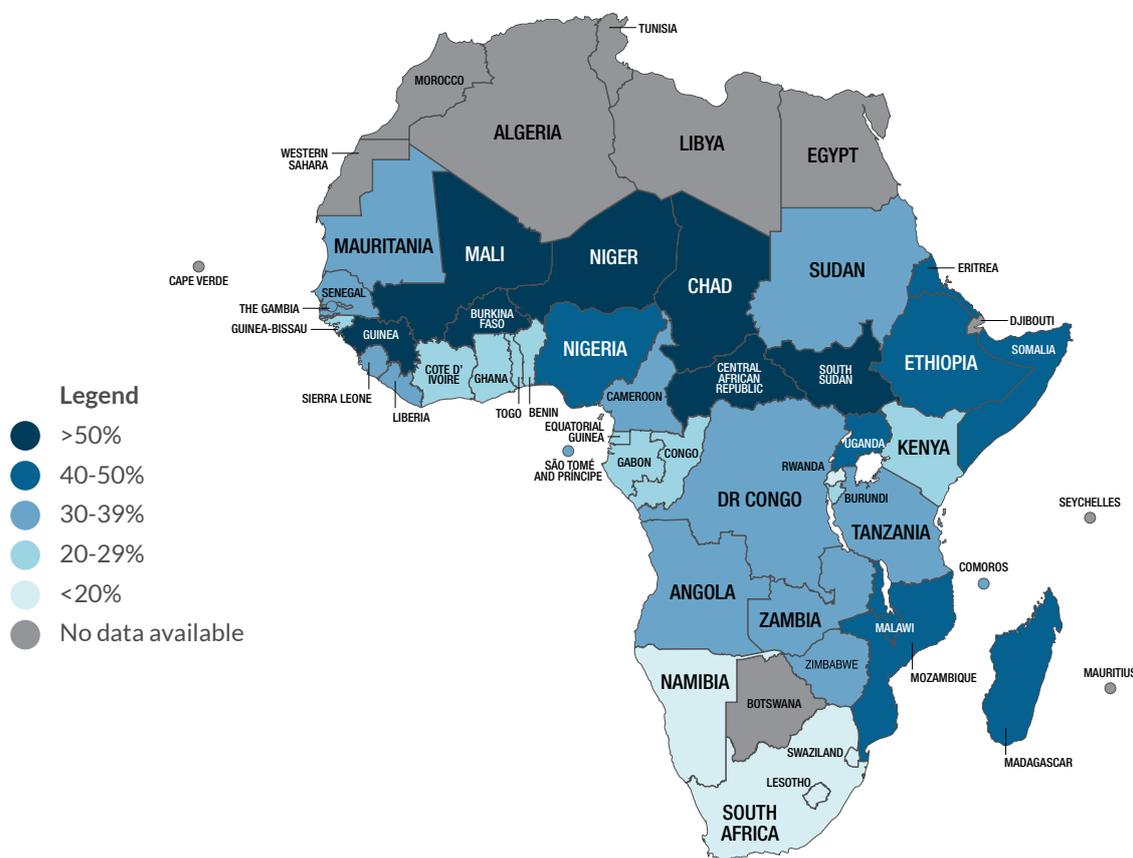
Source: Data from UNICEF global databases 2018, based on DHS, MICS and other nationally representative surveys, 2008–16.

5 Type I: partial or total removal of the clitoris and/or prepuce (clitoridectomy); Type II (excision) – partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora; Type III (infibulation) – narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris; Type IV - all other harmful procedures to the female genitalia for non-medical purposes (e.g., pricking, piercing, incising, scraping and cauterisation).

6 This report uses the term FGM, rather than female circumcision or female genital cutting, as 'FGM' is the terminology used in the Maputo Protocol. For discussion on different terms, see Banda, F. (2005). *Women, Law and Human Rights: An African Perspective*. Portland, OR: Hart Publishing (pp. 207–46).

Country specific data indicates that Niger has the highest prevalence of child marriage, with 76%, and Tunisia and Algeria the lowest, with 2% and 3%, respectively. As Figure 6.2 shows, in seven countries over 50% of the women and girls are married when they turn 18: these are 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).<sup>xv</sup>

Figure 6.2. Percentage of women aged 20–24 years who were first married or in union before age of 18<sup>xvi</sup>



Child marriage is slowly declining, particularly in Northern Africa. Yet in countries such as Burkina Faso the prevalence has been 50–52% for the past 30 years.<sup>xvii</sup> If the current trend continues, by 2050 Africa will become the region with the largest number of child marriages in the world.<sup>xviii</sup> When looking at West and Central Africa, where child marriage continues to be a common practice, some countries have shown great declines in child marriage (see Figure 6.3).<sup>xix</sup>

Figure 6.3. Percentage of women aged 20–24 years married or in union before age of 18, around 1990 and around 2015, and the decline in percentage<sup>xx</sup>

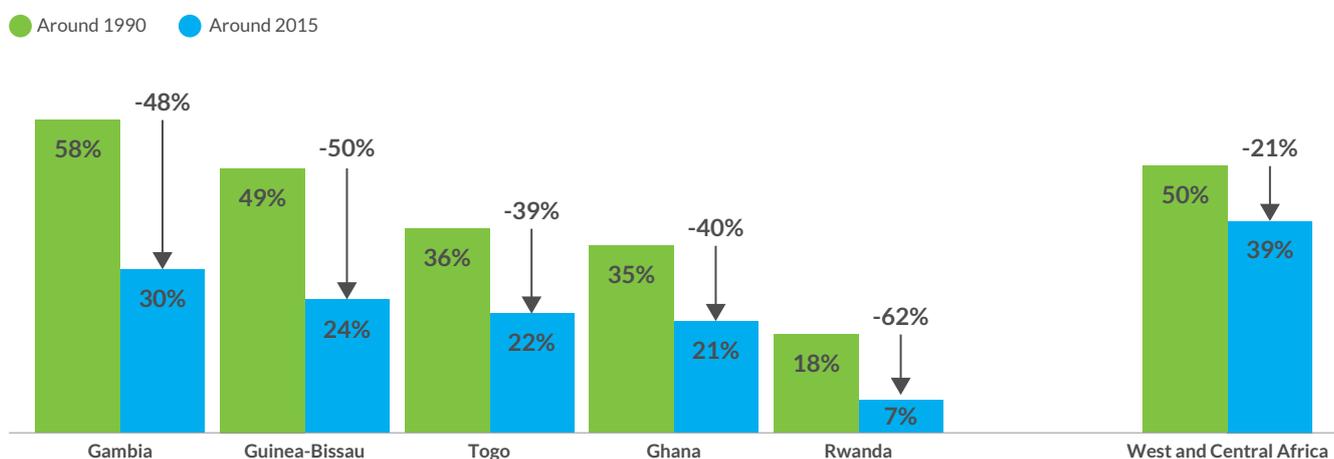
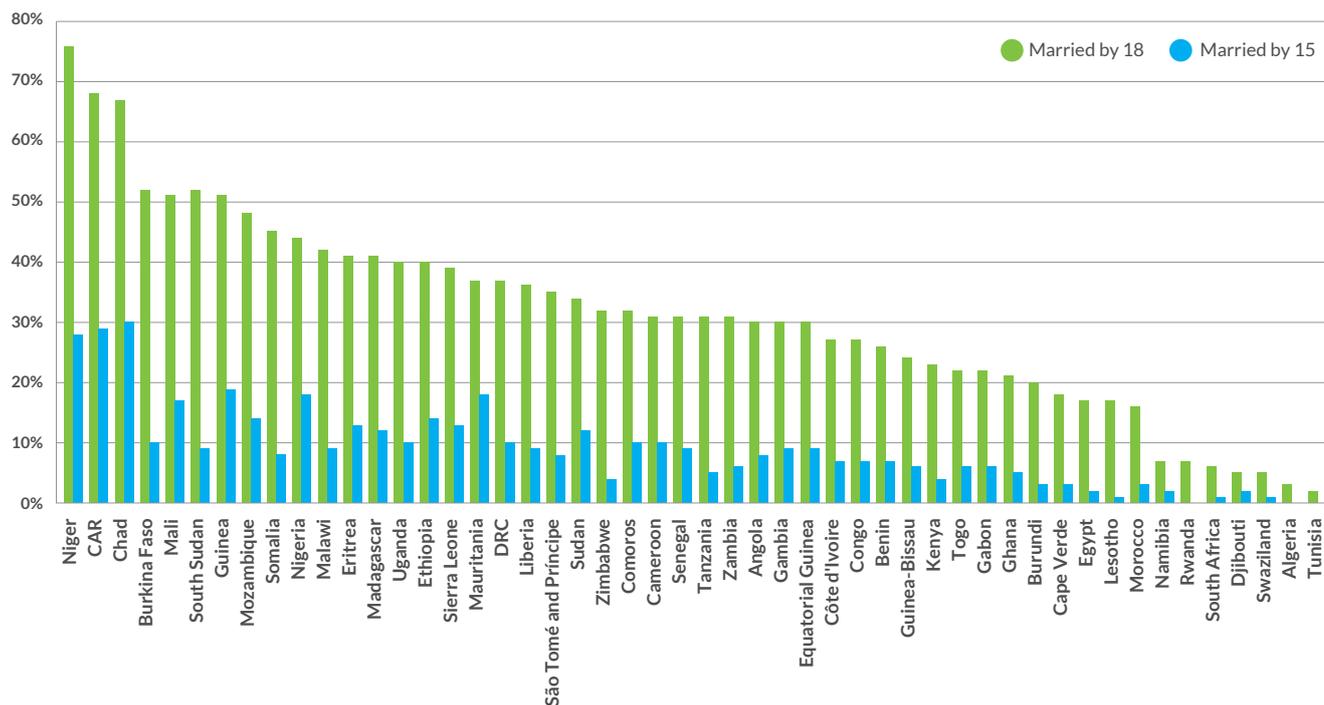


Figure 6.4. Percentage of women aged 20–24 years who were first married or in union before ages 15 and 18<sup>xxi</sup>

### 6.1.3 Causes and consequences of child marriage

Child marriages are often deeply entrenched in cultural, religious and social norms of unequal gendered power relations. They are an expression of **societal control and regulation** of women's sexuality and reproductive functions and reinforce gender power hierarchies by placing girls in subordinate positions. Girls and women married as children often lack control over resources and information, and risk being exposed to violence or physical and mental abuse of power.

Reasons for the practice by families and communities include a desire to preserve the 'purity' of girls and/or to protect them from violence. Families with limited resources and few options may want to ensure girls will be provided for, to receive the price or gift given to the bride's family or to release themselves from the burden of having to provide for a family member.<sup>7</sup> Women and girls living in rural areas, or in households with low incomes and levels of education, and those who are disabled, refugees or victims of conflict, can be more vulnerable to child marriage. In settings of conflict and insecurity, child marriage may be seen as a mechanism of protection against sexual violence and even of economic protection.<sup>xxii</sup> Similarly, parents of refugee girls may opt for early marriages to protect them from any danger they may be exposed to, for example in refugee camps.<sup>xxiii</sup>

Weak **birth and marriage registration** systems contribute to the continued practice of child marriage. Birth certificates are key to verifying the age of the person to be married. Marriage registration systems make sure that authorities check that those marrying are the legal age to be married. In many countries these systems are not very well regulated, and in others they do not even exist. But, even when birth certification and marriage registration systems are in place, they may not be used or accessed, owing to a lack of resources or of awareness among people of the existence of these systems. Also, customary or other religious marriages may ignore these requirements since these certificates are provided and required under formal laws.<sup>xxiv</sup> **Plural legal systems** further contribute to the practice of child marriage. Customary or religious laws may indicate a different age of marriage, and also have different requirements regarding consent. Enforcement of formal law can also be difficult in communities and areas where formal institutions are weak and where religious or traditional systems take a prominent place in life. Plurality of the law is discussed more in-depth at the end of this section.

7 The publication *Protecting the Girl Child* by Equality Now (2014) presents stories and profiles of girls and women in child marriages, and in addition gives insights into the national and societal context in which these take place and strategies to end child marriage and protect the rights of the girl child.

Lack of **education** is an important factor contributing to child marriage. Girls with no education or who are out of school are more susceptible.<sup>xxxv</sup> Six out of ten child brides in Malawi are reported to have had no formal education.<sup>xxxvi</sup> In Mozambique, lack of access to education is directly correlated with child marriage: 57.2% of women who never went to school are reported to be married by age 18.<sup>xxxvii</sup> The opposite relation has also been observed, for instance in Amhara (Ethiopia), where the ‘mean age of girls at marriage is rising as more girls are staying in school longer’.<sup>xxxviii</sup>

On the other hand, lack of education is also often a consequence of child marriage. The pressure to become a ‘wife’ can stop girls going to school, and girls who marry early often have no access to education. Early pregnancy can further constrain girls from going to school or force them to drop out. Child marriage may even be a contributing factor in perpetuating early marriage and low education of girls across generations, as mothers who marry early and have no access to education may be more ready to reproduce this practice with any daughters they may have.<sup>xxxix</sup>

Child marriage also affects the rights of girls to **health**, sexual and reproductive rights, integrity and education, among others. Girl brides are often socially isolated and cut off from their native family, friends and other sources of support.<sup>xxx</sup> Girl brides are at risk of malnutrition, slavery, domestic violence, sexual violence and other types of GVAW.<sup>xxxi</sup> Many girl brides marry older men, who often have more sexual experience and have had more sexual partners. This can expose girls to HIV and other STIs. The age difference undermines their power to negotiate condom use and limits their access to information on their SRHR or to contraception methods. This in turn increases the possibilities of early pregnancies as well as of maternal morbidity and mortality.<sup>xxxii</sup> Complications in early pregnancy and childbirth are the leading cause of death in girls aged 15–19 years old in low- and middle-income countries.<sup>xxxiii</sup> Table 6.1 shows the child marriage prevalence rates against selected health indicators in 10 countries of study with some of the highest child marriage rates in the region. Countries with high levels of child marriage also have high rates of maternal deaths and high adolescent birth rates.

**Table 6.1. Child marriage prevalence rates against selected health indicators in the 10 countries studied**<sup>xxxiv</sup>

Country	Total population (millions) 2014	Prevalence of child marriage (% married by 18)	Maternal mortality ratio (deaths per 100,000) 2013	Adolescent birth rate per 1,000 (women aged 15–19) 2012
Mali	15.8	55	550	172
Mozambique	26.5	52	480	166
Malawi	16.8	50	510	157
Uganda	38.8	46	360	146
DRC	69.4	39	730	135
Cameroon	22.8	36	590	128
The Gambia	1.9	36	430	88
Kenya	45.5	34	400	106
Mauritania	4.0	35	320	88
South Africa	53.1	6	140	54

#### 6.1.4 Prevalence of female genital mutilation

FGM is concentrated in 27 African countries from the Horn of Africa to the Atlantic coast.<sup>xxxv</sup> The highest prevalence rates are Somalia (98%) and Guinea (97%). Prevalence in the following eight countries is higher than 80%: Djibouti, Egypt, Eritrea, Guinea, Mali, Sierra Leone, Somalia and Sudan. In a few countries—Cameroon, Ghana, Niger, Togo and Uganda—rates are under 5%. Whereas the map (see map in Figure 6.5) does not provide data on prevalence in Southern Africa, and FGM may not have been practised there in earlier days, it may currently be practised among migrant communities in those countries.

It is important to take into account the large subnational variations in FGM prevalence, as national-level data can mask large differences between regions within countries. Rates of practice can vary considerably between regions and ethnic groups within a country, and this variation is observed in countries with low, moderate or high levels of FGM prevalence (see Table 6.2 below).<sup>xxxvi</sup> There are also strong variations in the age at which girls are cut (see Table 6.3).<sup>xxxvii</sup> In Eritrea, Ghana, Mali, Mauritania, Nigeria and Senegal, over 75% of the girls experiencing FGM are cut before their fifth birthday. At least 80% of girls experiencing FGM in CAR, Chad, Egypt and Somalia are cut between the ages of five and fourteen years. In some settings, girls are being cut at younger ages, before they go to school or are old enough and more sensitised on the consequences of FGM, and thus might resist the practice.

Figure 6.5. Map of percentage of girls and women aged 15–49 years who have undergone FGM in Africa<sup>xxxviii</sup>

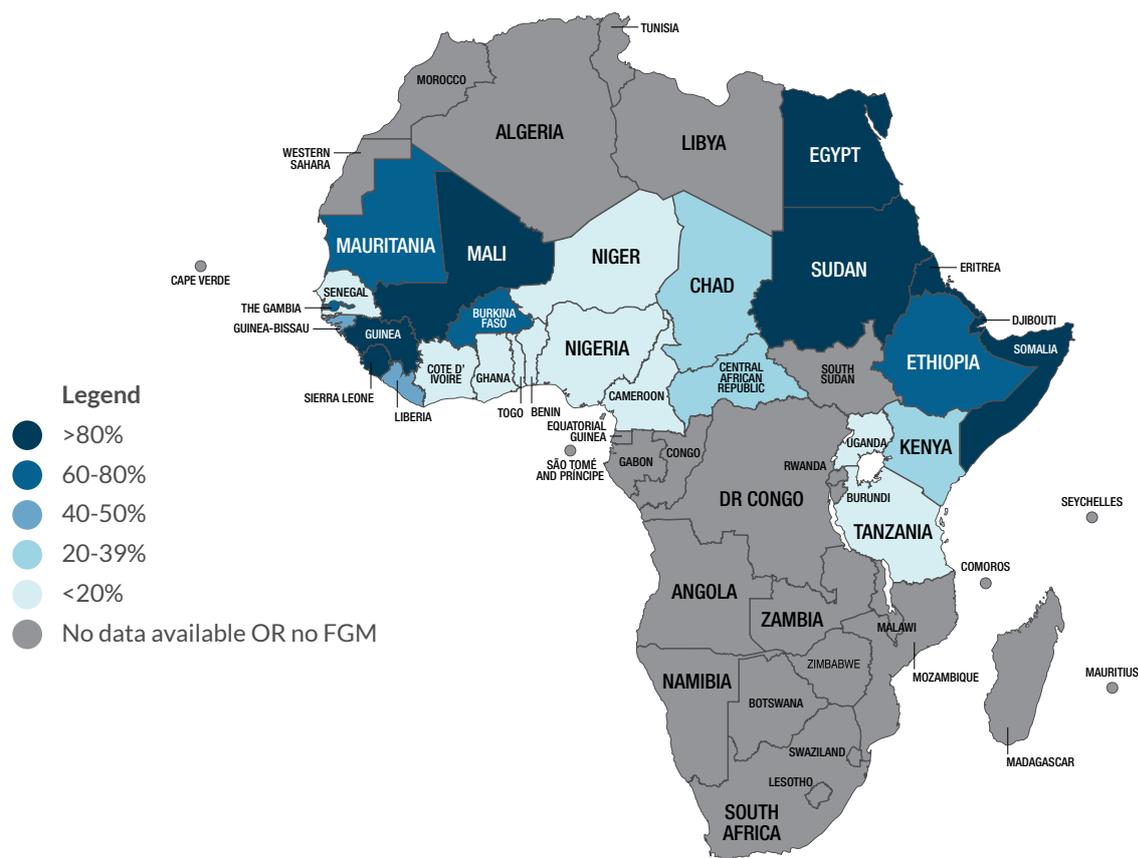


Table 6.2. Variation in FGM in regions within countries<sup>xxxix</sup>

Country	Range of FGM prevalence in subnational regions
Tanzania (low 10%)	0–71%
Senegal (moderately low 23%)	1–92%
Burkina Faso (moderately high 76%)	55–90%
Guinea (high 97%)	88–100%

Table 6.3. Age at which girls are cut<sup>xl</sup>

Age at cutting	Countries
Under 5 years	Nigeria, Mali, Eritrea, Ghana, Mauritania, Senegal (>75% girls cut) Ethiopia, Niger, Burkina Faso, Cote d'Ivoire, Tanzania (>50% girls cut)
5 – 9 years	Somalia, Togo, Chad, Djibouti, Guinea, Benin Guinea-Bissau, Sierra Leone, Kenya, CAR, Guinea-Bissau, Burkina Faso
10 – 14 years	Central African Republic; also in Kenya, Guinea-Bissau, Sierra Leone

### 6.1.5 Harmful practices, social norms and legal pluralism

Child marriage and FGM are highly **interrelated** as the latter is often practised as a 'rite of passage' to be married or initiation to womanhood.<sup>xli</sup> Most countries where FGM is practised also have a high rate of child marriage.<sup>xlii</sup> In Kenya, for example, within the Maasai community girls are under high pressure to marry early and face the risk of undergoing FGM as a rite of passage.<sup>xliii</sup> In many African countries, practices such as FGM and force-feeding, among others, are conducted as a way to 'prepare' girls for marriage and motherhood.

The practice of FGM and child marriage is critically affected by the existence of **plural legal systems**. Many countries in Africa know a plurality of laws, and this may affect people's rights negatively if these are in conflict with national law, and when the relations and potential contradictions between codified and customary law are not or weakly regulated. The fact that harmful practices are embedded in cultural and religious practices and/or norms regulated by customary or religious laws makes the way in which formal laws, such as constitutions and international treaties, recognise customary law and articulate how the two are related a critical concern.<sup>8</sup> Enforcement of formal law, and non-discrimination principles or provisions on age of marriage or harmful practice can be hard to enforce where formal institutions may be weak or non-existent and customary and religious laws rule people's behaviour, especially in rural areas. Law enforcement is even more challenging when it is regarded as a private matter in which the law should not interfere, and as a result people prefer to deal with these affairs internally with relatives or with a more familiar institution such as customary or religious authorities.<sup>xliv</sup> In order for human rights, equality before the law and non-discrimination to be respected and realised, it is imperative that constitutions and codified law provide that the right to practise culture and traditional or cultural practices is limited to the extent they infringe on other constitutional rights.

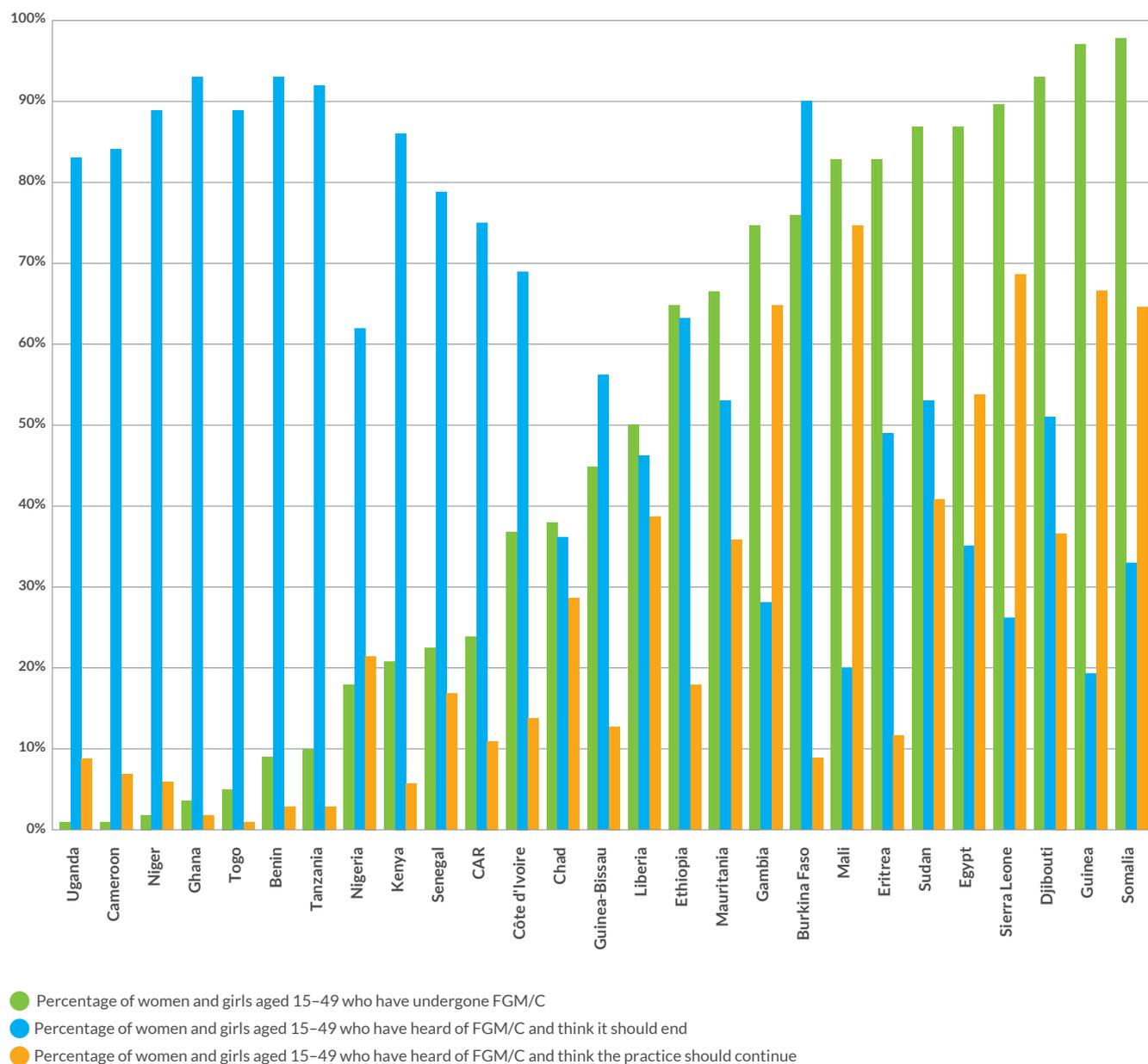
The intersections between child marriage, FGM and other harmful practices underline how they affect the dignity and integrity of women and girls, and that these different practices share the same structural causes. **Gender inequality**, poverty, limited education of girls and social, religious and cultural norms are key such causes. They work in a vicious cycle between causes, results and exacerbating factors of girls and women's vulnerability to discrimination and violence. Like child marriage, FGM is a practice by means of which women and girls' sexuality and reproductive functions are controlled and regulated. FGM also serves to deny women and girls sexual pleasure. It puts girls in subordinate positions where they lack control over their body and sexuality, and it perpetuates and reinforces male domination and patriarchal hierarchies. Like child marriage, FGM is strongly affected by cultural, religious<sup>9</sup> and social norms of gender unequal relations and female subordination. These norms affect the position of a person in the community and defying them can imply facing social stigma, isolation, dishonour and ostracism. FGM, and harmful practices more broadly, are both manifestations of these gender norms and reinforce them.

The **attitudes** of women and girls towards FGM vary between countries. More than half of the female population in Egypt, The Gambia, Guinea, Mali, Sierra Leone and Somalia think the practice should continue. Interestingly, though, in two-thirds of the countries where FGM is concentrated, the majority of girls and women think it should end (see Figure 6.7). In most countries, girls aged 15–19 years are less supportive of the continuation of the practice than women aged 45–49 years. When comparing women's and girls' attitudes to prevalence rates, 'In almost all countries, the percentage of girls and women who support the practice is substantially lower than the percentage of girls and women who have been cut, even in countries where FGM/C [female genital mutilation/cutting] is universal' (p. 53). The largest discrepancies are noted in Burkina Faso (9% in favour of the practice and 76% of girls and women having been cut), as well as in Djibouti, Egypt, Eritrea, Ethiopia, Somalia and Sudan.<sup>xlv</sup>

8 There are three basic constitutional models in which African states have responded to the presence of codified and customary law: (1) a strong cultural relativist model (allowing customary law to exist unfettered by formal law), (2) a weak cultural relativist model (recognising customary law but not addressing explicitly the hierarchies between formal and customary law, and (3) the universalist model (recognising customary law and the right to culture, but making these subject to non-discrimination and equality before the law). For a detailed and insightful reflection on customary law in post-colonial African states, see Banda, F. (2005). *Women, Law and Human Rights: An African Perspective*. Portland, OR: Hart Publishing (pp. 13–41 and 247–296). Banda also points to the extent to which culture, cultural identity and customary law have been reified, and undifferentiated and homogenised notions of African culture or African values are being constructed in the debates and legal frameworks around plural legalism. Related to this is also the extent to which the evolving and dynamic nature of pre-colonial customary law is recognised, as well as problematic constructions of binary notions of a unified African culture versus a monolithic West in an increasingly globalised and interconnected world. Banda quotes M. Chanock (in Na'im, A. 2002. *Cultural Transformation and Human Rights in Africa*), saying: 'in the representation of culture the voices of the elite overwhelm others' with 'assertions of culture... privileging some voices and patterns of acts, and ignoring and marginalising others' (p. 252 in Banda 2005).

9 Often these cultural and religious practices are more cultural practices veiled in religious terms, especially when the religious texts, scriptures or authorities do not provide a ground for harmful practices such as child marriage or FGM. FGM is not in the Bible or the Quran, but in many communities it is justified under a religious veil.

Figure 6.6. Percentage of women and girls aged 15–49 who have heard of FGM and think it should end



Source: UNICEF. (2013). *Female Genital Mutilation and Cutting. A Statistical Overview and Exploration of the Dynamics of Change*. New York: UNICEF.

## 6.2 CONTINENTAL AND REGIONAL POLICY FRAMEWORKS

**Child marriage** and **FGM** are specific forms of discrimination against women and girls. Art. 2 of the Maputo Protocol requires state parties to 'combat all forms of discrimination against women'. It especially states 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' (Art. 2, sub 1, b). This section first discusses the normative framework on harmful practices, and two subsequent sections focus on FGM and child marriage, respectively.

### 6.2.1 Harmful practices and the right to positive culture

Art. 5 of the Maputo Protocol explicitly speaks to the elimination of **harmful practices**, by prohibiting and condemning 'all forms of harmful practices which negatively affect the human rights of women and which are contrary to international standards'. This underlines how the commitment to eliminate harmful practices is linked not only to promoting the health and well-being of women but also to women's human rights. The definition articulates the negative effect of harmful practices on women and girls' right to life, health, dignity, education and physical integrity.<sup>xlvi</sup>

Another important provision in relation to harmful practices is in Art. 17 of the Maputo Protocol. This provides that 'women shall have the right to live in a **positive cultural context**' (Art. 17.1). The ACHPR (1981) speaks about duty of individuals 'to preserve and strengthen positive African cultural values' (Art. 29.7). This has to be read 'as being compatible with the rest of the Charter, especially its provisions on non-discrimination, and where women are concerned, the injunction in article 18(3) that the state has the obligation to eliminate "every discrimination against women"'.<sup>xlvii</sup> The Maputo Protocol makes this holistic interpretation of positive cultural context clear by referring in its Preamble to 'the preservation of African values based on the principles of equality, peace, freedom, dignity justice, solidarity and democracy'.<sup>xlviii</sup> Furthermore, the Maputo Protocol is cognisant of the male domination and often absent or weak participation of women in customary law and cultural institutions, and how this affects women and girls' representation and their rights and concerns in plural legal systems. It articulates women's right 'to participate in all levels in the determination of cultural policies' and that state should take all appropriate measures to enhance this participation (Arts 17.1 and 17.2).

Of at least equal value, are the provisions in the Maputo Protocol regarding women's and girls' socio-economic rights and their right to participate in political decision-making. Whereas the relations between harmful practices, ideas and perspectives on what constitutes culture and African values, and women's and girls' human rights has drawn a lot of attention, it has also been pointed out that there is a need to take a broader perspective and acknowledge how the violations of women's and girls' socio-economic rights and to their participation in decision-making are 'chief impediments to the enjoyment of rights by women'.<sup>xlix</sup> This underlines the importance of these rights article in the Maputo Protocol, including amongst others, Article 9 on the right to participate in political and decision-making processes, Article 12 on right to education and training, and Article 13 on economic and social welfare rights. Article 14 on health and reproductive rights obviously also has a major significance here, and is at the heart of chapters 7 and 8.

### 6.2.2 Female genital mutilation

**FGM** is explicitly articulated under the elimination of harmful practices. 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).

The ACRWC grounds the elimination of harmful practices in the need to protect and promote the welfare, dignity, normal growth and development of the child. It especially emphasises health and non-discrimination on the grounds of sex or other statuses as reasons to eliminate harmful practices (Art. 21). The AYC relates the elimination of traditional practices to the physical integrity and dignity of women (Art. 20) and to welfare and dignity, emphasising health, life and discrimination on the grounds of age, gender or other status (Art. 25).

In terms of the international women's rights frameworks, DEVAW (1993) explicitly speaks to FGM in its Art. 2 on violence against women. In fact, it specifically mentions 'female genital mutilation and other harmful practices to women' in its definition of violence against women (Art. 2a). In 2014, the CEDAW Committee and the Committee on the Rights of the Child adopted a Joint General Recommendation/Comment on harmful practices.<sup>10</sup> This links harmful practices to violence and to discrimination against women and girls. It offers an articulate understanding of harmful practices, as 'persistent practices and forms of behaviour that are grounded in discrimination on the basis of, among other things, sex, gender and age, in addition to multiple and/or intersecting forms of discrimination that often involve violence and cause physical and/or psychological harm or suffering' (Part V.15, p. 5). Four criteria determine whether to regard practices as harmful (Part V.16, pp. 5–6):

1. They constitute a denial of the dignity or integrity of the individual, and a violation of human rights and fundamental freedoms.
2. They constitute discrimination against women or children and result in negative consequences for them as individuals or groups.
3. They are traditional, re-emerging or emerging practices that are prescribed and/or kept in place by social norms that perpetuate male dominance and inequality of women and children.
4. They are imposed on women and children by family and/or community members or society at large, regardless of whether the victim provides or is able to provide full, free and informed consent.

FGM is one of the four forms of harmful practices in the Joint General Recommendation/General Comment. The second one is child or forced marriage.<sup>11</sup> The ACHPR Guidelines on Combating Sexual Violence and its Consequences, discussed in greater detail in Chapter 4, include FGM in their definition of sexual violence.

#### Elimination of harmful practices (Maputo Protocol, Art. 5)

States Parties shall prohibit and condemn all forms of harmful practices which negatively affect the human rights of women and which are contrary to recognised international standards. States Parties shall take all necessary legislative and other measures to eliminate such practices, including:

- a. creation of public awareness in all sectors of society regarding harmful practices through information, formal and informal education and outreach programmes;
- b. prohibition, through legislative measures backed by sanctions, of all forms of female genital mutilation, scarification, medicalisation and para-medicalisation of female genital mutilation and all other practices in order to eradicate them;
- c. provision of necessary support to victims of harmful practices through basic services such as health services, legal and judicial support, emotional and psychological counselling as well as vocational training to make them self-supporting;
- d. protection of women who are at risk of being subjected to harmful practices or all other forms of violence, abuse and intolerance.

The significance of the Maputo Protocol's provisions lie not only in the unequivocal determination to prohibit and eradicate harmful practices, but also in the comprehensive articulation of the **obligations of states** in this.<sup>1</sup> Art. 5 provides for four strategies to eliminate harmful practices:

1. *Prohibiting* harmful practices and FGM, through legislative measures backed by sanctions (Art. 5b);
2. Going beyond prohibition and prevention by calling for *support and rehabilitation* services to victims of harmful practices (Art. 5c);
3. Requiring states parties to *protect* women who are at risk of being subjected to such practices, abuse and violence (Art. 5d);
4. Calling for further prevention through public *awareness-raising* (Art. 5a).<sup>ii</sup>

The need for awareness-raising is also underscored in Art. 2 of the Maputo Protocol, which points to the need for a change in social and cultural practices, to engage with social and cultural norms, attitudes, beliefs and practices, in order to combat all forms of GVAW, including harmful practices. Art. 2.2. provides that 'States Parties shall commit themselves to modify the social and cultural patterns of conduct of women and men through public education, information, education and communication strategies, with a view to achieving the elimination of harmful cultural and traditional practices and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes, or on stereotyped roles for women and men.'

<sup>10</sup> This acknowledges that the issue of harmful practices was less known at the time the two conventions were drafted and adopted. Yet both conventions include provisions that oblige states to prevent and eliminate harmful practices. Joint General Recommendation No. 31/General Comment No. 18 'should be read in conjunction with the relevant general recommendations and general comments issued by the Committees', more specifically CEDAW General Recommendation No. 19 (violence against women), CRC General Comment No. 8 (the right of the child to protection from corporal punishment and other cruel or degrading forms of punishment) and CRC General Comment No. 13 (the right of the child to freedom from all forms of violence). 'The content of CEDAW General Recommendation No. 14 on female circumcision is updated by the present joint general recommendation/general comment' (Part II.5, p. 2).

<sup>11</sup> Joint General Recommendation No. 31/General Comment No. 18 addresses four specific forms of harmful practices: FGM, child and/or forced marriage, polygamy and 'crimes committed in the name of so-called honour'.

### 6.2.3 Child marriage

As mentioned above, the CEDAW Committee/Committee on the Rights of the Child Joint General Recommendation No. 31/ General Comment No. 18 articulates child and forced marriage as one of the four forms of harmful practices. The ACRWC (1990) explicitly addresses child marriage in the context of harmful social and cultural practices: 'Child marriage and the betrothal of girls and boys shall be prohibited and effective action, including legislation, shall be taken to specify the minimum age of marriage to be 18 years and make registration of all marriages in an official registry compulsory' (Art. 21, sub 2).

Child marriage is also prohibited under the Maputo Protocol, which states that women and men shall enjoy equal rights and are regarded as equal partners in marriage. It specifies, among other things, that marriage cannot take place 'without the free and full **consent** of both parties' (Art. 6a) and that 'the minimum age of marriage for women shall be **18 years**' (Art. 6b). The equal rights of women and men in marriage, and the right to full and free consent of intending spouses is in line with the UDHR<sup>12</sup> and CEDAW.<sup>13</sup> The Maputo Protocol is more specific in the minimum age of marriage: whereas the UDHR speaks of 'full age' and CEDAW of a minimum age, the Maputo Protocol explicitly articulates that marriage under the age of 18 shall have no legal effect. The provision that every marriage shall be recorded and **registered** is also of significance for child marriage, as it implies that unregistered marriages are not valid.<sup>iii</sup>

#### Marriage and child marriage (Maputo Protocol, Art. 6)

States Parties shall ensure that women and men enjoy equal rights and are regarded as equal partners in marriage. They shall enact appropriate national legislative measures to guarantee that:

- a. no marriage shall take place without the free and full consent of both parties;
- b. the minimum age of marriage for women shall be 18 years;
- c. every marriage shall be recorded in writing and registered in accordance with national laws, in order to be legally recognised;

In 2017, a **Joint General Comment from the ACHPR and ACERWC** was adopted regarding ending child marriage.<sup>iii</sup> This aims to 'elaborate on the nature of State Party obligations that arise from Article 6(b) of the Maputo Protocol and Article 21(2) of the African Children's Charter, both of which prohibit child marriage'. The Joint General Comment is further positioned against the adoption of the *African Common Position on the AU Campaign to End Child Marriage in Africa*. The ACHPR and the AU Special Rapporteur on the Rights of Women, in collaboration with the Centre for Human Rights, also published a 'Report on Child Marriage in Africa'.<sup>iv</sup> The scope of the Joint General Comment includes 'children in child marriages, children at risk of child marriage, and women who were married before the age of 18'.

The Joint General Comment provides guidance on the normative content of the Maputo Protocol and ACRWC (the 'African Children's Charter'), and articulates the obligations for state parties. It starts with providing the principles underlying and guiding its interpretation:

1. *The best interests of the child*: This should be given primary consideration in actions concerning the child. Child marriage curtails 'the enjoyment of children's human rights' and has negative physical, psychological, economic and social consequences. This principle cannot be used as a justification of a marriage of a child in any circumstance (p. 5).
2. *Freedom from discrimination*: The right to freedom from discrimination based on sex and gender is a fundamental basis for the interpretation of other provisions. 'Child marriage is a manifestation of gender inequality and constitutes discrimination based on sex and gender', and should hence be eliminated (p. 5).
3. *Rights to survival, development and protection*: The African Children's Charter enshrines the right to survival, development and protection of each child. Child marriage poses 'a considerable threat to the survival and development of women and children, especially girls, children with disabilities, migrant children, children who are refugees and children in child-headed households' (p. 6).
4. *Participation*: A child has the right to communicate and express their views and opinions, and also these views must be heard and taken into consideration. These rights are violated when children are married or betrothed without their personal, full and free consent. It is in the best interests of the child to not tolerate exceptions of the minimum marriageable age of marriage at 18.

<sup>12</sup> The UDHR (1948) provides that 'men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution' (Art. 16.1) and that 'marriage shall be entered into only with free and full consent of the intending spouses' (Art. 16.2) (emphasis ours).

<sup>13</sup> CEDAW 1979 provides that 'States Parties shall take all appropriate measures to eliminate discrimination against women in all matters related to marriage and family relations and in particular, ensure on the basis of equality of men and women' (Art. 16, sub 1). This includes 'the same right to enter marriage' (Art. 16.1a), and 'the same right to freely choose a spouse and to enter into marriage only with free and full consent' (Art. 16.1b). It also provides that 'the betrothal and the marriage of a child shall have no legal effect, and all necessary action shall be taken to specify a minimum age for marriage, and to make the registration of marriages in an official registry compulsory' (Art. 16, sub 2) (emphasis ours).

In addition to these four guiding principles, the Joint General Comment underlines that women's and children's rights are interrelated, and that this calls for a simultaneous consideration of the Maputo Protocol and the ACWRC. The core terms are defined in Box 6.2.

#### Box 6.2. Definitions of child, marriage and consent

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

**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).<sup>14</sup> 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. The Commission and Committee recognise that older children may have the capacity. However, despite the evolving capacities of older children to make decisions about their lives and the fact that they may have the capacity to consent to sex, medical treatment and other acts, the language of the Maputo Protocol and the African Children's Charter clearly stipulates that children under the age of 18 are not capable of giving full and free consent to a marriage.

The normative framework regarding child marriage provided by the African Children's Charter and the Maputo Protocol is that:

- Child marriage and the betrothal of girls and boys is **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, as the African Children's Charter does not make a distinction between forms of law (civil, customary or religious).
- 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 Joint General Comment provides guidance on the obligations of states in ending child marriage (summarised in Table 6.4 below). A notable obligation in the legislative measures is that 'Legislative measures that prohibit child marriage must take precedence over customary, religious, traditional or sub-national laws.' This means that 'States Parties with plural legal systems must take care to ensure that prohibition is not rendered ineffectual by the existence of customary, religious or traditional laws that allow, condone or support child marriage' (Joint General Comment, p. 9). In addition to this, 'States Parties are encouraged to promote the participation of parents, particularly fathers, religious leaders and community leaders in ending child marriage' under 'other measures'.

<sup>14</sup> The requirement of free and full consent is recognised in several international human rights instruments, including in Art. 16(2) of the UDHR and Joint General Recommendation No.31 of the CEDAW Committee/General Comment No.18 of the Committee on the Rights of the Child.

**Table 6.4. State obligations on ending child marriage**

*The Joint General Comment from the ACHPR and ACERWC* provides an extensive explanation of the three sets of state obligations on ending child marriage.

<b>Legislative measures</b>	Ensure prohibition of marriage under the age of 18, without exception
	Ensure personal, full and free consent to marry
	Undertake constitutional reform
<b>Institutional measures</b>	Implement verification procedures (birth registration, age verification and marriage registration)
	Ensure full enforcement of laws, penalties and sanctions
	Around education: Including retention in school (including pregnant girls), and ensuring sanitary facilities and reduction of exposure to violence
	Ensure access to and uptake of health services: Including access to comprehensive SRHR, to SRH services without third party consent; developing and implementing comprehensive sexuality education and information programmes with age-appropriate information; authorising medical abortion as provided in Maputo Protocol
	Promote access to justice: Awareness-raising about the law, toll-free helplines, free legal aid; specialised police units and training of prosecutors, magistrates and judges; provide for appropriate remedies
	Provide redress and support for those already married
	Capacity-building and training (of government officials, teachers, health providers, police, judicial officers, religious, community and traditional leaders, etc.)
	Data collection
	Resource allocation and budgeting
	<b>Other measures</b>
Develop and implement national action plans and early warning programmes	
Promote the role of men and traditional and religious leaders	
Develop and implement special measures to prevent child marriage among children at higher risk	
Reparation of victims	
Awareness and public information campaigns	

## 6.3 NATIONAL LEGAL AND POLICY FRAMEWORKS

This section looks at the legal and policy frameworks at the national level regarding harmful practices, in particular child marriage and FGM. It tracks the extent to which the commitments in the Maputo Protocol and important related documents are being implemented at the national level. Is the legal age of marriage guaranteed at 18 years, and does this apply to religious and customary marriages as well? Can parents, guardians or other third parties provide consent to allow for a marriage under the legal minimum age? What are the provisions on harmful practices, and in particular FGM? And do countries have an action plan or programmatic response to end either of these practices?

We have formulated seven legal and policy indicators to capture progress and gaps regarding child marriage and FGM in the country's legal and policy frameworks. These are explained in Table 6.5. The first four relate to child marriage and the latter three concern FGM. This section then discusses trends, gaps and contestations on these indicators, first for the continent as a whole and then region by region. The final section of the chapter proceeds to presenting case studies that complement the tables and narrative analysis on the national legal and policy frameworks.

**Table 6.5. 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

Table 6.6 and 6.7 present an overview of legal and policy frameworks regarding child marriage and FGM respectively. For an explanation of the regional units used here, see section 1.6.3 in chapter 1). Please note that the total for the continent has been recalculated, as some countries are included in more than one region.<sup>15</sup> The main trends regarding the legal and policy frameworks regarding **child marriage** are that eight in ten countries sets the legal age of marriage at 18. But there are legal loopholes in 34 of the 45 that have the legal age of marriage at 18, in the sense of not having guaranteed full and free consent, and that the legal age of marriage applies to customary and religious marriages as well. In total, full and free consent of the marrying parties is not guaranteed in a total of 36 African countries. 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 due to missing data. The nine countries where the legal age at marriage is lower than 18<sup>16</sup>, also all nine do not guarantee explicitly full and free consent.

Table 6.6 also shows that a total of 33 countries have launched national plans to end child marriage, and most prominently in Western Africa, and 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. Launching a campaign to end child marriage does not directly translate in post-launch activities. According to a 2016 report, about three out of five of the countries that had had the launch, had progressed into establishing a coordination mechanism and/or developing a national plan and/or started implementing activities. Two out of five had not (yet) progressed beyond the launch itself.<sup>17</sup>

**Table 6.6. Continental and regional overview of legal and policy indicators, Child marriage**

Harmful practices – child marriage	INDICATORS											
	Legal age at marriage at 18			Full and free consent (with-out exceptions)			Legal age of marriage applies to all marriages			Action/strategic plan/campaign to end child marriage		
	Y	N	M	Y	N	M	Y	N	M	Y	N	M
Western (15)	10	5	0	3	10	2	7	5	3	14	0	1
Eastern (11)	9	2	0	5	6	0	10	1	0	5	6	0
Central (11)	9	2	0	4	6	1	4	3	4	5	4	2
Southern (16)	14	2	0	3	13	0	7	4	5	7	2	7
Northern (7)	6	0	1	2	4	1	1	0	6	3	0	4
Country total (55—without duplications)	45	9	1	15	36	4	26	12	17	33	9	13

The overview of national legal and policy frameworks regarding **FGM** is presented in Table 6.7. The main trends emerging are that less than one in five countries has a constitutional provision eliminating harmful practices. Among the many countries that lack a constitutional provision on the elimination of harmful practices, several have a provisions that recognise customary law and indicate it cannot contradict the Constitution (e.g. Angola, Namibia, South Africa).

About three out of five countries has a statutory law prohibiting FGM specifically; another seven countries (in the Southern region) have statutory law that prohibits harmful practices, without explicitly addressing FGM. Of these seven, Malawi and Swaziland also have a constitutional provisions, whereas Namibia, Botswana, Lesotho, Mauritius and Zimbabwe do not. Thirteen countries do not have a legal provision prohibiting FGM, or otherwise harmful practices; these countries also lack a constitutional provision on the latter.<sup>17</sup> 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.<sup>18</sup>

About half, that is 27 countries have a programmatic response or action to end FGM. Almost all countries in the Western region, and two-thirds in Eastern region countries. There is only one Southern country with a programmatic response, which might 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.<sup>19</sup>

<sup>15</sup> A few countries are part of more than one region used as an analytical unit here. For the 'total' of the continent, these duplications should be counted only once. (Angola and DRC are in both Central and Southern regional unit, Rwanda and Burundi are in both Eastern and Central, and Tanzania is in both Eastern and Southern regional unit of analysis).

<sup>16</sup> Angola, Burkina Faso, Gabon, Guinea Bissau, Mali, Niger, Senegal, Sudan and Tanzania.

<sup>17</sup> Algeria, Angola, Burundi, Cabo Verde, Comoros, Liberia, Libya, Mali, Morocco, Mozambique, Rwanda, Sao Tome & Principe, Seychelles, Sierra Leone, Tunisia. (missing data on legal prohibiting of FGM for Angola and Tunisia).

<sup>18</sup> Ghana, Ethiopia, Sudan, Somalia and Uganda score positively on all three indicators; South-Sudan, Malawi and Swaziland have both a constitutional and statutory law provision.

<sup>19</sup> Liberia, Mali and Sierra Leone.

Subsequent sections of this chapter discuss regional and national details in terms of trends, gaps and key contestations in the national legal and policy frameworks on harmful practices. In different regions, countries have also undertaken institutional reform, most visibly in the establishment of a National Committee on eliminating harmful practices more broadly, or child marriage or FGM specifically. Contestations across the regions relate to contradictions between codified and customary law. With respect to FGM, medicalisation of FGM is a worrisome trend that is not aligned with full prohibition and elimination of harmful practices and FGM in particular. There are also attempts of pro-FGM campaigners and actors to allow for FGM when women give consent (e.g. in Kenya and Sierra Leone); these are also counter to the Maputo Protocol provisions, and actually undermine its implementation. The realisation of women's and girls' rights regarding harmful practices and FGM is further constrained by weak enforcement of the law, resulting in little prosecution of perpetrators.

**Table 6.7. Continental and regional overview of legal and policy indicators, FGM**

Harmful practices – FGM	INDICATORS									
	Constitutional provision eliminating harmful practices			Legal provisions prohibiting FGM				Programmatic response or action plan to end FGM		
	Y	N	M	Y	HP	N	M	Y	N	M
Western (15)	1	14	0	11	0	4	0	14	1	0
Eastern (11)	5	6	0	9	0	2	0	8	3	0
Central (11)	0	11	0	7	0	3	1	3	4	4
Southern (16)	2	14	0	5	7	3	1	1	1	14
Northern (7)	0	6	1	2	0	3	2	2	3	2
Country total (55—without duplications)	8	46	1	32	7	13	3	27	10	18

### 6.3.1 Western region

#### Trends, gaps and contestations

The legal and policy frameworks of the states in the Western region show many similarities; only a few countries have a different profile. With respect to child marriage, Cape Verde, The Gambia, Guinea, Sierra Leone and Togo have three positive scores on the four indicators. Almost half of the countries in the region meet only two of the four legal and policy indicators regarding child marriage. Liberia stands out as having in place all legal provisions on child marriage in line with the Maputo Protocol, and also an action plan to end child marriage.

With respect to the indicators on harmful practices and FGM, ten of the fifteen states legally prohibit FGM and have a programmatic response to end the practice, but lack a constitutional provision to eliminate harmful practices. Liberia, Mali and Sierra Leone have a programmatic response to end FGM but all lack legal or constitutional provisions on harmful practices or FGM. Ghana stands out as having the strongest profile of three positive scores. Cape Verde, on the other hand, scores negatively on all three.

Table 6.8. Key legal and policy indicators in Western Africa, Harmful practices

Country	INDICATORS						
	Legal age at marriage at 18	No exceptions (full and free consent)	Applies to all marriages	Action/strategic plan/campaign to end child marriage	Constitutional provision eliminating harmful practices	Legal provisions prohibiting FGM	Programmatic response or action plan to end FGM
Benin	Yes	No <sup>20</sup>	-	Yes	No	Yes	Yes
Burkina Faso	No <sup>21</sup>	No <sup>22</sup>	No <sup>23</sup>	Yes	No	Yes	Yes
Cape Verde	Yes	Yes	Yes	-	No	No	No
Côte d'Ivoire	Yes	No <sup>24</sup>	-	Yes	No	Yes	Yes
The Gambia	Yes	Yes	No <sup>25</sup>	Yes	No	Yes	Yes
Ghana	Yes	No <sup>26</sup>	No <sup>27</sup>	Yes	Yes	Yes	Yes
Guinea	Yes	No <sup>28</sup>	Yes <sup>29</sup>	Yes	No	Yes	Yes
Guinea Bissau	No <sup>30</sup>	No <sup>31</sup>	Yes	Yes	No	Yes	Yes
Liberia	Yes	Yes <sup>32</sup>	Yes	Yes	No	No	Yes
Mali	No <sup>33</sup>	No <sup>34</sup>	No <sup>35</sup>	Yes	No	No <sup>36</sup>	Yes
Nigeria	Yes	-	No <sup>37</sup>	Yes	No	Yes	Yes
Niger	No <sup>38</sup>	No <sup>39</sup>	Yes	Yes	No	Yes	Yes
Senegal	No <sup>40</sup>	-	-	Yes	No <sup>41</sup>	Yes	Yes
Sierra Leone	Yes	No <sup>42</sup>	Yes	Yes	No	No <sup>43</sup>	Yes
Togo	Yes	No <sup>44</sup>	Yes	Yes	No	Yes	Yes

20 Law No. 2002-07 of 24 August 2004 on the Code of Persons and the Family (Loi n°2002-07 du 24 August 2004 portant Code des personnes et de la famille) states the following: A minor under 18 years old cannot marry without the consent of the person exercising parental authority over them. This consent must include the identity of the two future spouses. The consent should be given either by the statement made to an officer of civil status or to a notary, prior to the marriage and it is valid even if it is given during the celebration (Art. 120).

21 The law set the legal age for girls to marry is 17 and 21 for boys; however, this is not enforced since most marriages take place in traditional and religious ceremonies.

22 Marriage can take place for girls under 15 and boys under 18 'if a court awards special dispensation, although this is rarely used as many marriages are conducted in traditional ceremonies' ([www.amnesty.org/en/press-releases/2016/04/burkina-faso-forced-early-marriage-facts/](http://www.amnesty.org/en/press-releases/2016/04/burkina-faso-forced-early-marriage-facts/)).

23 The legal age of marriage applies only to marriages registered by the state, not to traditional and religious ones ([www.amnesty.org/en/latest/news/2016/04/burkina-faso-forced-and-early-marriage-puts-thousands-of-girls-at-risk/](http://www.amnesty.org/en/latest/news/2016/04/burkina-faso-forced-and-early-marriage-puts-thousands-of-girls-at-risk/)).

24 'Article 1 of the Civil Code provides the minimum age of marriage at 18 for women and 21 for men. The court can, however, make exceptions for serious (unspecified) reasons.' A girl can marry under the age of 18 and a boy under 21 with the parental consent ([www.girlsnotbrides.org/child-marriage/cote-divoire/](http://www.girlsnotbrides.org/child-marriage/cote-divoire/)).

25 Though the law set the marriage age at 18, under customary law girls can marry between the ages of 12 and 17.

26 The minimum age of marriage is set at 18 for both girls and boys; however, they can marry with parental consent at 16.

27 Under customary law, marriage can still take place under the age of 18 years.

28 Art. 268 of the Guinean Children Code 2008 stipulates: 'Nevertheless, the President of the Republic, on report of the Minister of Justice, may, by Decree, grant exemptions on age for compelling reasons. The application is made to the Public Prosecutor or the President of the Tribunal which is forwarded to the Attorney General. An expedition of this Order is then attached to the marriage certificate.'

29 Though the minimum age of marriage is set at 18 for both boys and girls, most marriages under 18 take place under religious and traditional ceremonies.

### Trends in legal, policy and institutional reform

**Constitutional provisions:** Ghana is one of the few countries where FGM is prohibited under the Constitution: Art. 26(2) provides that 'All customary practices which dehumanise or are injurious to the physical and mental wellbeing of a person are prohibited.' The Ghanaian Constitution goes even further in its Art. 39(2) to condemn any traditional practices that are detrimental to the health and safety of the person. In 1994, Ghana amended its Criminal Code to make FGM a criminal offence under Art. 69A. No other states in the Western region have provisions in their Constitution regarding harmful practices. Senegal's Constitution explicitly prohibits and punishes forced marriage and defines it as a violation of personal freedom (Art. 18).

**Statutory law and policy responses on child marriage:** Western Africa is home to countries with the highest percentage of child marriage, and most countries are parties to international and regional human rights instruments<sup>42</sup> that explicitly set the minimum age for marriage at 18. This legal requirement is met by two-thirds of the countries. In five countries, however, marriage is allowed under the age of 18: Niger (15 years), Guinea Bissau (16 years), Mali (16 years), Senegal (16 years) and Burkina Faso (17 years). In almost two-thirds of the states, full and free consent is not guaranteed, and exemptions to the legal age of marriage are allowed by consent of parents, courts, the minister of justice or the president. The legal age of marriage applies to customary, religious and traditional marriages in only eight of the fifteen countries in the region.

Momentum around ending child marriage has gained ground across the region, and Burkina Faso,<sup>43</sup> The Gambia,<sup>44</sup> Ghana<sup>45</sup> and Togo,<sup>46</sup> among other countries, have taken affirmative measures, such as putting in place national action plans or strategies. Burkina Faso, The Gambia, Ghana, Liberia, Mali, Niger, Nigeria, Senegal and Sierra Leone have launched national campaigns as part of and in line with the AU Campaign to End Child Marriage. Burkina Faso, Ghana, Liberia, Niger and Sierra Leone have only launched the campaign whereas The Gambia, Nigeria and Senegal have taken further steps towards implementation by establishing a coordination mechanism and national action plan (Nigeria) or, in addition, initiating implementing activities (The Gambia, Mali and Senegal).<sup>46</sup>

The government of Togo, in partnership with NGOs, has engaged in a range of actions to prevent early marriage, particularly through awareness-raising among community and religious leaders. Multiple initiatives have focused on helping girls stay in school. Messages broadcast through mass media, particularly local radio, have stressed avoiding early marriage and the importance of educating girls. With the exception of Cape Verde and Togo, all countries have launched a national campaign as part of the AU Campaign to End Child Marriage.

<sup>30</sup> Art. 1649 of the Child Code allows marriage under 16 years to take place with consent of parents or guardians.

<sup>31</sup> Although the law sets the minimum age of marriage at 18, girls can marry under 18 with the consent of a parent or guardian.

<sup>32</sup> With the adoption of the Children's Act in 2011, the provision on parental consent to marriage under 18 was repealed. Section 4: No person or society shall subject a child to any of the following practices: (a) Marrying any person when she or he is still under the age of 18. Section 3: Child shall mean any person below the age of 18 years. Section 16.15: Subjecting a Child to Harmful Practices: A person commits a felony of second degree if she or he subjects a child to any of the following practices: (a) Facilitating the marriage to any person when she or he is still under the age of 18.

<sup>33</sup> The legal age to marry is set at 16 for girls and 18 for boys; however, marriage can take place under customary and sharia for girls under 16.

<sup>34</sup> In some cases, a marriage can take place at 15 with the authorisation of a judge and the consent of the parents ([www.genderindex.org/country/mali/#\\_ftnref](http://www.genderindex.org/country/mali/#_ftnref)). Under customary and sharia law, it is possible for a girl to marry under the age of 16.

<sup>35</sup> Under customary and sharia law, it is possible for a girl to marry under the age of 16.

<sup>36</sup> Circular No. 99-0019 was issued in 1999, prohibiting FGM in hospitals.

<sup>37</sup> Marriage can take place under civil, customary and sharia law and each varies across the state. The marriage age varies from 18 years for girls in southern Nigeria to 12–15 in northern Nigeria.

<sup>38</sup> The law sets the minimum marriage age at 15 for girls and 18 for boys; however, a law has been initiated to bring the marriage age for girls to 18 but no information is available proving that it has been adopted.

<sup>39</sup> Under Art. 111 of the Family Code 1973, 'A marriage can only be contracted between a man over 18 years and a woman over 16 years unless granted exemption of age for a serious reason by the President of the Regional court after investigation.'

<sup>40</sup> The minimum age is set at 16 for girls and 18 for boys under Art. 111 of the Family Code 1973.

<sup>41</sup> Art. 18 of the 2001 Constitution: Forced marriage is a violation of personal freedom. It shall be forbidden and punished according to conditions laid down by law.

<sup>42</sup> UNCRC (1989), ACRWC (1990), CEDAW (1979), the Maputo Protocol (2003).

<sup>43</sup> Action Plan for the Eradication of Child Marriage (2004–06, 2008–10, 2016–25).

<sup>44</sup> 2016–20 Child Protection Strategy.

<sup>45</sup> National Strategic Framework on Ending Child Marriage (2017–26).

<sup>46</sup> National Programme against Child Marriage and Teenage Pregnancy (2014).

**Statutory law and policy responses on FGM:** Despite the alarming prevalence of FGM in Western Africa, the fight against the practice is gaining ground and two-thirds of the countries have enacted laws and policies banning FGM. Cape Verde, Liberia, Mali and Sierra Leone do not have legal provisions prohibiting FGM. The government of Sierra Leone did issue a ban on the practice during the 2014–15 Ebola outbreak, in order to stop the virus from spreading. Mali has no legislation expressly criminalising FGM but in 1999 the government issued a directive<sup>47</sup> that prohibits the practice in hospitals.<sup>lviii</sup> Moreover, a national action plan to end FGM (2008–11) has been adopted, which is supposed to pave the way for a law on FGM. This latter has not yet materialised, however.

The Gambia and Nigeria are the two most recent countries to outlaw FGM, in 2015. The greatest progress in addressing harmful practices in Nigeria has been seen in the passage of the Violence against Persons Prohibition Act in 2015. This aims 'to eliminate all forms of violence against persons, provide maximum protection and effective remedies for victims and punishments of offenders'.<sup>lviii</sup> Regarding FGM, the Act states that the act on a girl or woman is prohibited, and articulates the punishments for those who perform the practice on others.<sup>lix</sup>

**Institutional reform:** In Cote d'Ivoire, a 'Social Centre' has been put in place to deal with child marriage cases. This works in collaboration with families in order to find solutions. Guinea-Bissau has a National Committee to End Traditional Harmful Practices; in 2014, this prosecuted six people for practising FGM, with three out of the six convicted for up to three years' imprisonment.<sup>lx</sup> Burkina Faso established a National Committee for the Elimination of FGM in 1990 and in 2009 241 people were convicted for practising FGM.<sup>lxi</sup> Furthermore, in 2012, the Government of Burkina Faso made considerable steps by 'including modules on FGM in the curriculum of the National School of the Gendarmerie, the National School of the Financial Authorities, and the National Social Welfare Training Institute'.<sup>lxii</sup> The Ministry of Health of The Gambia has added FGM into the curriculum of the nursing school. Ghana established a Unit on Ending Child Marriage in 2014.

### Key gaps and contestations

A first gap relates to the small amount of countries with **constitutional** provisions to eliminate harmful practices. This stands in contrast with the relatively high number with constitutional provisions in the Eastern region. Second, countries where the legal age of marriage is set **below 18** do not correspond to the Maputo Protocol's provisions. A third gap relates to loopholes where either full and free **consent** is not guaranteed or the age of marriage does not apply to **customary and religious marriages**. A fourth gap concerns the countries where **FGM is not outlawed**.

A critical contestation relates to the **FGM age of consent** in Sierra Leone. Sierra Leone is one of the few countries in Western Africa where FGM is not prohibited, and the debate around FGM has proven very contentious. A clause on FGM was removed from the final version of the 2007 National Child Rights Act, and Parliament then decided it would not prohibit FGM; instead, it was agreed to put in place an age of consent. This means that a girl under 18 years cannot be cut but, when she reaches 18, she can make a free and informed decision as to whether she wants to undergo FGM.

Another contestation relates to the **medicalisation of FGM**. There is a growing trend across Western Africa for FGM to be carried out by medical professional such as nurses and midwives in health facilities. Parents are using medicalised FGM to prove their daughters have been cut, and the perception is that, since it is taking place in a hospital, the risks are minimised. This undermines the progress made so far towards elimination, as it actually tends to institutionalise FGM.

Another gap with respect to the eradication of FGM is the **lack of law enforcement**, despite FGM being an offence in most countries. Laws against the perpetrators of FGM are rarely enforced, because most cases take place in remote area where legal awareness tends to be low and traditional customs often prevail over the legal system. Weak law enforcement can be the result of a lack of political will or of resources. In Ghana, there is a strong will to enforce the law on FGM and the police are willing and have cooperated to stop the practice happening, but their **ability** to respond in remote communities in a timely or effective manner is severely limited. In January 2016, three women were tried and sentenced for performing FGM in the region of Kankan in Guinea.

Lack of law enforcement and cultural tolerance are undermining progress on both child marriage and FGM. Although most countries have laws and policies in place against FGM and child marriage, which are progressively reducing both practices, there is still a long way to go before both practices are completely eradicated. Governments in Western Africa must take concrete actions to put into practice national, regional and continent legislation and policies to end child marriage and FGM.

<sup>47</sup> Ministry of Health Circular Letter N° 0019 MSPAS-SG (7 January 1999).

### 6.3.2 Eastern region

#### Trends, gaps and contestations

The legal and policy frameworks of the countries in Eastern Africa show positive signs on many fronts, but also some notable gaps and weak spots. With respect to child marriage, Eritrea and Kenya score positively on all four legal and policy indicators. Rwanda and South Sudan also live up to the legal requirements of the Maputo Protocol regarding child marriage, but lack an action or strategic plan. The country with the weakest legal and policy frameworks regarding child marriage in the Eastern region is Tanzania, closely followed by Somalia, Sudan and Uganda.

Looking at FGM and harmful practices, Ethiopia, Somalia, Sudan and Uganda have the strongest profile on the three indicators; Burundi and Rwanda score lowest. The profiles of Djibouti, Eritrea, Kenya and Tanzania are more mixed: they lack a constitutional provision on harmful practices but score positively on FGM legal provisions and policies. South Sudan has constitutional and legal provisions on harmful practices and FGM in place but lacks a programmatic response towards FGM.

**Table 6.9. Key legal and policy indicators in Eastern Africa, Harmful practices**

Country	INDICATORS						
	Legal age at marriage at 18	No exceptions (full and free consent)	Applies to all marriages	Action/ strategic plan/ campaign to end child marriage	Constitutional provision eliminating harmful practices	Legal provisions prohibiting FGM	Programmatic response or action plan to end FGM
Burundi	Yes	Yes	Yes	No	No	No	No
Djibouti	Yes	No <sup>54</sup>	Yes	No	No	Yes	Yes
Eritrea	Yes	Yes	Yes	Yes	No	Yes	Yes
Ethiopia	Yes	No <sup>52</sup>	Yes	Yes	Yes	Yes	Yes
Kenya	Yes	Yes	Yes	Yes	No <sup>53</sup>	Yes	Yes
Rwanda	Yes <sup>54</sup>	Yes	Yes	No	No	No	No
Somalia	Yes	No <sup>53</sup>	Yes	No	Yes	Yes	Yes
South Sudan	Yes	Yes	Yes	No	Yes	Yes	No
Sudan	No	No <sup>56</sup>	Yes	Yes	Yes	Yes	Yes
Tanzania	No <sup>57</sup>	No <sup>58</sup>	Yes	No	No	Yes	Yes
Uganda	Yes*	No <sup>56</sup>	No <sup>60</sup>	Yes	Yes	Yes	Yes

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

**Constitutional provisions:** Five states in the Eastern region have constitutional provisions that explicitly outline the state's obligations with respect to harmful practices, child marriage and/or FGM. These are Ethiopia, Somalia, South Sudan, Sudan and Uganda.

In Ethiopia, Art. 34(2) of the 1995 Constitution states that marriage shall be entered into with the free and full consent of intending spouses. A possible drawback to this provision is contained in Art. 34(5), which states that the Constitution does not preclude the application of *religious or customary laws* in matters linked to family and personal law, with the consent of the parties.

<sup>48</sup> Family Code 2002: 'Minors can marry with the consent of a judge or the authorization of guardians'.

<sup>49</sup> Constitution of Ethiopia 1995: Art. 34(5) states that the Constitution does not preclude the application of religious or customary laws in matters linked to family and personal law, with the consent of the parties.

<sup>50</sup> Article 53 and 55 of the Kenyan Constitution protects children and youth from harmful practices. Because this prohibition is not explicitly related to all ages, Kenya has a negative score in this table.

<sup>51</sup> 21 years of age. A woman may enter marriage at 18–20 years with the permission of, *inter alia*, the minister of justice.

<sup>52</sup> Family Code No. 23/75 1975: One may marry at 16 if a guardian consents. A court may grant an exemption on age if necessary.

<sup>53</sup> Marriage of Non Muslims Act 1926: Age of marriage for a girl is 13 and a boy 15. Consent is required for marriage in writing from a father, a mother if the father is dead or a guardian if both parents are deceased.

<sup>54</sup> Girls can marry at 15, boys at 18. In July 2016, the Constitutional Court ruled that marriage under the age of 18 was illegal, and stated that Sections 13 and 17 of the Marriage Act were unconstitutional (see Case study 11 on Tanzania in this chapter on the High Court decision, and the appeal).

<sup>55</sup> Law of Marriage Act 1971: Third party consent is utilised to override minimum age of marriage requirements.

<sup>56</sup> Marriage Act (Cap 251) requires consent for parties who have not attained 21 years of age.

<sup>57</sup> Customary Marriage (Registration) Act (Cap 248) finds marriages of girls 16 years of age valid.

Art. 15(4) of the 2012 Provisional Constitution of Somalia indicates that *female circumcision* is a cruel and degrading practice and is tantamount to torture. The circumcision of girls is prohibited. Art. 31(1) stipulates that the state shall strive to eliminate emerging and existent cultural practices that negatively affect society.

Art. 16(4)(b) of the Transitional Constitution of South Sudan places an obligation on the state to enact laws that combat *harmful customs and traditions* that undermine the dignity and status of women. Further, Art. 17(1)(g) states that 'Every Child has the right not be subjected to negative and harmful cultural practices which affect his or her health, welfare and dignity.'

The 2005 Interim National Constitution of the Republic of Sudan stipulates in Art. 32(2) that the state shall combat harmful practices that undermine the dignity and status of women.

With respect to the age of marriage, Art. 31 of Uganda's 1995 Constitution states that the *age of marriage* is 18. This is, however, contra-indicated in other national laws, such as the Customary Marriage, which validates the marriage of a 16-year-old girl.

All other states—Burundi, Djibouti, Eritrea, Kenya, Rwanda and Tanzania—have provisions that may be used to address harmful practices. These focus on the principles of non-discrimination and equality before the law, torture, inhuman and degrading treatment, the right to liberty and security of the person, consent to marriage unions and the right to choose one's spouse and respect of international instruments such as the Maputo Protocol, CEDAW and the UNCRC, which have provisions that prohibit harmful practices and outline state obligations thereto.

**Statutory law and policy responses on child marriage:** All the states in the Eastern region have laws that outline the age of marriage. In the majority of the countries, the legal *age of marriage* is set at 18 (Burundi, Djibouti, Eritrea, Ethiopia, Kenya, Somalia, South Sudan and Uganda). Two countries do not guarantee 18 as the minimum age of marriage. In Tanzania, it is 14/15 years for girls and in Sudan it is 13 (non-Muslims) and 10 (Muslims). The consent of parents or guardians is required. Rwanda stands out for its higher age of marriage, at 21 years of age; a woman may enter into a marriage between 18 and 20 years with the permission of, *inter alia*, the minister of justice.

In all but one country, the minimum age of marriage applies to formal as well as *customary and religious marriage*. In Uganda, customary marriages with a girl of 16 years can be considered valid. In half of the countries in the region, the *full and free consent* of the woman entering a marriage is not guaranteed; Djibouti, Ethiopia, Somalia, Sudan, Tanzania and Uganda allow parents, guardians or other third parties to provide consent to a marriage.

Five states have launched a national *campaign* to end child marriage: Eritrea, Ethiopia, Kenya, Sudan and Uganda. These national campaigns are part of and in line with the AU Campaign to End Child Marriage. In this campaign, the AU provides key policy guidance on highlighting the harms and redress mechanisms needed to tackle child marriage in Africa. Of these countries, Ethiopia has established a coordination mechanism for implementation of the campaign. Uganda has gone several steps further by establishing a coordination mechanism and a national plan and through organisation of campaign implementation activities.<sup>lxiii</sup>

Kenya has a specific policy that outlines how to address FGM and child marriage with respect to adolescents. Beyond this, all other states have gender development plans that broadly outline their commitment to address GVAW. This can provide a basis for policy responses on child marriage, as well as FGM, if these are considered acts of GVAW. Unfortunately, there is no guarantee that this is the case, in the absence of explicit references to the same.

**Statutory law and policy frameworks on FGM:** Nine states have statutory laws that specifically prohibit FGM: Djibouti, Eritrea, Ethiopia, Kenya, Rwanda, South Sudan, Sudan, Tanzania and Uganda. In certain instances, this is linked to the advancement of other rights issues. For instance, in Tanzania it is linked to addressing GVAW and the right to education in the context of the 2016 Education Act and the 1998 Sexual Offences (Special Provisions) Act, respectively. Burundi and Rwanda do not prohibit FGM, and also lack constitutional provision to eliminate harmful practices. All countries that prohibit FGM also have a programmatic response to end the practice; the only exception here is South Sudan.

**Institutional reform:** With regard to institutional measures, commendable strides can be observed in at least four countries. Djibouti has a National Committee for the Total Abandonment of All Forms of Excision, established in 2009. In the same year, Ethiopia established a National Committee on the Eradication of Harmful Traditional Practices. Kenya established the Anti-FGM Board in 2012; two years later (2014) it established the Office of the Director of Public Prosecutions Anti-FGM and the Child Marriage Prosecution Unit.

### Key gaps and contestations

Key gaps with respect to child marriage relate to discrepancies in the **minimum age** of marriage. Two states do not see 18 as the minimum age, as outlined in the Maputo Protocol. In these two countries, Sudan and Tanzania, there is also a difference for girls and boys: boys have a later minimum age of marriage. A second key gap concerns **contradictions** in legal provisions regarding the age of marriage (Uganda). A third relates to provisions where third parties, such as parents, guardians, the minister of justice or others can **consent** to a marriage union. This can be utilised to override general minimum age of marriage requirements.

A fourth gap is the **lack of comprehensive policies and strategies to address child marriage**. In most of the states reviewed, there is an absence of clear laws and policies that specifically outline the steps states should take to address the issue of child marriage. Taking normative guidance from the Joint General Comment on Child Marriage (ACHPR and ACEWRC), as well as developing strategies in line with the AU Campaign to End Child Marriage, can resolve this policy gap.

A fifth gap is that half of the countries do **not outlaw harmful practices**, and some lack legal provisions prohibiting FGM. Retrogressive trends are also emerging with respect particularly to FGM. A critical issue undermining the elimination of FGM relates to arguments for the **medicalisation of FGM**, which are gaining root. Initial advocacy against FGM pointed to the crudeness of the methods used, among other harms. Medicalisation is in part a way to respond to this criticism by sanitising the FGM process. However, this approach fails to take into account other, non-medical, harms such as the assault on women and girls' bodily integrity, dignity and equality, and is therefore at odds with the Maputo Protocol.

Another worrisome issue is the trend, for instance in Kenya, towards convicting victims and/or survivors of FGM. This **penalises victims**, especially when they are sentenced to prison terms and/or fines for failure to report FGM. Conviction of the victim also goes against the spirit and intention of the Prohibition of FGM Act 2011, as it was intended to protect and not further victimise victims of FGM. This trend is now the subject of court litigation towards establishing a more protective legal stance for victims.

Claims that adult women allegedly **consensually engage in FGM** also work against the prohibition of FGM. Pro-FGM campaigners are intentionally misrepresenting well-established human rights and constitutional principles that forbid FGM by arguing that adult women can 'consensually' engage in FGM. In Kenya, this has been vigorously challenged in court by state and non-state actors; a determination on the matter is anticipated in 2018/19.

### 6.3.3 Central region

#### Trends, gaps and challenges

**Child marriage:** Child marriage is a critical concern for the Central region, especially in countries such as CAR and Chad, which have the highest prevalence rates not only the region but also on the African continent, but also for Angola, Cameroon, DRC, Equatorial Guinea and Gabon. National legal frameworks show progress as well as weak spots and gaps in the Central region. In nine countries, the legal age of marriage is set at 18. In Burundi and Rwanda, all three requirements for prohibiting child marriage are met. The minimum age of marriage is set at 18 years, and there are no exceptions to this. This also counts for Chad, which in addition to this also has an action plan in place for ending child marriage. In six other countries (Cameroon, CAR, Congo Republic, DRC, Equatorial Guinea and São Tomé and Príncipe), the legal framework has loopholes. The law in CAR sets the age of marriage at 18, but allows for exceptions by allowing third-party consent to a marriage.

The minimum age of marriage is not guaranteed at 18 in Angola and Gabon, whose legal and policy framework also scores low on the other indicators. Of the nine countries that do have the legal age of marriage set at eighteen, five have an action plan or campaign in place. Gabon's legal age of marriage is not set at 18, yet the country does have an action plan to end child marriage. Cameroon has a similarly contradictory legal and policy framework, with an action plan to end child marriage but no strong legal provisions on child marriage that would be in line with the Maputo Protocol.

**FGM:** With respect to FGM, seven out of eleven countries have legal provisions to prohibit FGM, but only three have a programmatic response to actually end the practice. These seven include Chad and CAR, where FGM prevalence rates are relatively high, at 38% and 24%, respectively. There are no legal provisions that prohibit FGM in Burundi, Rwanda and São Tomé and Príncipe.

None of the countries has provisions in their constitutions to eliminate harmful practices. Burundi, Rwanda and São Tomé and Príncipe do not score positively on any of these three indicators related to FGM and harmful practices.

**Table 6.10. Key legal and policy indicators in Central Africa, Harmful practices**

Country	INDICATORS						
	Legal age at marriage at 18	No exceptions (full and free consent)	Applies to all marriages	Action/strategic plan/campaign to end child marriage	Constitutional provision eliminating harmful practices	Legal provisions prohibiting FGM	Programmatic response or action plan to end FGM
Angola	No	No <sup>58</sup>	-	-	No <sup>62</sup>	-	-
Burundi	Yes	Yes	Yes	No	No	No	No
Cameroon	Yes <sup>63</sup>	No <sup>64</sup>	-	Yes	No	Yes	Yes
CAR	Yes	No <sup>65</sup>	-	No	No	Yes	Yes
Chad	Yes <sup>66</sup>	Yes	Yes <sup>67</sup>	Yes	No	Yes	Yes
Congo Republic	Yes <sup>68</sup>	No <sup>69</sup>	No <sup>70</sup>	-	No	Yes	-
DRC	Yes <sup>71</sup>	No <sup>72</sup>	No <sup>73</sup>	Yes <sup>74</sup>	No	Yes <sup>75</sup>	-
Equatorial Guinea	Yes	Yes	No <sup>76</sup>	Yes <sup>77</sup>	No <sup>78</sup>	Yes	No
Gabon	No	-	-	Yes	No <sup>79</sup>	Yes	-
Rwanda	Yes <sup>80</sup>	Yes	Yes	No	No	No	No
São Tomé and Príncipe	Yes	No <sup>81</sup>	Yes <sup>82</sup>	No <sup>83</sup>	No	No	No

<sup>58</sup> There are exceptions; boys may marry at 16 and girls at 15 with the permission of a person endowed with authority over them, or where it seems to be in the best interests of the child seeking marriage.

<sup>59</sup> Art.7 prohibits customs that are contrary to the Constitution and the rights of women.

<sup>60</sup> There is incoherence in the legal age of marriage. The new Penal Code prohibits marriages under the age of 18 for women but the Civil Code of 1981 still allows marriages for girls above age 15.

<sup>61</sup> Le chef de l'Etat a le droit d'autoriser pour motif grave un mariage avant l'âge de puberté légale' (Code Civil Art. 52, ordonnance 29).

<sup>62</sup> The legal minimum age for civil marriage is 18, but marriage at 13 may be permitted if approved by a court and/or if the girl is pregnant. It is also legal with parents' consent.

<sup>63</sup> 'En vertu de l'article 144 du Code civil, l'âge minimum du mariage pour les femmes est de 15 ans'. The Penal Code 2017 criminalises marriages with girls and boys who have not reached the legal age of marriage. The legal age of marriage is not defined in the Penal Code. The ordinance to ban child marriage (2015) defines the minimum age of 18.

<sup>64</sup> The ordinance to ban child marriage (2015) criminalises civil, religious and traditional child marriage (Art. 5).

<sup>65</sup> Code de la Famille (Art. 128): 21 years for males, 18 years for females

<sup>66</sup> Exemptions: the Public Prosecutor of the People's Court or the District may grant waivers of age for serious reasons (Code of the Congolese Family, Art. 128).

### Trends in legal, policy and institutional reform

**Constitutional provisions:** None of the states in the region have provisions in their Constitution regarding harmful practices or child marriage. All states, however, have provisions that may be utilized to address harmful practices. These focus on the principles of non-discrimination and equality before the law, torture, inhuman and degrading treatment, the obligation of the state to protect women, youth and families, the right to liberty and security of the person, the right to physical integrity.

Most constitutions provide for the right to culture, cultural patrimony, respect of cultural identity, traditional values, religion and belief, and the need to protect national culture (Burundi, Cameroon, Congo Republic, Gabon, Rwanda) or recognise customary law or authority (Chad, DRC). Although constitutions do not explicitly ban harmful practices or FGM, they allow cultural, religious and customary practices *within the boundaries of the law*. They prohibit practices leading to personal harm and manipulation, the strengthening of inequality (Chad) and threats to national security, public order or morality (Congo Republic, DRC). Also, customary legal frameworks need to be verified against the Constitution (Chad) or should not be inconsistent with the Constitution or violate human rights (Rwanda). Only Angola has a provision specifically relating to women's rights in that it prohibits customs that are contrary to the rights of women.

**Statutory law and policy responses on child marriage:** The majority of countries in the region have adopted **18 years as the legal age of marriage**; some differentiate between girls and boys, with girls able to marry at a younger age (18) than boys (21) (e.g. Congo Republic and Rwanda). At least five states (Angola, Cameroon, CAR, Congo and São Tomé and Príncipe) allow girls to be married before 18 if their parents or judicial bodies give their consent. The CAR family code has an additional provision that marriage at age 13 is allowed if the girl is pregnant.

The penal codes of most countries have provisions on early, child or forced marriages. The Penal Code of Gabon, for example, penalises customary early marriage and forced marriage of girls under the age of 15 without their consent. Not all forms of forced marriage are prohibited. For example, the Penal Code of Congo Republic allows marriage between abductors and abducted minors under age 18 in the case of bride kidnapping. Abduction must have been free of violence and fraud and marriage can only be prosecuted after annulment by qualified people.

The strengthening of **civil registration systems** is a crucial strategy to prevent child marriage. Most countries in the region have recently strengthened their legal and policy frameworks for systematic birth registration. Countries like São Tomé and Príncipe (2009), Chad (2013), Angola (2015), CAR (2016), DRC (2016) and Rwanda (2016) have introduced specific birth registration acts or strategies. Most countries have penalties in the case of failure to register, or for late registration, such as Burundi.<sup>lviv</sup> Proof of age or the presentation of a birth certificate is required for marriage registration in most countries, and its absence penalised in some (e.g. DRC). It is expected that such birth certificates will provide legal protection against child marriage.

Cameroon, Chad, DRC, Equatorial Guinea and Gabon have launched **national campaigns to end child marriage, of which all, except** those of Equatorial Guinea and Gabon, are part of and in line with the AU Campaign to End Child Marriage. Cameroon and DRC have launched the AU campaign, with Cameroon also establishing a coordination mechanism. Chad has taken most measures towards implementation of the campaign, by establishing a coordination mechanism and a national plan and initiating implementing activities. In Chad, the campaign is combined with strategies to fight FGM. In CAR, forced and early marriage has been on the government's agenda in the context of harmful practices performed by, or ordered by, armed forces.<sup>lvv</sup>

67 The Family Code provides the possibility of pre-marriage (engagement) that includes cohabitation before official marriage.

68 Loi 10 Janvier 2009 Portant Protection de l'Enfant (Art. 49).

69 The Family Code 2016 stipulates that mandated representatives can give consent after approval by a judge (Art. 351) and that marriage can only take place after payment of the brideprice.

70 The Family Code 2016 stipulates that 'La célébration du mariage en famille se déroule conformément aux coutumes des parties, pour autant que ces coutumes soient conformes à la loi, à l'ordre public et aux bonnes mœurs'.

71 [www.girlsnotbrides.org/african-union-extends-campaign-to-end-child-marriage-until-2017/](http://www.girlsnotbrides.org/african-union-extends-campaign-to-end-child-marriage-until-2017/)

72 Code on Child Protection 2009, Art. 153.

73 Art. 22(2) of the Constitution states that the state protects all types of marriage celebrated according to law. The 'law' is not further defined. There is a law on customary marriages but it does not refer to age of marriage; this is supposed to be under review.

74 The campaign is mentioned in the 'Report on the Status of Child Marriage in Africa and the Evaluation of the AU Campaign to End Child Marriage' (Department for Social Affairs, AUC. 2016).

75 Art. 23(1) of the Constitution provides for the protection of people from their conception onwards and promotion by the state of the normal development of youth and the protection of their moral, mental and physical integrity, as well as his life within the home.

76 Arts 1(16) and 1(17) of the Constitution have provisions that state that *all* children have the right to physical and moral development and that youth should be protected from exploitation and moral, intellectual and physical neglect.

77 21 years of age. A woman may enter into a marriage between 18 and 20 years with the permission of, among others, the Minister of Justice.

78 In specific circumstances, family law allows girls under 14 and boys under 16 to marry. The law does not explicitly mention consent but demands that this be a free and voluntary decision.

79 There is no specific information on other types of marriages.

80 In 2016 a National Policy on Child Protection was approved but nothing specific on early marriage.

**Statutory law and policy frameworks on FGM:** Most countries, except for Burundi, Rwanda and São Tomé and Príncipe, have **legislation prohibiting FGM**. Gabon has enacted a specific law prohibiting FGM and has an additional reproductive health act that prohibits the practice. Chad has a reproductive health act that prohibits any cruel, inhuman or degrading treatment of the body, in particular of reproductive organs. CAR has a violence against women act that includes an article prohibiting FGM. Penal codes in Cameroon, CAR, Chad and Gabon strengthen such provisions by prohibiting FGM. Some penal codes have broader provisions: Congo Republic addresses violence resulting in mutilation and DRC prohibits 'barbaric practices'. Cameroon also has provisions on **other types of harmful practices** such as witchcraft, breast-ironing and organ enlargement.

CAR and Chad are the two countries in the region with the highest percentage of girls and women aged 15–49 years who have undergone FGM (respectively, 38% and 24%). In Cameroon, the practice is prevalent in some regions. Cameroon and Chad have a national action plan to fight harmful practices including FGM and child marriage and CAR has a national GVAW action plan as well as a national policy on reproductive health that addresses FGM. In Chad, women's rights organisations have organised campaigns against FGM since 1988.

**Institutional reform:** Cameroon, CAR and Chad have established national committees against harmful traditional practices and violence against women and girls. At the subnational level, Cameroon proposes to install local committees to fight FGM. The government collaborates with Muslim leaders to address early and forced marriage and FGM.

Apart from child marriage and FGM, governments and civil society address other harmful practices in their legal and policy frameworks and programmes. An example is the initiative in north-western Cameroon of Interfaith Vision Foundation to address legal pluralism with regard to harmful practices, in particular against widows. The Foundation has supported the set-up of widows' groups and, together with traditional authorities, has introduced a 'charter ending wife inheritance and degrading widowhood', used by different villages to arbitrate cases of violation of widows' rights.<sup>lxvi</sup>

### Key gaps and contestations

A first gap is that none of the states (except for Angola) in the region has explicit **constitutional provisions on harmful practices or FGM**—this is even more than case than in any of the other regions. Also, a lack of provisions to indicate that constitutions or international law prevail over other laws, such as customary law, reduces legal guarantees against harmful practices. Constitutions that stipulate that citizens have the obligation to reinforce cultural values (e.g. Burundi) have the same effect. Only Angola's Constitution explicitly prohibits customs that are contrary to the Constitution and the rights of women.

A second gap is that, although states have increased the minimum age of marriage, most have **one or more exceptions to this minimum age**. As a consequence, even rigorous enforcement of existing laws is unlikely to eliminate child marriage. Also, there is inconsistency in legislation regarding the minimum age of marriage. For example, in Cameroon and Chad, the penal codes have recently been updated to align with international conventions, but the civil codes are outdated and still allow marriage of girls from age 15.

Third, there are some gaps or **inconsistencies in legislation**. For example, Chad, does not have provisions against the medicalization of FGM, creating loopholes that could encourage health professionals to perform the practice.

Fourth, despite the clarity in statutory laws with respect to child marriage and FGM, such as reproductive health acts and penal codes, observers report a **lack of enforcement**. For example, in Chad, the Reproductive Health Act of 2002 is not yet accompanied by an application decree, which means the judiciary and the police cannot use the provisions in the Act. Insufficient budget allocations, inadequate capacity-building efforts and a lack of community programmes to address social norms can hinder the prevention of harmful practices and the acceleration of their abandonment.<sup>lxvii</sup>

### 6.3.4 Southern region

#### Trends, gaps and challenges

With respect to the legal and policy frameworks on child marriage of the countries in Southern Africa, the Revised SADC Protocol on Gender and Development reinforces 18 as the legal age of marriage and provides for the full and free consent of both parties entering a union, with no exceptions (Art. 8.2).

Malawi and Zimbabwe stand out with positive scores on each of the four legal and policy indicators regarding child marriage. Botswana, DRC, Lesotho, Madagascar, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland and Zambia all have a legal age of marriage set at 18, but also all have loopholes, either by allowing for third-party consent or for not applying the minimum age to customary and religious marriages. Comoros lives up to the legal requirements of the Maputo Protocol regarding child marriage but lacks an action or strategic plan. Tanzania has the weakest legal and policy framework, as it scores positively only on the indicator that the legal age of marriage applies to all marriages. Angola's legal and policy framework also does not look strong, with a legal age of marriage below 18, a lack of guarantees on full and free consent and missing data on the other two indicators.

Given that FGM is not commonly practised in most countries in the region, the legal and policy frameworks on this differ from those of other regions. Tanzania is the only country that has both legal provisions and a programmatic response to end FGM. Malawi and Swaziland have relatively stronger profiles, with both constitutional and legal provisions against harmful practices. Angola's Constitution prohibits customs contrary to women's rights. Most other countries lack a constitutional provision but do have statutory law regarding harmful practices. Comoros, Mozambique and Seychelles score negatively on both indicators.

**Table 6.11. Key legal and policy indicators in Southern Africa, Harmful practices**

Country	INDICATORS						
	Legal age at marriage at 18	No exceptions (full and free consent)	Applies to all marriages	Action/ strategic plan/ campaign to end child marriage	Constitutional provision eliminating harmful practices	Legal provisions prohibiting FGM	Programmatic response or action plan to end FGM
Angola	No <sup>81</sup>	No <sup>85</sup>	-	-	No <sup>85</sup>	-	-
Botswana	Yes <sup>82</sup>	No <sup>88</sup>	Yes <sup>89</sup>	-	No	HP	-
Comoros	Yes	Yes	Yes	No	No	No	No
DRC	Yes <sup>90</sup>	No <sup>91</sup>	No <sup>92</sup>	Yes <sup>93</sup>	No	Yes <sup>94</sup>	-
Lesotho	Yes <sup>95</sup>	No <sup>96</sup>	No <sup>97</sup>	Yes <sup>98</sup>	No	HP	-
Madagascar	Yes	No <sup>99</sup>	No <sup>100</sup>	Yes	No	Yes <sup>101</sup>	-
Malawi	Yes	Yes	Yes	Yes	Yes <sup>102</sup>	HP	-
Mauritius	Yes	No <sup>103</sup>	- <sup>104</sup>	-	No	HP	-
Mozambique	Yes	No <sup>105</sup>	-	Yes	No	No	-
Namibia	Yes	No <sup>106</sup>	Yes	-	No <sup>107</sup>	HP	-
Seychelles	Yes	No <sup>108</sup>	-	-	No	No	-
South Africa	Yes	No	Yes	-	No <sup>109</sup>	Yes	-
Swaziland	Yes <sup>110</sup>	No <sup>111</sup>	-	-	Yes <sup>112</sup>	HP	-
Tanzania	No <sup>113</sup>	No <sup>114</sup>	Yes	No	No	Yes	Yes
Zambia	Yes <sup>115</sup>	No <sup>116</sup>	No	Yes	No	Yes	-
Zimbabwe	Yes	Yes <sup>117</sup>	Yes	Yes	No	HP	-

81 The legal age is 16.

82 There are exceptions: boys may marry at 16 and girls at 15 with the permission of a person endowed with authority over them, or where it seems to be in the best interests of the child seeking marriage.

83 Art. 7 prohibits customs that are contrary to the Constitution and the rights of women. The provision says the validity and legal force of custom that does not contradict the Constitution or threaten human dignity shall be recognised.

84 The minimum age of marriage is set at 21.

85 Parental consent can lower the age of marriage for children, allowing them to marry.

86 Chapter 29:01 of the Marriage Act provides that 'No insane person who is incapable of giving consent to a marriage and no person below the age of 18 years may marry.' It also provides that 'No minor or person below the age of 21 years not being a widower or widow may marry without the consent in writing of his or her parents or guardians.'

87 Loi 10 janvier 2009 Portant Protection de l'Enfant (Art. 49).

### Trends in legal, policy and institutional reform

**Constitutional provisions:** Countries in the Southern region have progressed in terms of integrating gender equality and women's rights norms in their legal frameworks. By 2017, 10 countries had reviewed their constitutions to harmonise these with the SADC Protocol on Gender and Development 2016: Angola, DRC, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, Zambia and Zimbabwe.<sup>115</sup> Since 2005, Angola (2010), Botswana (2006), Malawi (2017), Mozambique (2007), Namibia (2014), Seychelles (2011), Swaziland (2006), Zambia (2009) and Zimbabwe (2013) have successively undertaken constitutional amendments with a bearing on gender equality. These amendments include provisions on freedom from forced marriage, prohibition of harmful cultural practices, rights of the (girl) child and women's rights and the age of marriage.

Angola and Swaziland have specific provisions in their Constitutions that prohibit or invalidate customs or practices that violate women's rights or discriminate against women. Swaziland's Constitution states that women have the 'right to refuse to undergo or uphold any customary practice to which her conscience is opposed, and that interpretation of customary law in a manner that is consistent with the constitution'. Angola, Namibia and South Africa have constitutional provisions regarding the recognition of customary law, and note that this cannot contradict the Constitution, or in South Africa's case the Equality Clause.

Botswana, South Africa and Swaziland have amended their constitutions to provide gender equality, non-discrimination, protection of bodily integrity and security of person, as well as protection against inhuman and degrading treatment; such provisions provide a strong basis for advocacy for combating harmful practices.

**Statutory law and policy responses on child marriage:** As a result of intensive efforts at country level, incidence of child marriage has declined in several countries in the Southern region. Legal and constitutional reforms in raising the minimum marriage age for girls and boys to 18 years have contributed to these recent declines. In 14 countries, the minimum age of marriage is now 18 years. In four of these (Botswana, Lesotho, Swaziland and Zambia), the legal age of marriage is actually 21 years. Angola and Tanzania's minimum age is under 18: it is allowed at 16 and 15 years, respectively.

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- 88 The Family Code 2016 stipulates that mandated representatives can give consent after approval by a judge (Art. 351) and that marriage can only take place after payment of the brideprice.
- 89 The Family Code 2016 stipulates that: 'La célébration du mariage en famille se déroule conformément aux coutumes des parties, pour autant que ces coutumes soient conformes à la loi, à l'ordre public et aux bonnes mœurs.'
- 90 [www.girlsnotbrides.org/african-union-extends-campaign-to-end-child-marriage-until-2017/](http://www.girlsnotbrides.org/african-union-extends-campaign-to-end-child-marriage-until-2017/)
- 91 Code on Child Protection 2009, Art. 153.
- 92 The minimum age of marriage is set at 21.
- 93 Parental consent to a marriage where children are below 18 is permitted.
- 94 Under customary practice, the age of marriage is upon attaining puberty.
- 95 Contained in the National Multisectoral Child Protection Strategy 2014/15–18/19.
- 96 There can be an exception if parents obtain a waiver from a local official.
- 97 Under customary marriage, there is no age limit.
- 98 Code of déontologie médicale Art. 39 states that no mutilating intervention can be performed without informing the applicant and without his or her consent.
- 99 The Constitution invalidates customs or practices that discriminate against women.
- 100 With parental consent, minimum age limits can be waived.
- 101 There seems to be only one type of marriage in Mauritius (civil), but this could not be fully established.
- 102 Marriage can occur before attaining the age of 18 with parental consent in exceptional circumstances.
- 103 Consent for persons to marry before attaining 18 years may be granted by a public official.
- 104 The Constitution recognises customary law only to the extent that it does not conflict with the Constitution.
- 105 Marriage can take place before 18 years under grave circumstances when sought by parents.
- 106 The Constitution provides that customary law shall not be applied where it contradicts the Equality Clause.
- 107 Marriage is set at 21 years of age. A woman may enter into a marriage between 18 and 20 years with the permission of, *inter alia*, the minister of justice.
- 108 With parental consent, marriage can take place before the age of 18.
- 109 The Constitution states that a woman has the right to refuse to undergo or uphold any customary practice to which her conscience is opposed, and that interpretation of customary law must be carried out in a manner that is consistent with the Constitution.
- 110 Girls can marry at 15, boys at 18. In July 2016, the Constitutional Court ruled that marriage under the age of 18 was illegal, and stated that Sections 13 and 17 of the Marriage Act were unconstitutional (see also Case study 11 on Tanzania in this chapter on the High Court decision, and the appeal to it).
- 111 Law of Marriage Act 1971: third-party consent is utilised to override minimum age of marriage requirements.
- 112 Marriage is set at 21 years of age.
- 113 Marriage can take place at 16 years if parents give consent.
- 114 A Constitutional Application Judgement determined that, with effect from 20 January 2016, no male or female may enter into any marriage, including an unregistered customary law union or any other union, including one arising out of religion or religious rite, before attaining the age of 18 years.
- 115 This does not refer to Comoros, which joined SADC in 2017.

The positive picture regarding 18 being the minimum age of marriage in most Southern countries is set off by many legal framework loopholes. Full and free consent is guaranteed in only three countries: Comoros, Malawi and Zimbabwe. In all other countries, exemptions are allowed when parents, and in a few cases public officials, give consent for marriage of a girl before the age of 18. Such anomalies are driven by customs and traditions that view girls as marriageable from a very young age. To compound this, in only six countries does the legal age of marriage at 18 apply to all marriages. As a result, in many countries there is space under customary law to marry off girls who attain puberty. Such contradictions between customary and codified law continue to undermine women's enjoyment of their rights. This is critical because countries practise legal pluralism, with statutory law alongside or co-existing with customary, and in some instances religious, laws. In four countries, it could not be established whether the legal age of marriage applied to customary and religious marriages or not.

The SADC model law, while non-binding, is a positive development, particularly given that it was a consensus initiative aimed at distilling best practices and positive standards across the region. Its emphasis on a minimum age of 18 for marriage age is laudable, and already countries like Zimbabwe and Malawi have moved to undertake the necessary legal and constitutional reforms to comply with this. Civil society actors are using this model law to lobby governments to adopt its standards (see also Case study 9 in this chapter).

Gains are being made in addressing child marriages in Malawi and momentum is gathering in South Africa, Zambia and Zimbabwe. The SADC Gender Protocol is accredited with having 'triggered a revolution with court judgments in the region in favour of women and children in the area of marriage and family laws'.<sup>lxviii</sup> In Zimbabwe, the Constitutional Court has declared all forms of marriage of girls below 18 years unconstitutional, as well as laws that allow for underage marriages. Malawi has followed by raising the age of marriage to a minimum of 18 years, and other countries in the region are being lobbied to follow suit. However, these changes are taking place after long drawn-out legal battles or prolonged periods of vigorous lobbying and debate, often challenged by a strong backlash from conservative forces.

Lesotho, Malawi, Mozambique and Zambia have initiated campaigns to end child marriage. Countries that have launched campaigns as part of and in line with the AU Campaign to End Child Marriage include DRC, Madagascar and Zimbabwe. DRC has only launched the campaign, whereas Madagascar and Zimbabwe have progressed towards implementation.<sup>lxix</sup>

**Statutory law and policy responses on harmful practices:** As FGM is not commonly practised in the Southern region, except for among migrant groups in some countries, the indicators regarding legal provisions prohibiting FGM and a programmatic response to the same effect may not be most relevant here. Child as well as forced marriage, including marriage by abduction, is, however, a prominent harmful practice in the region. Other harmful practices identified in the region include accusations of witchcraft against old women, widowhood rituals (including widow inheritance and widow cleansing through sexual assaults), dry sex, abduction, claims for dowry refunds, property dispossession and virginity testing. Son preference and taboos around sexual and reproductive rights are still a powerful tradition, resulting in neglect, deprivation and discriminatory treatment of girls to the detriment of their physical and mental health, and can include prohibition of contraceptive use.

In Southern Africa, harmful cultural practices are based on stereotypes of the inferior status of women. Such patterns of discrimination reinforce practices that drive women into situations that compromise their autonomy and bodily integrity, often under coercive, dangerous and violent circumstances. These cultural practices, which exist in different forms, 'wear down the physical and psychological health and integrity of individuals, especially women and girls'.<sup>lxx</sup> Many of them cause extreme forms of physical and psychosocial pain and others subject women and girls to inhuman and degrading treatment that exposes them to HIV and AIDS. The SADC Gender Protocol refers to the various forms of harmful practices in the region, albeit about the girl and boy child.

As mentioned above, two countries have constitutional provisions regarding the elimination of harmful practices. Five have legal provisions in statutory law that are specific about the prohibition of FGM: DRC, Madagascar, South Africa, Tanzania and Zambia. Of those five, Tanzania is the only country that also has a programmatic response to end FGM. Seven countries have provisions in statutory law on harmful practices: Botswana, Lesotho, Malawi, Mauritius, Namibia, Swaziland and Zimbabwe, often reflected in laws on the rights of the child or on sexual violence. Comoros, Mozambique and Seychelles lack any constitutional or legal provision regarding harmful practices.

The role of traditional authorities in averting harmful practices such as child marriage is critical, as traditional authority structures are well established in the majority of the countries in the Southern region. Champions in key leadership institutions in countries like Malawi and Zambia have integrated human rights standards within their spheres of influence and become essential drivers of change in combating harmful traditional practices. In Zimbabwe, a constitutional amendment requires traditional leaders to comply with the Constitution (Art. 6), which harbours well for integrating human rights with cultural norms.

More countries are addressing the structural causes of harmful practices and looking at the role of culture and tradition *vis-à-vis* their human rights obligations under various international and regional women's rights frameworks. The Law Commission of Zimbabwe and the National Gender Machinery are working to harmonise customary laws to ensure conformity with constitutional standards in order to eliminate contradictions that may create ambiguity in the application of the law.<sup>lxxi</sup>

The South African Law Reform Commission in 2014 undertook a study on the appropriateness of the laws on *ukuthwala* (a tradition that allows a man to abduct a woman he wishes to marry, even if he has not proposed love) and the impact on the girl child.<sup>lxixii</sup> This stated that, as a customary practice, *ukuthwala* is tantamount to forced marriage, child marriage and violence against women and young girls, and constitutes a gross violation of the rights of women and girl children that can in no way be justified. The Commission concluded that constitutional recognition of cultural diversity should not be used as an excuse for or to sanction the violation of the rights and liberties of women and children. Later on, the Commission annexed to the report a Draft Prohibition Of Forced Marriages and Child Marriages Bill.<sup>lxixiii</sup> Pronouncements from critical institutions endowed with reformative mandates have the propensity to eventually transform the *status quo* of harmful cultural practices.

### Key gaps and contestations

The key gaps in the legal and policy frameworks relate to **exemptions to the legal age** of marriage, when parents can provide consent for marriage before the age of 18, and **customary and religious marriages** not falling under the minimum age of marriage. With respect to **harmful practices**, the majority of the countries have legal provisions regarding their elimination, but three do not.

One key contestation is that, while half of the states in the Southern region have either a constitutional or a statutory law provision on harmful practices or FGM, almost all constitutions provide for the **right to practise one's own culture**. Harmful practices are contentious in that, while some view them as human rights violations, others claim them as cherished cultural norms and rituals. Even where laws are in place, they may not be adhered to by all women and men in communities or religious and cultural institutions. In the area of personal status law, these contradictions and contestations often do not resolve themselves in favour of women's rights, particularly with regard to marriage, divorce and inheritance rights, property rights, SRHR and parental rights.

### 6.3.5 Northern region

#### Trends, gaps and challenges

The legal and policy frameworks with respect to child marriage and FGM seem relatively weak in the Northern region. With respect to child marriage, all countries have a legal age of marriage of 18, but four countries (Egypt, Mauritania, Morocco and Tunisia) do not guarantee full and free consent. For the other two (Algeria and Libya), full and free consent is guaranteed in the law but it is not clear whether this applies to all marriages. The latter point is actually not clear for five of the six countries.

Regarding FGM, none of the countries in the Northern region has a constitutional provision to eliminate harmful practices. Three countries also lack legal provisions and a programmatic response on FGM; for Tunisia this data is missing. Only Egypt and Mauritania have a legal ban on FGM and also have a programmatic response to end the practice.

**Table 6.12. Key legal and policy indicators in Northern Africa, Harmful practices**

Country	Indicators						
	Legal age at marriage at 18	No exceptions (full and free consent)	Applies to all marriages	Action/ strategic plan/ campaign to end child marriage	Constitutional provision eliminating harmful practices	Legal provisions prohibiting FGM	Programmatic response or action plan to end FGM
Algeria	Yes <sup>119</sup>	Yes <sup>120</sup>	-	-	No	No	No
Libya	Yes <sup>121</sup>	Yes <sup>122</sup>	-	-	No	No	No
Egypt	Yes	No <sup>123</sup>	-	Yes	No	Yes	Yes
Tunisia	Yes	No <sup>124</sup>	-	-	No	-	-
Mauritania	Yes	No <sup>125</sup>	-	Yes	No	Yes <sup>126</sup>	Yes
Morocco	Yes <sup>127</sup>	No <sup>128</sup>	Yes <sup>129</sup>	-	No	No	No
Western Sahara	-	-	-	Yes	-	-	-

<sup>116</sup> The age of marriage is 18 for females, 21 for males.

<sup>117</sup> Courts have the discretion to lower the age of marriage. There are exceptions: boys may marry at 16 and girls at 15 with the permission of a person endowed with authority over them, or where it seems to be in the best interests of the child seeking marriage.

<sup>118</sup> Art. 6 of Act No. 10 of 1984, regulating marriage and divorce and their consequences, sets eligibility for marriage at 20 years.

<sup>119</sup> This allows for judicial discretion whereby a court may, with the consent of the guardian, authorise marriage before attainment of majority age.

<sup>120</sup> Various limitations: the Civil Code limits the ability of a woman to enter into a marriage, requiring that she has the consent of a male guardian. An inter-faith marriage between a Muslim woman and a non-Muslim man is also restricted. 'Le chef de l'Etat a le droit d'autoriser pour motif grave un mariage avant l'âge de puberté légale' (Code Civil Art. 52, ordonnance 29).

<sup>121</sup> While Tunisia's Personal Status Code sets equal marriage conditions for both men and women, a 1973 administrative directive forbids the registration of a marriage of a Muslim woman to a non-Muslim man. It includes no such restriction on Muslim men.

<sup>122</sup> The legal guardian of a girl under the age of 18 years can request local authorities allow the marriage to take place.

<sup>123</sup> A bill was approved by the Council of Ministers in 2016 that stipulates that the right to reproductive health is a universal right guaranteed to all throughout the course of their lives. It also prohibits all forms of violence against women, including FGM. No information is available on whether the bill has passed into law.

<sup>124</sup> The Moroccan Family Code 'Moudawana' raised the legal age of marriage to 18 years for both girls and boys in 2004; it was previously set at 15 for girls.

<sup>125</sup> Article 20 of the Family Code 'Moudawana' stipulates that 'The Family Affairs Judge in charge of marriage may authorize the marriage of a girl or boy below the legal age of marriage as stipulated in preceding Article 19, in a well-substantiated decision explaining the interest and reasons justifying the marriage, after having heard the parents of the minor who has not yet reached the age of capacity or his/her legal tutor, with the assistance of medical expertise or after having conducted a social enquiry.'

<sup>126</sup> If a judge has refused to authorise an underage marriage, the parents organise a traditional marriage ceremony, which consist of reading the 'Fatiha'—a verse of the Quran. Art. 22(2) of the Constitution avers that the state protects all types of marriage celebrated according to law. The 'law' is not further defined. There is a law on customary marriages but this does not refer to the age of marriage. This is supposed to be under review.

### Trends in legal, policy and institutional reform

**Constitutional provisions:** All of the states in the Northern region have constitutional provisions, which are considered essential in protecting women and girls from harmful practices. While none of the states reviewed has a constitutional provision eliminating harmful practices, most expressly proscribe violence. Algeria prohibits all forms of physical or psychological violence or indignity and Egypt guarantees the equality of women in all spheres and the protection of women from all forms of violence. Children (girls) are also protected from violence and sexual exploitation. Egypt additionally prohibits trafficking within its Constitution. Tunisia's Constitution also includes a commitment to eradicate GVAW. Morocco's Constitution prohibits incitement to violence. All the states reviewed also have provisions on equality and non-discrimination on the basis of sex or gender, which also provides a key foundation for women's protection from harmful practices.

**Statutory law and policy responses on child marriage:** All the states reviewed have laws that outline the age of marriage as 18. In four states reviewed, free and full consent to enter into marriage is burdened with several exceptions, with the most common being the consent of male guardians or parents playing a significant role. Three countries have initiated a programmatic response to child marriage: Egypt, Mauritania and Western Sahara. None of the countries has launched a campaign as part of or in line with the AU Campaign to End Child marriage.<sup>lxiv</sup>

In 2004, Morocco adopted a new Family Code ('Moudawana'), which grants women considerable rights that did not exist in the previous Islamic-based family law. The reform of the Family Code gives women the right to divorce and also sets the minimum age of marriage for girls at 18 years (it had been 15). However, Art. 20 stipulates that a judge can authorise an underage marriage.<sup>127</sup> Even if a judge denies authorisation for an underage marriage, the parents can organise a traditional marriage ceremony, which consists of reading the 'Fatiha', a verse of the Quran, so the marriage can take place.<sup>lxv</sup>

Morocco has also revised its Penal Code, in particular the contentious Art. 475(2), which allowed rapists to marry their victims to escape criminal charges.<sup>128</sup> This revision took place after protest sparked throughout the country in 2012, when a 16-year-old girl committed suicide after being forced to marry her rapist. Tunisia, in its newly passed law on GVAW, has also removed a controversial article that allowed rapists to escape punishment through marrying the victim. This provision had previously resulted in instances of child marriage sanctioned by law.

**Statutory law and policy responses on FGM:** Of the states reviewed, FGM is criminalised in Egypt and Mauritania. FGM is not a common practice in Morocco and Tunisia and this could explain the lack of laws and measures in this regard. Only Egypt and Mauritania seem to have programmatic responses with respect to FGM.

In Mauritania, the 2016–20 National Strategy on Reproductive Health sets FGM as a 'public health concern'.<sup>lxvi</sup> Furthermore, the government has put the eradication of FGM in the country's Strategy on Accelerated Growth and Prosperity 2016–30.<sup>lxvii</sup> The Government of Mauritania in partnership with CSOs and religious leaders has been advocating for the abandonment of FGM in hospitals and for educating health professionals on its damaging effect. Furthermore, the country has been raising awareness through the media and information campaigns. In 2010, the Iman of Nouakchott issued a *fatwa* (religious decree) against the practice of FGM and called for its total abandonment.<sup>lxviii</sup>

<sup>127</sup> Art. 20 stipulates 'The Family Affairs Judge in charge of marriage may authorize the marriage of a girl or boy below the legal age of marriage as stipulated in preceding Article 19, in a well-substantiated decision explaining the interest and reasons justifying the marriage, after having heard the parents of the minor who has not yet reached the age of capacity or his/her legal tutor, with the assistance of medical expertise or after having conducted a social enquiry.'

<sup>128</sup> The controversial article stated that 'When a marriageable minor thus removed or divorced has married his kidnapper, he can only be prosecuted on the complaint of the persons having the right to request the annulment of the marriage and cannot be condemned until after this marriage annulment has been pronounced.'

## Key gaps and contestations

In most countries in the Middle East and North Africa, some cultural and religious practices embedded in the law are discriminatory to women. This leads to **inequality in marriage and inheritance rights based on cultural values**. In some instances, women and girls are subjected to virginity tests, which are conducted by a doctor at the request of the woman's family, prior to marriage, and may result in vaginal reconstruction if deemed necessary.<sup>lxxxix</sup> In Libya, in some instances virginity tests are utilised in court cases.<sup>lxxx</sup> On inheritance, in Algeria succession laws are based on Sharia; women do not inherit equally on the same basis as men.<sup>129</sup> Similarly, in Tunisia, where there are any sons, the males inherit twice as much as the females. In most countries in the region, women's right to divorce is restricted as a result of cultural and religious norms (see also Chapter 5, Northern region).

These inequalities in marriage and inheritance laws also relate to marriage provisions directly relevant to child marriage. Loopholes exist that undermine the full and free consent of women and girls in marriage. In Mauritania, the legal age of marriage is set at 18 for girls; however, a marriage can take place if the guardian requests this from the local authorities. In Egypt, where the age of marriage is 18, the law merely prohibits but does not criminalise the practice of child marriage. As a result, child marriage is still frequently practised in the country. Religious and traditional beliefs and customs are reported as stalling the progress of ending child marriage.<sup>lxxxi</sup>

In Algeria, a woman cannot marry without the permission of her **male guardian**; although she cannot be compelled to marry against her wish, the absence of a guardian renders any marriage invalid. In Libya, while forced marriages are forbidden, the practice of male guardianship in areas of a woman's personal status, both *de jure* and *de facto*, prevents women exercising their rights on the same basis as men. In Algeria, Egypt and Tunisia, a Muslim woman is not allowed to marry a non-Muslim man, whereas a Muslim man can marry a non-Muslim woman.

Another critical contestation relates to the **medicalisation of FGM**. Egypt has one of the highest rates of FGM, despite a law prohibiting the practice. Criminalisation of FGM has led to increased medicalisation of the process. In fact, the government inadvertently contributed to the initial trend of medicalisation, as its initial response to FGM in the 1990s was to permit only government medical doctors to perform FGM.<sup>lxxxii</sup>

Another challenge relates to law enforcement. In Mauritania, FGM is widely practised, despite its criminalisation. **Lack of law enforcement** is a key issue in the fight against FGM in Mauritania. To date, religious leaders in Mauritania have issued several *fatwas* against FGM and although these ban FGM, they do not go further in terms of providing 'enforcement and sanctions' against the perpetrators, which means it is a common practice in the country.<sup>lxxxiii</sup> Moreover, women's rights groups have raised issues regarding the Penal Protection Code for Children, claiming that the legislation is not enough to fight FGM, since Art. 12 criminalises FGM only if it 'causes harm'.<sup>lxxxiv</sup>

<sup>129</sup> A daughter is entitled to half of her brother's share, and, where there is no brother, that of the share of male relatives. However, a woman is free to retain or dispose of her property as she wishes.

## 6.4 CASE STUDIES

The last section of this chapter presents seven case studies that document initiatives and strategies towards realising women and girls' rights with respect to child marriage and FGM. The case studies illustrate the wide prevalence of violations of the human rights of girls and young women on these issues, and also highlight the gaps and weaknesses in national legal and policy frameworks. The different case studies also point to the linkages between GVAW, in particular sexual violence and rape, and child marriage. They also highlight the importance of education and of keeping girls in schools, as part of strategies to end child marriage as well as FGM. Schools also come up as sites where girls not only get educated for a future but also are informed and gain awareness on SRHR issues.

The case studies capture a diverse range of strategies to realise women and girls' right and end child marriage and FGM. Two case studies concern initiatives at the regional level. One is the decision of the ACHPR on a complaint about the abduction, rape and forced marriage of a 13-year-old Ethiopian girl. The other presents the instrument of a model law, which SADC has used to facilitate and strengthen legal reform in the Southern region towards eliminating child marriage. Four other cases speak to national-level change processes, many of them involving legal reform on either FGM or child marriage. The cases from Malawi and Tanzania both underline the importance of broad mobilisation and cooperation between varied stakeholders in legal reform. In Malawi, this has included the engagement of traditional leaders and chiefs as well as youth activists in raising awareness and bringing about legal reform. The case study in Tanzania captures the collaborative efforts of a broad network of CSOs, including child rights' activists, and the case they brought to the High Court on discriminatory law with respect to child marriage. Youth champions are also key in Madagascar, where efforts are taken to end child marriage and violence against children, raising awareness in schools, with parents and in communities. The case study on faith-based approaches to ending FGM in West Pokot in Kenya focuses on the subnational and community level, and the role of local churches in raising awareness and triggering social norm change. Traditional and religious leaders are visible as change agents in this case study on West Pokot, the one in Malawi and also the one on FGM in Sierra Leone. The last case illustrates the controversies that surround the banning of FGM, and the different views that different groups may have on the desirability and feasibility of certain strategies to realise women and girls' rights in such highly polarised and politicised debates.

Several insights regarding strategies to realise women and girls' rights and end child marriage and FGM emerge from these seven case studies:

- **Loopholes and weaknesses in national legal frameworks** on child marriage and FGM undermine women and girls' human rights. Such loopholes and weaknesses, often related to plural legal systems and customary law and practices, need to be addressed.
- **Legal reform** comes about in response to different strategies—litigation in either national courts or the regional ACHPR, the utilisation of model law or national-level advocacy campaigns.
- Legal reform is important in itself, and contributes to social norm change. However, shifts in **societal perceptions and attitudes** require more focused effort from a range of actors.
- **Networks and coalitions of CSOs** play a central role in legal as well as social norm change. These include women's organisations and activists, youth champions and leaders and faith-based organisations.
- **Youth champions and leadership** are key in awareness-raising campaigns, in promoting legal reform and as well as empowering girls and boys and young women and men.
- The engagement of **traditional and religious leaders** can be critical to strategies to ending child marriage and FGM. Such leaders can play progressive roles, within communities, in traditional institutions and in relation to policy frameworks and society. In other cases, they may voice conservative perspectives and can resist strategies to realise women and girls' rights.

### Case study 8. Rape, abduction and forced marriage in Ethiopia: a girl pursues justice at the ACHPR

In 2003, a 13-year-old Ethiopian girl was abducted, raped and forced to marry her rapist. After a court sentencing, the abductors were released. Equality Now and the Ethiopian Lawyers Association filed a complaint at the ACHPR, which in 2016 issued a landmark decision on the failure of Ethiopia to fulfil its obligations as a state.

Ethiopia has a high rate of child marriage and is ranked 15th on the African continent in terms of child marriage prevalence. Two in every five Ethiopian girls are married before their eighteenth birthday, and about one in seven girls by the age of fifteen (see also Section 6.1 of this chapter). While child marriage rates have declined, from 60% many years ago to today's 40%, they are still very high. Child marriage is perpetuated by the common practice of marriage by abduction.

In 2002, a 13-year-old girl was abducted by several men, and raped by one of them. She managed to escape and her abductor was arrested, but while out on bail he abducted her again and forced her to sign a marriage certificate while holding her captive for over a month. Her abductors were eventually sentenced to 10 and 8 years of imprisonment, in 2003. Shortly after, however, they were released through an arbitrary appeals process.<sup>lxxxv</sup>

With support from Equality Now and the Ethiopian Women Lawyers Association (EWLA), the girl pursued all available local remedies, to no avail. In 2007, Equality Now and EWLA filed a complaint before the ACHPR against Ethiopia on behalf of the girl. They argued that Ethiopia's failure to punish the perpetrators was a violation of the African Charter on Human and Peoples' Rights. The case itself stalled, for various reasons, but eventually, in 2016, the ACHPR issued a landmark decision in favour of the girl.<sup>lxxxvi</sup> The ACHPR found that the Ethiopian state had failed to protect her and to prevent her abduction, rape and forced marriage, and also failed to ensure effective prosecution. The ACHPR awarded a significant monetary award of \$150,000. Moreover, it called for Ethiopia to undertake various long-term reforms, such as judicial training.

This case was trail-blazing, as one of only two cases filed before the ACHPR dealing exclusively with women and girls' rights. In addition, the case served to solidify the jurisprudence that the state can be held liable for the actions of both state and non-state actors. This accountability standard is vital to enhance the protection of women and girls from violence, harmful practices and other human rights violations that occur predominantly in the private or domestic sphere.

Aside from the case, Equality Now and EWLA's advocacy on the ground also contributed to reforming the law that allowed a rapist to escape criminal charges if he married his victim. The reformed law also introduced more severe penalties for rape. The advocacy conducted before and around the case also drew national as well as international attention, which in turn may have contributed to reducing child marriage rates in Ethiopia.

## Case study 9. SADC adopts model law on child marriage

The SADC model law on child marriage is a regional initiative to facilitate and strengthen legal reform towards its eradication. The model law, among other things, addresses the contradictions in legal frameworks in the region, which are the result of legal pluralism. The drafting and adoption of the SADC model law involved working on the legislative process at regional level and taking inputs from key stakeholders in civil society and the development arena, at both national and regional levels.

Across Africa, 125 million girls and women alive today were married before their 18th birthday. An estimated one in four young women in Southern Africa aged 20–24 years is married or in union before the age of 18 years.<sup>lxxxvii</sup> Child marriages are largely driven by high poverty levels, gender inequity, traditions and religion, and limited educational opportunities for girls.<sup>lxxxviii</sup>

In Southern Africa, while there have been attempts in some countries to reform the legal framework around child marriage, there are still disparate laws around marriage, with some countries setting 18 as the minimum age, while others allow girls as young as 14 to marry. Legal pluralism means some countries provide exceptions to the minimum age of marriage on parental consent or authorisation of the court or other authority. Other countries allow customary or religious laws to dictate lower ages of marriage than that stated in formal or statutory laws.<sup>lxxxix</sup> Under such legal regimes, parents follow the line of least resistance in marrying off children without facing legal sanctions. It is these contradictions that led to regional leaders and stakeholders to consider developing a law that would serve as a guide on how to harmonise legal positions with a view to eradicating child marriage.

On 3 June 2016, the SADC-PF at its 39th Plenary Assembly meeting in Swaziland adopted a Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage. The Plenary Assembly comprises representatives of all the member states' national legislatures and is thus the highest decision-making body. The model law is non-binding in nature. It has great value addition for the region as it tackles the contradictions flowing from legal pluralism that are evident in the various laws across the region.

Efforts to undertake and develop a Model Law commenced in 2014. The 35th SADC-PF Plenary Assembly, held in Mauritius in June 2014, called upon the region to undertake concerted efforts to eradicate child marriages. This led to the SADC-PF, the Association of European Parliamentarians with Africa (AWEPA) and Plan 18+ Zambia Sub-Regional Group convening a Regional Dialogue on Child Marriages in 2015 in Johannesburg, South Africa. The outcome of this dialogue was a Six Step Road Map on the development of a model law with the necessary reference information. It was hoped that, just like with the SADC Model Law on HIV, a Model Law on Child Marriage would serve as a reference document to facilitate countries to develop their own child marriage-related laws. The model law serves as 'a specific, evidence-based document that our Members of Parliament and other stakeholders can use when they advocate for the rights of the region's girls and boys... useful to Parliamentary legal drafters as they draft Acts of Parliament.'<sup>xc</sup>

Thereafter, the SADC-PF mobilised financial and technical resources to develop a SADC Model Law on Child Marriage in June 2015.<sup>xcii</sup> SADC consultations were held at regional and national level with key stakeholders in government, civil society, traditional institutions and human rights commissions as well as those affected by child marriage.<sup>xcii</sup> Organisations like Plan International (Southern Region) undertook advocacy strategies to share the SADC model law draft widely at the national level with parliamentarians, law reform institutions, cabinets, parliaments and traditional leaders, pushing the imperative to adopt and domesticate the law. The Southern African Litigation Centre funded the drafters to convene and to embark on work on the proposed model law.<sup>xciii</sup>

In March 2016, 30 representatives of civil society working to end child marriage in SADC countries reviewed the model law and provided insights into how to make it more responsive to the lived realities of women and girls in the region. The emphasis was on prevention and also mitigation of the effects of child marriage for those already in such unions. The civil society representatives provided concrete recommendations for the SADC-PF to consider. Legal drafters from the SADC member states convened in Johannesburg, South Africa, prior to the 39th session of the Plenary Assembly to address all inconsistencies in the draft model law and ensure its passage by national parliaments.<sup>xciv</sup> They hailed from Malawi, Mauritius, Mozambique, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe and met for five days to review the draft and ensure its conformity with the legal objective of eradicating child marriage.<sup>xcv</sup>

Various partners supported the development of the model law, including civil society actors actively combating child marriage as well as development partners. These included the UN Population Fund (UNFPA) East and Southern Africa Regional Office, the UN Development Programme (UNDP), Plan International's 18+ Ending Child Marriage in Southern Africa Programme, the Southern African Litigation Centre and Girls Not Brides.<sup>xcvi</sup>

## Case study 10. Malawi Ending Child Marriage Campaign: When elders and youth converge around common goals

This case study illustrates the sustained efforts by different sections of society, as well as the many steps involved, in bringing about and realising legal reforms that are critical to ending child marriage. Malawian youth activists advocated for the engagement of traditional and religious leaders, and also collected signatures to demand legal reform. The Malawian experience also highlights the key role of traditional institutions and individual traditional leaders in challenging and ending harmful practices, despite resistance from parents and even peer traditional leaders. These combined efforts point to the transformative power inherent in intergenerational and diverse but united collaboration by civil society, affected populations of young girls and boys and traditional authorities to reform laws and counter harmful social norms.

Malawi has one of the highest rates of child marriage in Africa and globally. According to the UNICEF database 2005–13, 12% of girls are married before the age of 15 and 50% before they are 18. Early marriage in Malawi has resulted in girls suffering from attendant problems of early pregnancy, high maternal mortality rates, violence, high school dropout and poverty.

In 2015, Malawi passed the Marriage, Divorce and Family Relations Act, raising the minimum age of marriage from 15 to 18 years for all forms of marital union: statutory, customary, religious and marriage by repute or permanent cohabitation. The passage of this law was an important milestone, but it was not in conformity with the Constitution, which contained a legal loophole that allowed children between 15 and 18 years to marry with parental consent. Further, the Constitution set the age of a child at 16 and the Penal Code Amendment Act (2011) set the age of sexual consent at 16. As such, there remained a legal conundrum with regard to age.

This led to several sustained lobbying and advocacy efforts to pressure the government into harmonising the Constitution to conform to Malawi's commitments under CEDAW, the UNCRC and the SADC Protocol on Gender and Development. Two unconventional campaign strategies from the not-so-usual quarters stand out in this regard.

Traditional authorities in Malawi are customary institutions that wield considerable influence in terms of personal status law, given that they are the vanguards of culture, tradition and values. In customary marriages, chiefs have influence: they can approve or annul a marriage under the various customary practices. Traditionally, customary institutions are seen as gatekeepers of conservative societal forces and practices rather than as allies in the human rights movement. In fact, with this in mind, Malawi's Stop Child Marriage campaign in 2011, led by Genet and Let Girls Lead, had trained around 200 girls in Chiradzulo district of southern Malawi to lobby 60 village chiefs to ratify and enact by-laws to stop early marriage and harmful sexual initiation practices.<sup>xvii</sup>

Thus it was significant in 2013 when the senior and paramount chiefs in Malawi, as considerable opinion leaders, adopted a declaration calling for the age of marriage to be set at 18 years. Chiefs had been noting with concern the negative effects of early or forced child marriage on girls' development. A number of progressive chiefs decided to take proactive sanctions against the practice, to discourage parents who, in circumstances of poverty or hardship, wanted to marry off their girls as a means of sustenance. In the words of one chief, 'What we do is that if a girl is married before 18 the parents on both sides pay a fine of a goat. We are encouraging the parents to send the girls back to school and we are developing bye laws at traditional authority level.'

In an encouraging move, many other chiefs have passed by-laws and are moving to sanction village heads who promote or in any way endorse child marriages and related rituals. Chief (Inkosi) Theresa Kachindamoto has been labelled 'The Terminator' by Al Jazeera for annulling 850 child marriages in three years and has banned the sexual initiation of girls, which is a necessary precursor to child marriage under customary law. She has striven to ensure that the children from these marriages are returned to school, as well as sanctioning village heads who allow customary child marriages to take place. It is reported that, to date, she has terminated a total of 2,549 child marriages. With other traditional leaders, she has also developed a model by-law for her region, aligned with national law, that seeks to outlaw all child marriages, harmful cultural practices and gender-related abuse.

According to UNICEF Malawi, she has accomplished this by engaging strategically with groups of mothers, peer educators, members of village development committees, faith-based leaders and NGOs, and has even set out to convince the couples themselves in a door-to-door campaign.<sup>xviii</sup> In the face of resistance from community members, she convinced 50 sub-chiefs to sign on to abolishing customary marriages involving children and to annul any such marriages within her jurisdiction, dismissing those who did not comply after agreeing to the measures.

Chief Kachindamoto recalls how seeing 14-year-old girls who already had two children compelled her into action. Today, besides annulling marriages, she spends time speaking with girls about their rights and future, and persuades their parents to be supportive. 'I try to convince them that if you educate your girl you will have everything in the future,' she said.<sup>xix</sup>

Malawian youth were not slack to advocate for their rights to have a childhood and not be married off prematurely. Youth-driven campaigns to end child marriage under the banner *Youth Engagements Advocates* were undertaken in partnership with Plan International Malawi. Memory Banda, a key 20-year-old figure in the youth-led campaign, was driven by the personal experience of her sister's suffering as a child wife at the age of 11 to engage government authorities on the issue. In September 2016, youth campaigners at a National Girls' Conference presented the first lady of Malawi with over 42,000 signatures from more than 30 countries worldwide,<sup>6</sup> seeking to address the issue of the constitutional loophole. Youth groups from all over the country presented similar petitions to the Ministry of Justice and Constitutional Affairs and the Ministry of Gender, Children and Social Welfare, as well as meeting with the paramount chiefs. In February 2017, Malawi amended its Constitution to remove the loophole allowing parental consent for children under 18 to marry, thus aligning it with the Marriage, Divorce and Family Relations Act.

## Case study 11. Ending child marriage in Tanzania

**The Tanzania Ending Child Marriage Network is a coalition of 35 CSOs that employs a range of strategies to end child marriage. One of the network's members undertook a court case to challenge the country's highly problematic legal provisions on the legal age of marriage for girls. The High Court of Tanzania ruled that the law should be reformed.**

Child marriage prevalence is high in Tanzania: almost two out of five girls in Tanzania are married before their 18th birthday.<sup>4</sup> On account of this, women and children rights advocates in Tanzania came together to work towards ending child marriage in the country. They formed the Tanzania Ending Child Marriage Network (TECMN), a coalition of 35 CSOs, launched on International Day of the Girl Child on 11 October 2012.

The coalition employs various strategies towards ending child marriage in Tanzania. First, it works on increasing awareness of the harmful impact of child marriage at the community, national and international levels. Second, it advocates for policy reforms; this has included litigation initiatives, as discussed below. Third, it undertakes resource mobilisation to support married girls and those who are at risk. Finally, it works towards strengthening learning and coordination between organisations working to end child marriage in Tanzania. This is critical to ensure the response to child marriage is effective and to eliminate duplication of efforts, usually rife among CSOs.

One of the critical challenges facing the effort is that the law (the Law of Marriage Act 1971) sets the marriage age for girls at 15 with parental consent and even 14 with court consent, while that for boys is set at 18. The law therefore expressly sanctions child marriage in contravention of various international and regional laws and standards to which Tanzania has acceded. On account of this, one member of the coalition, Msichana Initiative, an organisation that advocates for the rights of women and girls, undertook to challenge the impugned provisions of the law in Tanzania's courts. In a landmark decision, the High Court of Tanzania ruled in July 2016 that the Law of Marriage Act must be revised to eliminate inequality in the minimum age for marriage for boys and girls. The High Court directed the government to update its laws within a year. However, an appeal has since been filed, halting application of the decision as of the current time.

The potential impact of this decision is momentous, as prohibition of a harmful practice is a critical first step towards its eradication. Legal sanction of a harmful practice impedes advocacy efforts, as it influences societal perceptions, which are key in determining practice. Another noteworthy impact comes by way of the development of jurisprudence. The High Court, convinced by the petitioners' arguments, noted that Tanzania's law on child marriage was not in harmony with its obligations under the Maputo Protocol as well as the ACRWC. Two lessons can be drawn from this. The first is that lawyers have a duty to canvass their arguments, relying on the rich normative framework of human rights that exists beyond their borders. Second, judges and magistrates should similarly hold states to account on the basis of their existing obligations, which range from constitutional guarantees to international agreements that they have acceded to, such as the Maputo Protocol.

This illustration from Tanzania presents to women's rights advocates valuable lessons on the value of coalescing around major rights issues, such as through the use of coalitions. Also important is the lesson that pertinent rights contestations and obstacles should be tackled through legal means while at the same time maintaining strong advocacy strategies.

## Case study 12. Youth leadership in ending child marriage and violence against children in Madagascar

This case study looks at the work of the Young Women's Christian Association, in partnership with the national government in Madagascar and other stakeholders, to end child marriage and stop violence against children and girls. Youth champions play a key role in the awareness campaign in schools.

Madagascar launched its AU campaign to end child marriage in 2015. Child marriage is one of the major problems facing children, and its prevalence in the country is over 40%; this rate is higher in the south and south-west regions, where more than six out of ten girls enter into a union before reaching 18. Madagascar is committed to achieving the SDGs; ending child marriage is key to this.

In 2007, Madagascar adopted a law on the Rights and Protection of Children (Law No. 2007-023), whose Art. 1 provides for the protection of children from any form of abuse. In the same year, a law on Marriage and Matrimonial Regimes (Law No. 2007-022) was adopted, which sets the age of marriage at 18 for both sexes. However, marriages at a younger age are possible with authorisation from the Tribunal and if there are serious reasons. In 2014, another important law was adopted, on Combatting Trafficking in Human Beings; this repeals, amends and supplements earlier law.

Since 2017, a National Strategy for the Fight against Child of Marriage has been in place. This aligns with the priorities of the National Development Plan and is linked to SDG 3 (on good health and well-being for all, at all ages) and SDG 5 (achieving gender equality and empowering all women and girls). The strategy envisages Madagascar as a country where families and communities adopt lasting behaviour that repels the union/marriage of children. It seeks to reduce the prevalence of child marriage from 41.2% to 21.2% during the period 2018–24. The strategy has been developed over a long period of time, and with close consultation between the Ministry of Population, Social Protection and Promotion of Women, key sector ministries, technical and financial partners, civil society and UNICEF. Children themselves have been consulted in this process, during field trips and through surveys, and their recommendations are taken into account.

The National Strategy for the Fight against Child Marriage will strengthen several initiatives already in place, such as the Minimum Support Service Package for child victims of violence and exploitation. It also will continue to support the Child Protection Network, with different actors at national and subnational levels collaborating and coordinating their complementary work for a common goal: protection of the child. The strategy also strengthens 'vonjy centres', which offer free medical and psychosocial care as well as legal support to girl and boy victims of sexual violence.

The Young Women's Christian Association (YWCA) Madagascar is one of the few CSOs that has participated in the strategy and is involved in its implementation. YWCA has developed communication tools on child marriage to be used in the strategy and its engagement is closely linked to its *Stop Marriage of Children – Stop Violence* project, launched in 2015. This is a preventive awareness-raising and training campaign to save future generations from child marriage. The campaign encourages girls in primary schools, aged nine and over, to stay in school as long as possible and continue their studies. Education can function as a means of preventing child marriage, because the mere fact that a girl goes to school can reinforce the idea that she is still a child and not a woman or a wife. The awareness and training focus on the nature, causes and harmful effects of child marriage as well as other harmful practices and GVAW, and on access to SRH services and sex education. It also seeks to ease barriers to school attendance. The campaign focuses primarily on girls in schools, and also uses communication materials such as posters, banners and brochures.

Parents are also an important audience for the campaign, and they are sensitised on child marriage and supported to end the early marriage of girls. The campaign seeks to mobilise families and parents to become agents of change and take part in efforts to end child marriage. In addition, the campaign hopes to establish relations with traditional leaders and religious authorities. It plans to bring together mayors, community organisations, traditional authorities and religious leaders to make them aware of the legal provisions that set the age of marriage at 18. It also seeks to sensitise them to the harmful consequences of child marriage and to stimulate a change in behaviour.

Working in schools is a key element of the *Stop Marriage of Children – Stop Violence* campaign. SRH has been taught for a long time in Madagascar schools, in a way that is adapted to different age groups. The government works with UNFPA to advance access to SRH services. YWCA's engagement in this field focuses on SRHR as enshrined in the Maputo Protocol. Its work seeks to address the linkages between child marriage and GVAW. Very recently, YWCA entered into a partnership agreement with the Ministry of National Education. This partnership will be highly important in the campaign's work in schools and will enable YWCA to integrate its awareness-raising on child marriage and SRHR in the school curriculum, covering the entire country.

### Case study 13. Sierra Leone: mobilising chiefs and religious leaders to address FGM

Sierra Leone has ratified the Maputo Protocol, which prohibits FGM, but has not adopted a law to ban the practice. The country has a highly controversial provision that outlaws FGM before the age of 18 but after that requires consent of the girl or woman to be cut. The case study points to the strong controversies around FGM in Sierra Leone, and highlights the tough choices that anti-FGM activists make on what strategies to follow to promote change in a highly polarised society. It also illustrates the importance of social norm change and working with traditional leaders in order to change perceptions towards FGM. Anti-FGM campaigners are divided on whether an under-18 ban will have any lasting impact in terms of total abandonment of the practice, and do not see this as a desirable strategy to be followed elsewhere.

Sierra Leone is one of the countries in Africa where FGM is widely practised: almost nine in ten women between the ages of 15 and 49 have undergone the cut. Sierra Leone is also one of the few countries in West Africa that does not have a law prohibiting the practice, despite the fact that the country has ratified the Maputo Protocol, which prohibits all forms of FGM.

In Sierra Leone, FGM is carried out by the 'Bondo' secret society, also known as 'Sande', as part of the rites of passage for girls from childhood into womanhood. The Bondo is an exclusive women's secret society in Côte d'Ivoire, Guinea, Liberia and Sierra Leone, led by the Soweï, which is the name of the women leaders who are the guardians of the society. Girls are taken into the bushes for the rite of passage, where they are taught how to be a good wife, how to cook, how to take care of the house and how to respect the family in-laws.

FGM is a requirement for anyone who wants to be member of the Bondo. The Bondo is a powerful entity and an important part of Sierra Leonean society, and leaders are seen as the guardians of culture and tradition and respected by the community. They promote the well-being of the members of the society and serve as a platform for the social and political interests of women. One of their key roles is to advance and encourage solidarity between the Bondo and the 'Poro' (a secret society for men).

There is no law in Sierra Leone prohibiting FGM, and the practice is widely condoned and even supported by politicians and community members. Anti-FGM campaigners have faced many challenges over the years when trying to push the government to outlaw the practice. This is mainly because of the power of the Bondo over the community and politicians' fear of losing in elections if they are seen as supporters of a ban on FGM. Some politicians actually sponsor FGM initiation ceremonies in exchange for votes.<sup>cii</sup>

The debate around the ban of FGM is a very heated in Sierra Leone, which has put anti-FGM campaigners' lives and careers in danger over the years. The Bondo has argued for the continuation of FGM by claiming the right to defend their cultural practice, which has been around for decades. The debate has divided the country into those opposed to the abandonment of FGM and those opposed to its practice, on the basis that it violates the human rights of women and girls.

In 2007, a provision for FGM ban was removed from the Child Rights Act for fear of upsetting the traditional leaders in the country. The final law means does not outlaw FGM, but it introduced a clause on 'age of consent' to discourage parents from initiating girls under 18, indicating that girls should be at the age of consent for the initiation. This means that, after age 18, girls must give their consent if they are to be cut.<sup>ciii</sup> This provision has been fiercely criticised, within Sierra Leone but also on the continent and internationally.<sup>130</sup> It is argued that the age of consent will have little or no impact, as traditionally parents and guardians make decisions for their daughters, no matter their age.

The Advocacy Movement Network (AMNET), an anti-FGM campaign organisation based in Freetown, Sierra Leone, decided to promote the age of consent. AMNET aims to end all forms of violence against and social exclusion of the most vulnerable of the society through advocacy and engagement with policy-makers to adopt and enforce legislation to protect women, children and youths.<sup>civ</sup> Having witnessed the continued backlash against anti-FGM campaigners in the country and the hardening of the attitudes of those who supported the practice, AMNET chose to tackle the issue through a practical approach. Although the long-term goal is to put an end to the practice of FGM in Sierra Leone, the organisation's view is that real social change can only happen through a step-by-step process.<sup>cv</sup> AMNET believes that, through education, information and sensitisation, it may be possible to change people's attitude towards FGM and therefore end the practice. Hence, it promotes the 'age of consent' as a short-term goal to eventually lead to the total abandonment of the practice in the future.

<sup>130</sup> There have also been temporary bans of FGM in Sierra Leone, which have also been subject to criticism. During the Ebola crisis in West Africa in 2014, the Government passed a law to ban FGM to stop the spread of the virus. Furthermore, the Government recently temporary banned the practice during the planning of the March 2018 election in a bid to stop politicians buying votes through the financial support of initiation ceremonies (Voice of America. 2018. 'Seeking Fair Elections, Sierra Leone Bans FGM During Campaign Season'. [www.voanews.com/a/seeking-fair-elections-sierra-leone-bans-fgm-during-campaign-season/4240062.html](http://www.voanews.com/a/seeking-fair-elections-sierra-leone-bans-fgm-during-campaign-season/4240062.html)).

AMNET's campaign emphasises the need to sensitise the population and particularly the Paramount Chiefs by convincing them to sign a memorandum of understanding (MoU) with AMNET banning the practice of FGM for girls under the age of 18.<sup>cvii</sup> The MoU with the Paramount Chiefs allows them to work closely with the Bondo to ensure that no girl under 18 is cut. This is done through training to strengthen the capacity needs of their partners, and working with the Paramount Chiefs to report and investigate cases of girls being cut under 18 and other cases of child abuses. AMNET also collects data on the underage practice of FGM and child abuses, such as the date of the offence, the time, the perpetrator and the judgement, to ensure the child receives the protection needed.<sup>cvii</sup>

This case highlights how culture is used to justify harmful practices against women; it also shows the need to work with traditional leaders in order to change attitudes. To date, Sierra Leone is one of the very few countries in Africa and especially in West Africa with no legislation prohibiting FGM.

## Case study 14. Faith-based approach to tackling FGM in Kenya

An indigenous church in West Pokot in Kenya is actively engaged in a variety of strategies to change community perceptions and practices towards ending the practice of FGM. With community guidelines and forums, as well as a rescue school for girls under threat of FGM, the church seeks to prevent girls from undergoing FGM. Because of the link between FGM and child marriage, efforts to abandon FGM also contribute to a reduction in the rate of child marriage.

Kenya has enacted a comprehensive legislative framework including the Children's Act 2001 and the Prohibition of Female Genital Mutilation Act 2011. However, while the country has made significant progress,<sup>131</sup> total abandonment of the practice has not yet been realised, and it remains particularly ingrained in some communities. The Pokot community is one of these. One church in West Pokot is playing an active role in working towards the abandonment of FGM. The *Dini ya Roho Mafuta Pole Church* (Church of the Gentle Holy Spirit/Mafuta Pole) is an indigenous church under the umbrella of the Kenya Chapter of the Organisation of African Independent Churches (OAIC), which guides Mafuta Pole on various development issues including the FGM initiative in discussion.<sup>132</sup> OAIC has also brought on board a faith-based organisation, Faith to Action, to provide technical support to Mafuta Pole by way of development of organisational documents and content for community training sessions.

The change that Mafuta Pole wants to bring is in the perceptions of the community relating to FGM. The church has over 30,000 members within the county of West Pokot. With active agents of change within the community, the chances of community behaviour towards FGM changing are high. The initiative is targeted at community members, most of whom are congregants of the church. The church has in place various strategies to tackle FGM. One of these involved the development of guidelines known as Boma Guides. These give direction and provide guidance to the local churches, called Bomas, on how to cater to and advise the local community.<sup>133</sup> One of the provisions of this Boma Guide commits to the abandonment of FGM by the community. The Boma Guides also condemn child marriage. This is important, considering that in West Pokot and many other communities, once a girl undergoes FGM, she is considered fit for marriage. As such, tackling FGM will also reduce the incidence of child marriage.

The church strategies also seek to strengthen girls' education through encouraging school attendance and retention. The church has established a rescue school for girls who are under threat of FGM as well as for others who are in need. This initiative is locally supported: the church members contribute livestock, which are then sold to sponsor school fees for the girls in the school. Other initiatives, often led by youth, contribute to progress on the FGM initiative. The youth section of the church holds regular meetings during school holidays, thus targeting both school-going and non-school-going youth. During these retreats, young women are taught about health issues, including FGM and menstrual hygiene. Joint sessions with both young men and young women enable them to discuss FGM and can influence both genders' perceptions of the practice.

These strategies work collectively to provide security for girls and young women, removing them from a potentially harmful environment all the while educating them and building their capacity—all of which increases their chances of resisting the practice.<sup>134</sup> In terms of results, several church leaders note that their neighbours are beginning to emulate their actions by preventing their girls from undergoing FGM, and also by enrolling them in school. There is also an anticipated impact on child marriage.

The initiative has not been without difficulties. Mafuta Pole is an indigenous church, meaning it is built on both cultural and biblical values. Traditionally, women in Pokot have not enjoyed equal status, and their value, recognition and leadership have been muted. Members of the community who hold onto this traditional view are still against recognition of girls' value, including in education, health and inheritance, among other areas. Church leaders address these constraints by holding education community forums targeted at villagers on the elimination of FGM, relying on both health- and science-based and biblical arguments to change perceptions. For instance, before this initiative began, this area had one of the highest rates of fistula in Kenya. Older women who were mutilated and now suffer from fistula are thus used as change agents to demonstrate the harms of FGM. In addition, the church uses religious texts to work towards the total abandonment of FGM.

<sup>131</sup> National prevalence of FGM in Kenya stands at 21% (KDHS 2014) compared with 27% in 2008/09 and 32% in 2003 ([https://www.unicef.org/kenya/JP\\_on\\_FGM\\_-\\_BRIEF.pdf](https://www.unicef.org/kenya/JP_on_FGM_-_BRIEF.pdf)).

<sup>132</sup> African Independent Churches (AICs) were founded during the colonial period, and have developed indigenous forms of worship, theology and social organisation. They often see themselves as custodians of African values. AICs have played an ambivalent role in terms of advancing women and girls' rights. In some cases, they have tolerated FGM and other harmful practices as a way of resisting what they perceive as cultural imperialism. On the other hand, they are more gender-sensitised than missionary churches; women are very present in AICs and have made an invaluable contribution to the growth of the churches. The work of Mafuta Pole and the OAIC to fight FGM is a considerable shift towards the progressive promotion of women and girls' rights in the church and its communities.

<sup>133</sup> In its organogram, the headquarters of the church is known as Jerusalem, the mid-level as Zion and the smallest unit, represented by the local churches, as Boma.

<sup>134</sup> In addition to the specific strategies, the church itself also leads by example, as it adheres to the Kenyan Constitution's two-thirds rule of gender representation in its leadership and programmes. For example, among its leadership, five out of fifteen are women; out of eighty in a theology class offered by the church, thirty are women.

Another way the church addresses difficulties is that each Boma has a mechanism for resolving household conflicts. This is like a council that also has women elders. If a family comes to the mechanism with a conflict, its members rely on both scripture and culture to resolve it. Where resolution fails, the council rescues the child if the dispute is FGM-related. There are also consequences for errant members in this regard, ranging from being stripped of leadership roles and being de-flocked (excommunicated) from the church community, which affects status and trade, as most of the members of the community are members of the church. In this regard, the church has a positive and exacting influence on the community.

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## Chapter 7

# Reproductive rights and sexual and reproductive health

## 7.1 ISSUE ANALYSIS

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

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

### 7.1.1 Fertility and contraception

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

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

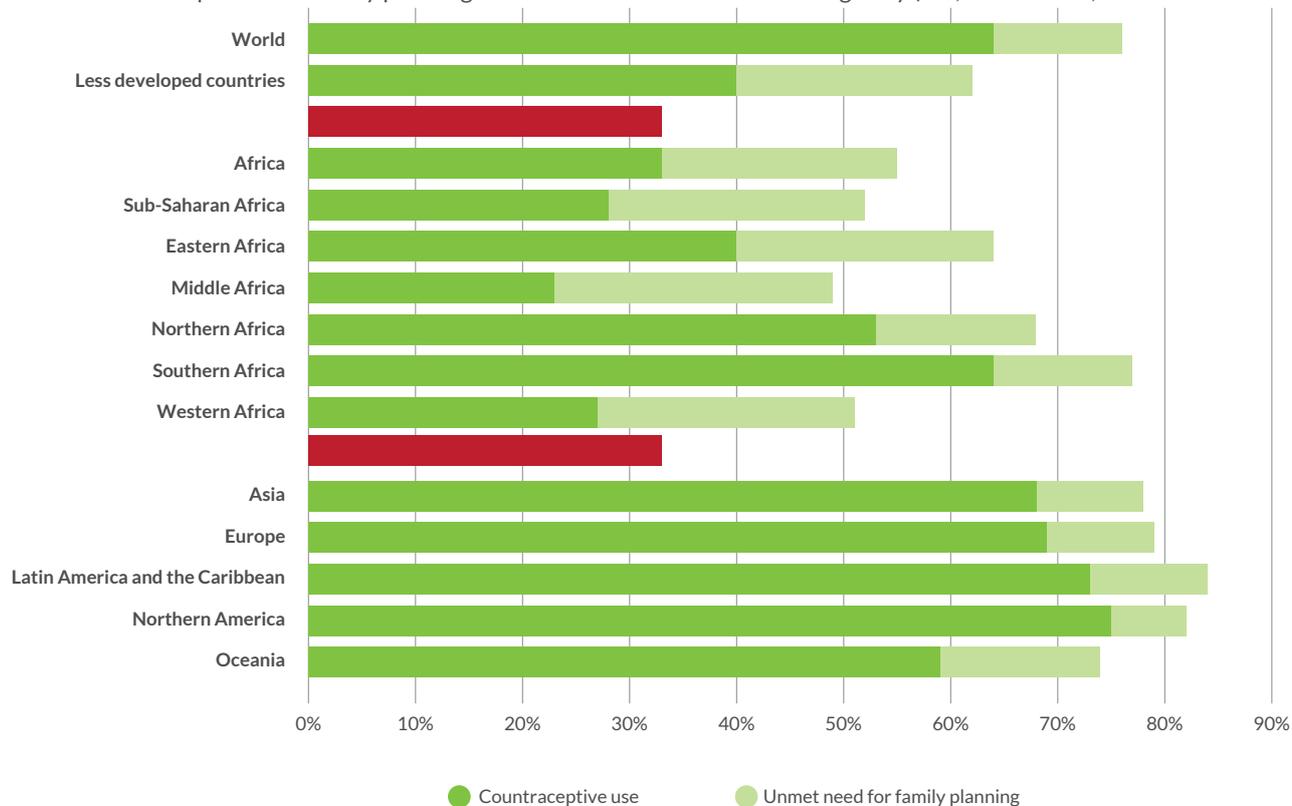
<sup>1</sup> This refers to women using any method of contraception, so includes both modern and traditional or natural methods.

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

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

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

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



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

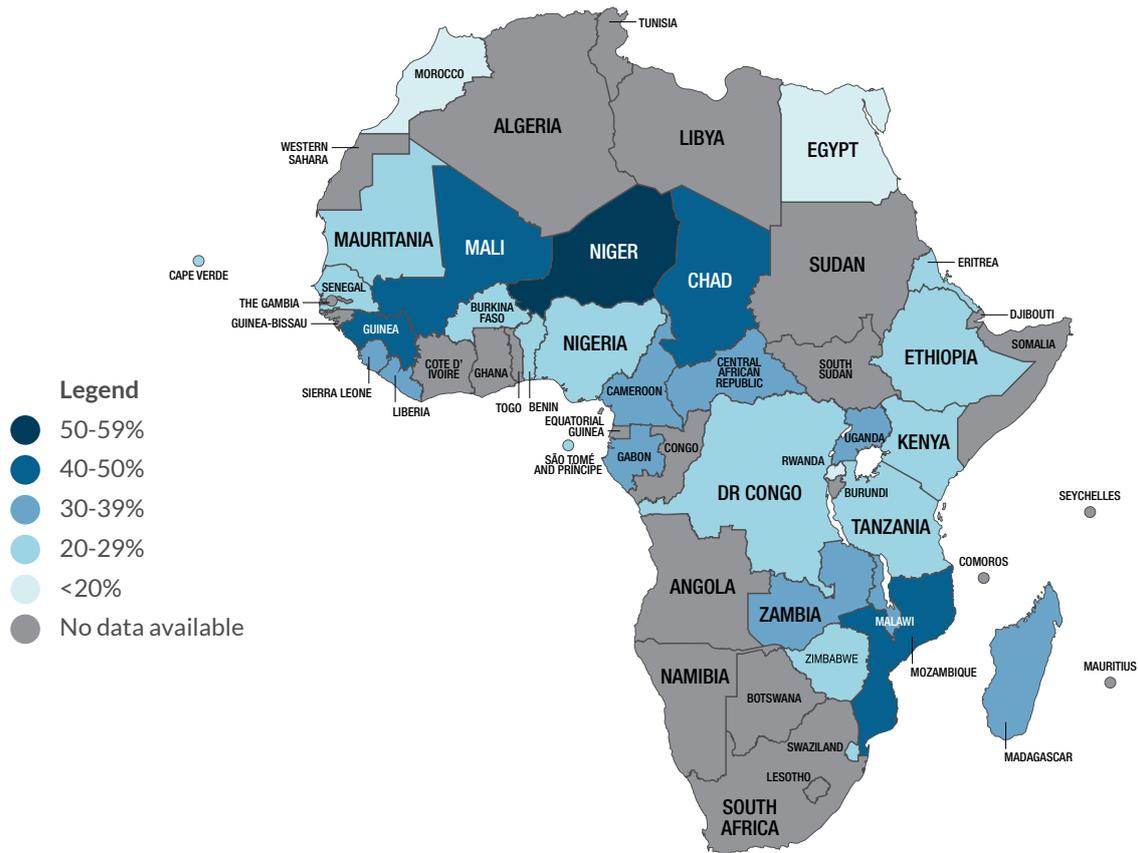
This clarification on terminology proves relevant when considering fertility, contraception and unmet need among adolescents.

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

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

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

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

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

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

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

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

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

## 7.1.2 Maternal mortality and morbidity

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

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

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

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

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

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

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

### 7.1.3 Unsafe abortion

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Regions	Total abortions per year (millions)	Total of safe abortions (millions) (%)	% of less-safe abortions	% of least-safe abortions	Total of unsafe abortions (millions) (%)
Worldwide	55.9	30.6 (54.9%)	30.7%	14.4%	25.1 (45.1%)
Developing countries	49.3	24.8 (50.5%)	12.4%	16.3%	24.3 (49.5%)
Africa	8.2	2.0 (24.4%)	27.6%	48.0%	6.2 (75.6%)
Eastern	2.7	0.6 (23.9%)	29.2%	46.9%	2.0 (76.1%)
Middle	1.0	0.1 (11.8%)	19.2%	69.0%	9.0 (88.2%)
Northern	1.9	0.6 (29.0%)	26.6%	44.4%	1.4 (71.0%)
Western	2.1	0.3 (15.3%)	32.6%	52.1%	1 820 000 (84.7%)
Southern	0.5	0.4 (73.5%)	19.4%	7.1%	135 000 (26.5%)

Note: African regions based on UNDESA Population Division regions.

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

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

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

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

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

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

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

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

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

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

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

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

## 7.2 CONTINENTAL AND REGIONAL POLICY FRAMEWORKS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### 7.2.2 The right to family planning education

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

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

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

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

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

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

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

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

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

The core features of CSE are that it is:

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

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

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

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

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

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

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

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

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

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

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

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

### 7.2.4 The right to safe abortion

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## 7.2.5 Obligations of states

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

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

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

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

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

<sup>18</sup> Voluntary sterilisation.

## 7.3 NATIONAL LEGAL AND POLICY FRAMEWORKS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### 7.3.1 Western region

#### Trends, gaps and contestations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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- 35 In addition to the cases above, abortion is permitted when the woman's age is an issue and in incapacity to care for the child.
- 36 Art. 15 of the 2010 Constitution: 'Each one has the right to health and to the physical well-being. The State has the duty to promote them, to fight against the epidemics and the social calamities.'
- 37 The Portuguese law forbidding abortion has not been repealed; however, it is not enforced and abortion is largely tolerated.
- 38 Indication for abortion to safe women's life by interpreting 'general principles of necessity'
- 39 Art. 8: 'The Republic shall direct its policy towards ensuring for all citizens, without discrimination, opportunities for employment and livelihood under just and humane conditions, and towards promoting safety, health and welfare facilities in employment.'
- 40 Art. 16 of the 1992 Constitution: 'Education, instruction, formation, work, housing, leisure, health, and social protection shall constitute recognized rights.'
- 41 Section 17 of the 1999 Constitution: '(3) The State shall direct its policy towards ensuring that- c) the health, safety and welfare of all persons in employment are safeguarded and not endangered or abused; (d) there are adequate medical and health facilities for all persons.'
- 42 According to Abortion Policies: A Global Review, published by the UN, Nigeria has two abortion laws: one for the northern states and one for the southern states. Both specifically allow abortions to be performed to save the life of the woman. In addition, in the southern states, the holding of *Rex v. Bourne* is applied, which allows abortions to be performed for physical and mental health reasons.
- 43 Art. 13 of the Constitution: 'Every person has the right to enjoy the best state of physical and moral health.'
- 44 Art. 8: 'The Republic of Senegal guarantees to all citizens their individual fundamental freedoms such as the right to health.'
- 45 The country's Criminal Code completely prohibits pregnancy termination; the Code of Medical Ethics allows an abortion if three doctors testify that the procedure is necessary to save a pregnant woman's life.
- 46 Indication for abortion to safe women's life by interpreting 'general principles of necessity'
- 47 While the Constitution does not mention the right to health, it does under Art. 8 (3) stipulate that 'The state shall direct its policy towards ensuring there are adequate medical and health facilities.'
- 48 The 2015 Safe Abortion Act was passed in December 2015 by Parliament; however, it has been blocked since then at the State House. The law would give new hope for women and girls by changing the 150-year old colonial 1861 Abortion Law to allow the termination of a pregnancy under any circumstances up to 12 weeks. Furthermore, it would allow abortion in cases of incest, rape and foetal impairment up to 24 weeks.
- 49 Art. 2 of the Safe Abortion Act 2015 stipulates that abortion services may be also provided on felonious intercourse. This law has been passed by Parliament, but has not been signed by the President.
- 50 According to Art. 34 of the Constitution, the state recognises citizens' right to health and works to promote it.

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

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

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

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

### Key gaps and contestations

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

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

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

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

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

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

## 7.3.2 Eastern region

### Trends, gaps and challenges

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Key gaps and contestations

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

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

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

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

### 7.3.3 Central region

#### Trends, gaps and challenges

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

75 Art. 23 of the Constitution refers to the responsibility of the state to promote primary health care.

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

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

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

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

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

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

76 Gutmacher Institute. (2016). 'Abortion in Africa'. Fact Sheet.

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

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

79 São Tomé and Príncipe is listed as 'other' on the CARMMA scorecard.

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

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

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

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

## Key gaps and contestations

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

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

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

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

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

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

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

### 7.3.4 Southern region

#### Trends, gaps and challenges

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

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

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

Country	INDICATORS								
	Constitutional provision on health	Joined/ launched CARMMA campaign	Government funding for health >5% of GDP	Government funding for health >15% of general government expenditure	Legal access to safe abortion under specified circumstances				
					When the life of the mother is threatened	When pregnancy poses threat to mental or physical health of mother	In cases of foetal impairment	In cases of sexual assault, rape or incest	Allowed under other circumstances
Angola	Yes <sup>82</sup>	Yes	Yes	No	Yes	PH + MH <sup>83</sup>	Yes <sup>83</sup>	No <sup>85</sup>	No
Botswana	No <sup>84</sup>	Yes	No	No	Yes	PH + MH	Yes	Yes	No
Comoros	Yes	Yes	No	No	Yes	H	No	No	-
DRC	Yes <sup>87</sup>	Yes	No	No*	No <sup>88</sup>	No	No	No	No
Lesotho	Yes	Yes	Yes	No*	Yes <sup>89</sup>	H	Yes	Yes	No
Madagascar	Yes	Yes	No	No*	Yes <sup>90</sup>	No	No	No	No
Malawi	Yes	Yes	Yes	Yes	Yes <sup>91</sup>	No	No	No	No
Mauritius <sup>92</sup>	No	No <sup>93</sup>	No	No	Yes	PH + MH	Yes	Yes <sup>94</sup>	No
Mozambique	Yes	Yes	No	No	Yes	PH + MH	Yes	Yes <sup>95</sup>	Yes
Namibia	No	Yes	No	No*	Yes	PH	Yes	Yes	No
Seychelles	Yes	Yes	No	No	Yes	PH + MH	Yes	Yes	Yes <sup>96</sup>
South Africa	Yes	Yes	No	No*	Yes	PH + MH	Yes	Yes	Yes <sup>97</sup>
Swaziland	Yes <sup>98</sup>	Yes	Yes	Yes	Yes <sup>99</sup>	MH	-	Yes	No
Tanzania	No	Yes	No	No*	Yes	H	No	No	-
Zambia	Yes <sup>100</sup>	Yes	No	No*	Yes	PH + MH	Yes	No	Yes <sup>101</sup>
Zimbabwe	Yes <sup>102</sup>	Yes	No	No	Yes	PH	Yes	Yes	No

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Legal guarantees to safe abortion:** The vast majority of countries in the region allow for abortion to save a mother's life. DRC is the only country where abortion is prohibited altogether, though saving the life of a woman as a necessity can be used as a defence. In Madagascar and Malawi, it is allowed only to save the life of the mother.<sup>100x</sup>

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### Key gaps and contestations

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

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

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

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

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

### 7.3.5 Northern region

#### Trends, gaps and challenges

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### Key gaps and contestations

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

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

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

## 7.4 CASE STUDIES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### Box 7.5. IPPF Declaration on Sexual Rights

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

#### Preamble

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

#### Guiding principles

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

#### Sexual rights

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

Source: IPPF. (2008). Sexual Rights: An IPPF Declaration. [https://www.ippf.org/sites/default/files/sexualrightsippfdeclaration\\_1.pdf](https://www.ippf.org/sites/default/files/sexualrightsippfdeclaration_1.pdf)

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

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

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

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

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

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

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

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

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

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

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

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

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

<sup>124</sup> For example training of Muslim clergy on child spacing (family planning), FGM, early marriage and modern contraception. Videos part 1 <https://www.youtube.com/watch?v=YyvWabFZuxo> and part 2 [https://www.youtube.com/watch?v=NBvD\\_2Vx750](https://www.youtube.com/watch?v=NBvD_2Vx750)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Case study 22. EAC Open Health Initiative

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Case study 24. Reforming abortion law in Rwanda

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<sup>130</sup> Ngwena, C. (2014). *Human Rights and African Abortion Laws: A Handbook for Judges*. Nairobi: Ipas.

## Chapter 7 ENDNOTES

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## Chapter 8

# HIV and AIDS

### 8.1 ISSUE ANALYSIS

#### 8.1.1 HIV, AIDS and human rights

HIV, or Human Immunodeficiency Virus, 'targets the immune system and weakens people's defence system against infections and some types of cancer'.<sup>i</sup> It affects the CD4 cells, making the body less resistant to infections and other diseases.<sup>ii</sup> When the number of CD4 cells is low, a person has Acquired Immunodeficiency Syndrome (AIDS).<sup>iii</sup> There is no cure for HIV infection, but antiretroviral therapy (ART) has proved successful in controlling the virus and helping prevent transmission.<sup>iv</sup> The HIV virus is spread through certain body fluids such as blood, breast milk, semen and vaginal secretions. It is not transmitted by kissing, hugging, shaking hands or sharing personal objects, food or water.<sup>v</sup> In the 1980s, HIV was seen as confined to MSM, sex workers and intravenous drug users, with few women affected by the epidemic. In 2003, a significant milestone was reached when for the first time it was reported that half of the people living with HIV (PLWHIV) were women.<sup>vi</sup>

HIV has been a global concern for more than 80 years<sup>vii</sup> but it was only in the late 1980s that it started to be addressed from a human rights perspective. This happened at the first International Consultation on AIDS and Human Rights in 1989, which was followed by a series of consultations resulting in the 2006 International Guidelines on HIV/AIDS and Human Rights.<sup>1</sup> It was then recognised that the full realisation of human rights and fundamental freedoms for all was essential in the response to global AIDS.<sup>2</sup> This entailed looking at fundamental human rights such as the rights to health, non-discrimination, equality, participation, dignity and access to justice. Given the disproportionate impact of HIV on women and girls, the human rights of women and girls are at the heart of the fight against HIV and AIDS.

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- <sup>1</sup> The Second International Consultation on HIV/AIDS and Human Rights took place in 1996 and the Third in 2002. Since then, various international forums have taken place at which states have made major commitments to HIV prevention treatment and care and recognising the relationship between HIV and fundamental human rights. These include the 2005 World Summit Outcome, the political declaration of the 2006 High Level Meeting on AIDS and various African Summits on HIV (2001, 2015). See the 2006 International Guidelines on HIV/AIDS and Human Rights: <http://www.ohchr.org/Documents/Publications/HIVAIDSGuidelinesen.pdf>
  - <sup>2</sup> In 2015, the UN Human Rights Council reaffirmed such recognition in its Resolution 30/8.

### 8.1.2 HIV prevalence and new infections: regional trends

HIV and AIDS continue to be a major public health issue in Africa, where there are 25.6 million PLWHIV out of the 36.7 million worldwide.<sup>viii</sup> The majority of these live in Eastern and Southern Africa (ESA), where there were 19.4 million PLWHIV in 2016, 59% of them adult women (see Table 8.1). In Western and Central Africa, 52% of the 6.1 million PLWHIV are women. Notably, this region has a relatively high burden of HIV: 'While it contains 7% of the world's population, the region is home to 17% of the world's people living with HIV and accounts for 30% of the world's AIDS-related deaths.'<sup>ix</sup> HIV prevalence in the Middle East and North Africa (MENA) region is much lower, at 230,000.<sup>3 x</sup> In 2017, the 15 countries with the highest HIV prevalence in the world were in Africa. Swaziland (27.2%), Lesotho (25.0%), Botswana (21.9%), South Africa (18.9%) and Namibia (13.8%) featured as the top five.<sup>xi</sup>

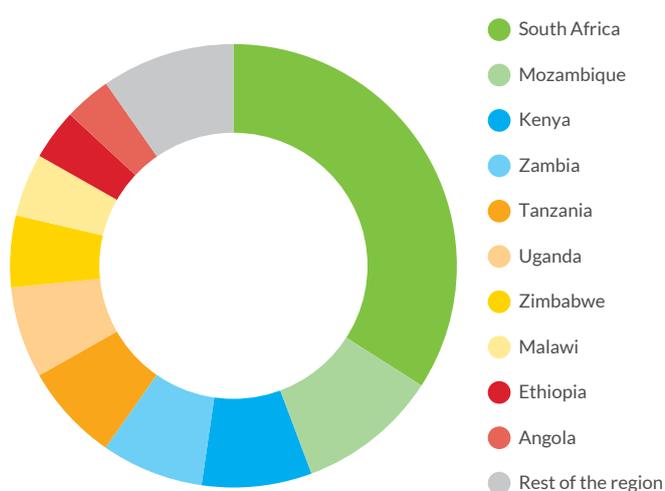
**Table 8.1. Number of people living with HIV in 2016<sup>xii</sup>**

	HIV prevalence (all ages)	Female adults (15+)	Male adults (15+)	Female adolescents (15–19)	Male adolescents (15–19)	Children (0–14)
Eastern and Southern Africa	19.4 million	10.9 million	7.2 million	740,000	530,000	1.3 million
West and Central Africa	6.1 million	3.2 million	2.4 million	260,000	200,000	550,000
Middle East and North Africa	230,000	82,000	140,000	5,200	4,500	9,300
Total	25.7 million	14.9 million	9.7 million	1.0 million	0.7 million	1.9 million
Percentage		58%	37.7%	3.9%	2.7%	7.4%

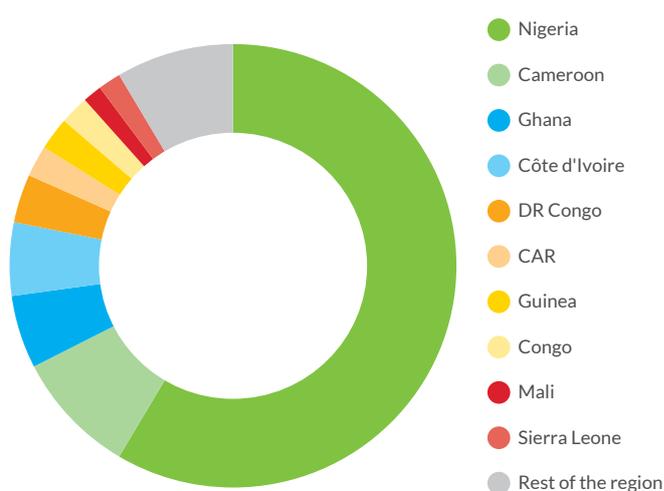
There has been a positive trend in the **reduction of new infections** globally in the past six years. In Sub-Saharan Africa, new infections declined by 41% between 2000 and 2014.<sup>xiii</sup> New infections tend to concentrate in specific countries in the different African regions. In ESA, a third of all new infections in 2016 were in one country: South Africa (see Figure 8.1). Another 50% of new infections occurred in Kenya, Malawi, Mozambique, Tanzania, Uganda, Zambia and Zimbabwe. Figure 8.2 shows that, in Western and Central Africa, Nigeria is the country with the highest HIV prevalence—and this is considerably higher than in other countries in the region.<sup>xiv</sup>

Figure 8.3 shows how, although Mozambique, Uganda and Zimbabwe are among the countries with the highest numbers of HIV new infections by 2016, from 2010 to 2016 the numbers in these countries declined considerably. Eritrea, Ethiopia and Madagascar, on the other hand, show an increase between 2010 and 2016. In the case of Western and Central Africa, Figure 8.4 shows that Burundi, Guinea-Bissau and Senegal have seen the most significant declines in new infections. In Congo, Ghana and Liberia, new infections increased more than 15% between 2010 and 2016. In many of the countries with high rates of new HIV infections, these are declining, for instance in Cameroon, DRC and Nigeria (slight decline) and Côte d'Ivoire (stronger decline).<sup>xv</sup>

**Figure 8.1. Distribution of new HIV infections by country, ESA, 2016**



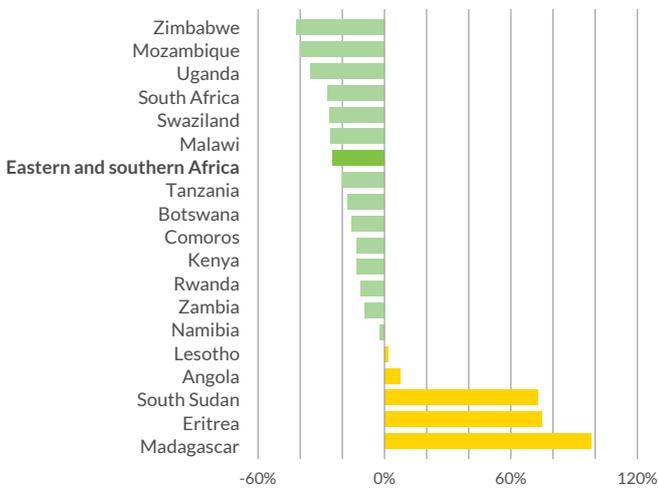
**Figure 8.2. Distribution of new HIV infections by country, WCA, 2016**



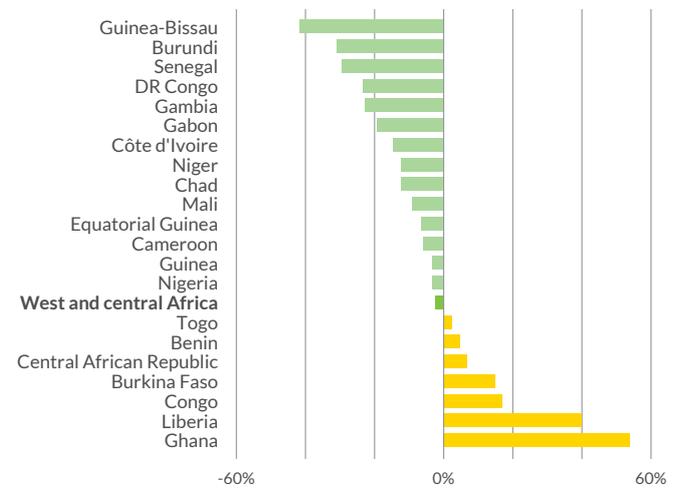
<sup>3</sup> No sex-disaggregated information is provided for the MENA region.

<sup>4</sup> All figures are estimates from UNAIDS. (2017). 'Ending AIDS: Progress towards the 90-90-90 Targets'.

**Figure 8.3. Change in new HIV infections by country, ESA, 2010–16 (%)**



**Figure 8.4. Change in new HIV infections by country, WCA, 2010–16 (%)**

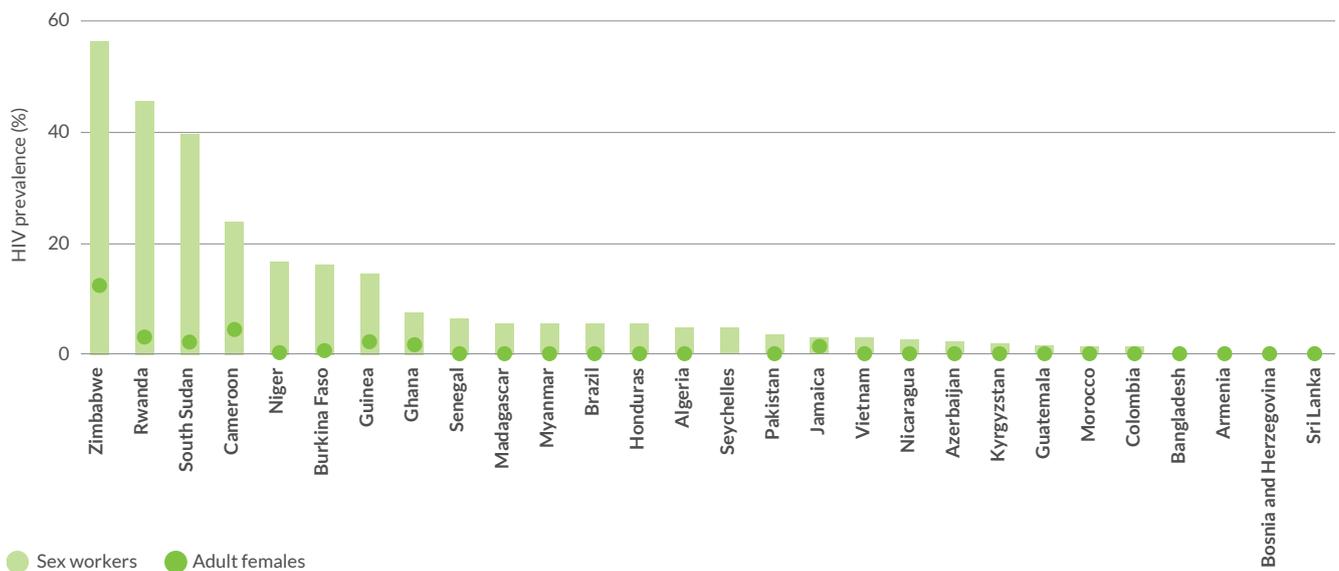


### 8.1.3 The disproportionate effect of HIV and AIDS on women and girls

HIV and AIDS affect women disproportionately. Young women aged 15–24 years in Sub-Saharan Africa are 2.5 times more likely to be infected than men.<sup>xvi</sup> Prevalence rates among women in ESA range from 14.5% in East Africa to 38.7% in Lusaka (Zambia) and 39.5% in Durban, South Africa.<sup>xvii</sup> By 2017, 56% of new infections among adults (15 years and older) in Sub-Saharan Africa were of women. Among young women between the ages of 15 and 22 years, the proportion of new infections is higher, at 66%.<sup>xviii</sup> In the MENA region, women accounted for 38% of newly infected adults, while young women aged 15–24 made up 48% of new infections.<sup>xix</sup> For the continent as a whole, AIDS-related illnesses are the second leading cause of death for young women aged 15–24.<sup>xx</sup>

Among women, female sex workers are particularly vulnerable to HIV, and are 13.5 times more likely to be living with HIV than other women.<sup>xxi</sup> 'An estimate of fifteen percent of HIV in the general female adult population is attributable to (unsafe) female sex work.'<sup>xxii</sup> By 2013, it was estimated that, of the 106,000 deaths from HIV as a result of female sex work globally, 98,000 had occurred in Sub-Saharan Africa.<sup>xxiii</sup> Figure 8.5 shows prevalence of HIV among female sex workers and the adult female population, and points to the higher vulnerability of sex workers to HIV. Nine of the ten countries with the highest HIV prevalence among sex workers, in 2016 are on the African continent: Zimbabwe, Rwanda, South Sudan, Niger, Burkina Faso, Guinea, Ghana, Senegal and Madagascar (see Figure 8.5).<sup>xxiv</sup>

**Figure 8.5. HIV prevalence among female sex workers compared with the adult female population<sup>xxv</sup>**



HIV and AIDS affect women and girls disproportionately in terms of higher susceptibility to becoming infected with HIV when exposed. The risk of women acquiring HIV through heterosexual vaginal sex is higher than that of men, partly because of biological factors. Women's specific physiological and hormonal characteristics make them more likely to contract HIV than men.<sup>xxxvi</sup> Social factors and in particular gendered unequal power relations play a major role in this as well.<sup>xxxvii</sup> These include the limited access of women and girls to SRH services, and in particular information about HIV and AIDS and SRHR in particular (see also Chapter 7). This is also affected by access to education: women who lack formal education are less likely to receive information on SRHR and HIV prevention and are more likely to fall into misconceptions and believe in myths.<sup>xxxviii</sup> Girls who are not at school are also to be more exposed to FGM and child marriage, which in turn increase the risk of HIV.

Gender unequal power relations between intimate partners or spouses are a critical factor, and can limit women and girls' abilities to protect themselves and negotiate safe sex. The economic dependency of women and girls on male partners can further reinforce constraints to women and girls protecting themselves against HIV infection. Women and girls' lack of property rights, and related lack of economic resources and low economic status, contributes to HIV infections, as they are associated with earlier sexual experience, lower condom use, having multiple sexual partners and the increased likelihood of transactional sex or physically forced sex.<sup>xxix</sup> A study conducted in South Africa and Uganda found that securing property rights had the potential to mitigate the consequences of HIV and AIDS, as it allows women to protect themselves from the virus, conduct testing and seek counselling and treatment.<sup>xxx</sup>

GVAW and harmful practices also increase women and girls' exposure to and risk of acquiring HIV and AIDS. In South Africa and Uganda, 'Adolescent girls who had been subjected to violence from a partner or who are in relationships with low levels of equality are at an increased likelihood of acquiring HIV.'<sup>xxxi</sup> GVAW has been proved to have a direct relationship with the risk of HIV infection, and can, for instance, be a strong limitation in terms of women's power to negotiate condom use, increasing their exposure to HIV.<sup>xxxii, xxxiii</sup> Furthermore, rape and forced sexual intercourse often result in injuries to women's vaginal tissue, which further increases the risk of HIV entering the bloodstream.<sup>xxxiv</sup> Harmful practices such as FGM, child marriage, virginity testing, widow inheritance and cleansing rituals are also a contributing factor to HIV.<sup>xxxv</sup> In the case of child marriage, (forced) intercourse with often older men, who may have had previous sexual partners, increases the risk of girls and young women contracting HIV. Moreover, South African women who have their 'sexual debut' before the age of 15 years are more likely to be HIV positive. Widow inheritance puts widows at risk of being infected by the male relative who 'inherits' her. Cleansing rituals, whereby a widow has to have sex with a man identified by the elders in the community, to 'clean' her from the burial ceremony of her late husband, increases the likelihood of her being exposed to HIV.<sup>xxxvi</sup>

HIV and AIDS also affect women and girls disproportionately because of the stigma and discrimination associated with HIV infection, and the effects this has on women and girls' lives. Stigma and discrimination persist in Africa and often affect women in particular.<sup>xxxvii</sup> Women living with HIV experience multiple types of discriminations on account of their HIV or health status. They face discrimination in their families and communities, such as being banned from community activities or cooking, but also in institutional settings, with women fired from their jobs and girls denied their right to attend school. It can also lead to the denial of treatment, or the opposite—that is, forced sterilization.<sup>xxxviii, xxxix</sup> Social perceptions that link HIV and promiscuity, such as in Zimbabwe, make people believe HIV-infected people are responsible for their disease and therefore 'don't deserve help'.<sup>xl</sup> In some cultures, as with the Ndau people in Zimbabwe, women are blamed for their husband's disease or death and accused of witchcraft. This leaves them ostracised and they may be sent away, losing their land and property.<sup>xli</sup> Specific **vulnerable groups** are more susceptible to discrimination based on their HIV and health status. This in particular concerns female sex workers, women refugees and migrants, women from ethnic minorities, women with disabilities and young women. Their vulnerable condition and position often prevents them from accessing information, prevention and care services.<sup>xlii</sup> In ESA, sex workers are criminalised and are highly stigmatised, which limits their access to prevention, treatment, care and support.

Stigma and discrimination can be both a cause and a consequence of HIV infection, as can GVAW, poor educational attainment and women's lack of economic independence. Women are reported to suffer violence at the hands of their partners after disclosing their HIV status to them.<sup>xliii</sup> Women and girls living with HIV often drop out of school, and this further limits their potential to be economically independent. Women and girls also tend to carry the responsibility for caring for relatives with HIV and AIDS, which in turn can affect their school enrolment and attainment.<sup>xliiv</sup> HIV stigma has reportedly led to loss of jobs, income or opportunities to work, for both women and men.<sup>xliv</sup> Women's property rights can become more fragile, as well as more valuable, for women and girls living with HIV, as well as women who give care and women widows. In Kenya, Malawi, Uganda and Zambia, it has been observed that 'HIV-related stigma and discrimination increases the likelihood of "property-grabbing" for affected widows.'<sup>xlvi</sup> In addition, stigma works as a deterrent to reporting or claiming property and inheritance rights violations, as evidenced in Cameroon, Ghana, Kenya, Mali, Nigeria, Rwanda, Tanzania, Uganda and Zimbabwe.<sup>xlvii</sup>

### 8.1.4 Testing and knowing one's status

Testing for HIV is essential to prevention as well as treatment, care and support services. An HIV test is the only way to know whether you have HIV. At the individual level, testing and counselling is key to protect oneself and one's partners, to access ART and to obtain care and support, as well as to reduce the risk of transmitting HIV to unborn babies. At the community level, denial, stigma and discrimination can be reduced and knowledge of HIV status can contribute to collective responsibility, care and action.

In 2014, the International AIDS Conference established the so-called 90-90-90 target for PLWHIV: 90% of people know their status, 90% of people who know their status are on treatment and 90% of people on treatment are virally suppressed.<sup>5</sup> These targets reflect an important shift in the approach to HIV treatment, away from a focus only on the number of people accessing ART and towards maximising viral suppression in PLWHIV.<sup>xlviii</sup>

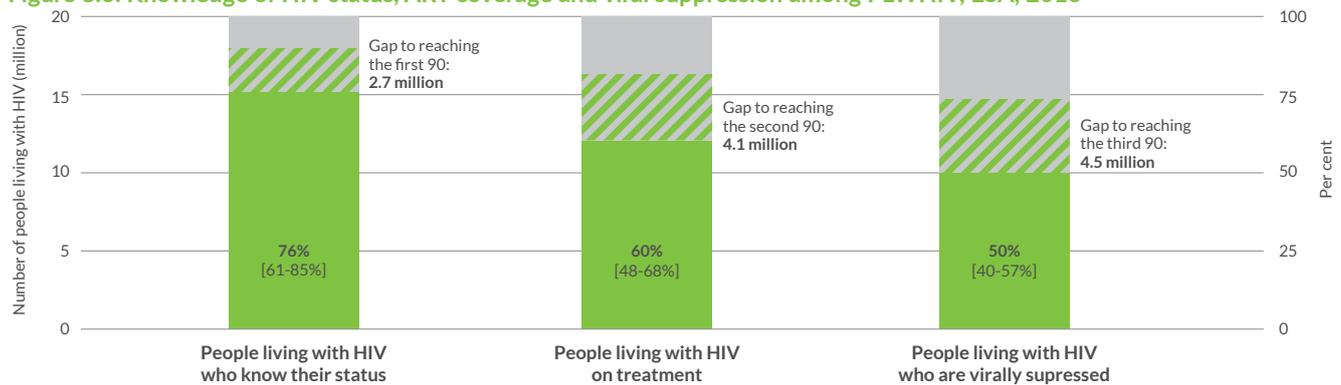
**90%** people know their status

**90%** people who know their status are on treatment

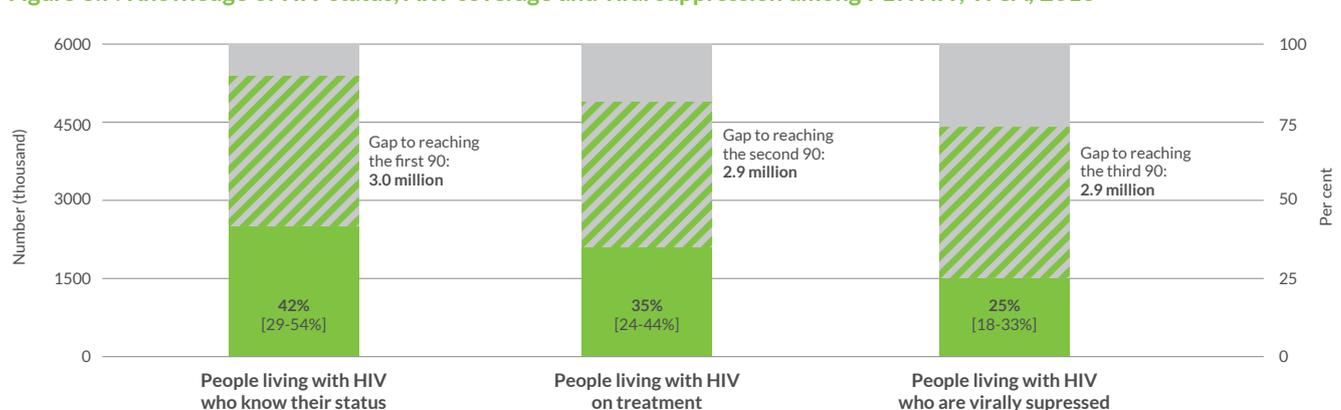
**90%** people on treatment are virally suppressed

In the past decade, a significant increase in the level of testing has been achieved, which has resulted in two-thirds of all PLWHIV knowing their status.<sup>xlix</sup> In ESA, over three out of four PLWHIV know their status, and this proportion (of 79%) for the period 2012–16 is nearly twice that in 2007–11. Moreover, nearly four in five who know their HIV status are on treatment, and 83% of people on treatment are virally suppressed (see Figure 8.6). In Western and Central Africa the figures are lower, but there was a fourfold increase between 2007–11 and 2012–16. By 2016, 42% of PLWHIV knew their status, out of whom 83% were on treatment, of whom 73% were virally suppressed (see Figure 8.7). Coverage of HIV testing and treatment in Western and Central Africa is below the global average. Meanwhile, for the African region as a whole, the gap to breach to reach the 90-90-90 targets remains large. Despite the increases seen in access to testing and services and in people knowing their status and receiving treatment, many PLWHIV are still unaware of their HIV status.<sup>l</sup>

**Figure 8.6. Knowledge of HIV status, ART coverage and viral suppression among PLWHIV, ESA, 2016<sup>li</sup>**



**Figure 8.7. Knowledge of HIV status, ART coverage and viral suppression among PLWHIV, WCA, 2016<sup>lii</sup>**



<sup>5</sup> Virally suppression is when ART 'reduces a person's viral load (HIV RNA) to an undetectable level. Viral suppression does not mean a person is cured; HIV still remains in the body. If ART is discontinued, the person's viral load will likely return to a detectable level': <https://aidsinfo.nih.gov/understanding-hiv-aids/glossary/1650/viral-suppression>

The gaps in the 90-90-90 continuum are often greater for men, young people and key populations.<sup>6</sup> Their access to testing is often lower, they are less likely to be linked to treatment and they have low viral suppression levels. Stigma and discrimination are among the factors that affect access to and levels of testing. This affects women in specific ways. Gender norms for married women, related to supposed purity and the sanctity of marriage, can prevent women from seeking testing or treatment. GVAW can stop women disclosing their status to their partner or seeking testing, counselling and even treatment out of fear of intimate partner violence.<sup>liii</sup>

Young people may face specific challenges, especially when they lack access to comprehensive information and sexual education, or when consent laws affect the ability of SRH health care. Apart from having limited information on provision of adolescent SRH services, adolescents and young people may also lack comprehensive knowledge and understanding of SRH issues, such as on how to prevent transmission of HIV. While there is a trend among both young women and young men of increasing knowledge on HIV prevention, general knowledge levels regarding HIV and AIDS remain low.<sup>liv</sup> Countries where young women and men aged 15–24 appear to have the least knowledge on prevention of HIV transmission and AIDS include Chad (11.2% of women, 15.4% of men), Eritrea (12.8% of women), Niger (13% of women, 24.8% of men), Congo (14.4% of women, 27.6% of men) and Côte d'Ivoire (15.7% of women, 24.6% of men).<sup>7,lv</sup>

Disclosure and forced testing are critical concerns in HIV testing. Knowing one's HIV status is a right recognised by various human rights treaties, including the Maputo Protocol (see Section 7.2 for more detail). The voluntary nature of testing is key, and WHO and UNAIDS do not support mandatory or compulsory testing of individuals on public health grounds. 'HIV testing, no matter how it is delivered, must always respect personal choice and adhere to ethical and human rights principles. Public health strategies and human rights promotion are mutually reinforcing.'<sup>lvi</sup> As a right, it cannot be forced, and should involve the right to decline testing.<sup>lvii</sup> Mandatory testing has the risk of further marginalising people infected with HIV. The 'five Cs' are key to voluntary HIV testing: **consent, confidentiality, counselling, correct results and connections**. A distinction needs to be made between voluntary counselling and testing (VCT), provider-initiated testing and counselling (PITC) and mandatory or forced testing (see Box 8.1).<sup>lviii</sup>

### Box 8.1. HIV testing models

**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.<sup>lix</sup>

**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.<sup>lx</sup>

**Mandatory or forced testing** concerns 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.<sup>lxi</sup> HIV testing can also be mandatory for pregnant women, and there are also trends of mandatory pre-marital testing (of both women and men), enacted in laws (DRC, Ethiopia) or by churches (Burundi, DRC, Ghana, Kenya, Nigeria, Tanzania and Uganda).<sup>lxii</sup>

Confidentiality and consent are of pivotal importance not only with respect to testing itself but also in relation to **disclosure** of results and decisions on medical treatment following the test result.<sup>lxiii</sup> Fear of discrimination or stigma makes women reticent to seek testing, treatment and care and even prevent them from disclosing their status to their partners.<sup>lxiv</sup> A study conducted in rural Zimbabwe found that 'Doctors are asked not to write the true diagnoses on the chart or the death certificates this causes problems for families and impacts on insurance.'<sup>lxv</sup> A number of countries in Western and Central Africa demand disclosure for PLWHIV to their partners.<sup>lxvi</sup> (Section 8.3 looks at discriminatory laws in national legal and policy frameworks—i.e., laws that require mandatory testing of pregnant women, force disclosure of a person's HIV status or criminalise HIV transmission.)

<sup>6</sup> Key populations include sex workers, people who inject drugs, gay men and other MSM, transgender people, clients of sex workers and other sexual partners of key populations.

<sup>7</sup> Based on data from most recent national DHS, ranging from 2009 to 2016.

**Forced and coerced sterilisation** based on stigma and discrimination has been identified as a serious threat to PLWHIV, and generates fear and thus affects testing and access to care and treatment. Forced sterilisation of HIV women has been reported in various countries.<sup>lxvii</sup> In Kenya, Namibia, South Africa and Uganda, for example, these practices are embedded in pervasive beliefs that these women ‘should not reproduce’, and in fact take place despite legal prohibitions.<sup>lxviii</sup> The 2014 South Africa HIV Stigma Index revealed that ‘7% of respondents reported that they were forced to be sterilized. In addition, 37% of the respondents said that access to ARV [antiretroviral] treatment was conditional on use of contraceptives.’<sup>lxix</sup> In 2015, the International Community of Women living with HIV Eastern Africa (ICWEA) in Uganda found that ‘20 of the 72 women interviewed who had been sterilized, were either forced or coerced to undergo sterilization, while 3 were forced to abort.’<sup>lxx</sup> In Namibia, a 2008 study observed that 40 women out of 230 women living with HIV (17%) stated that they had been coerced or forced into sterilisation.<sup>lxxi</sup> In Kenya, a 2012 report by the African Gender and Media Initiative (GEM) documented the stories of 40 HIV-positive women claiming to have been forcibly sterilised. At the end of 2017, the High Court heard two cases of five HIV-positive women who were subject to coerced sterilisation.<sup>lxxii</sup> In 2012, a landmark decision by Namibia’s Supreme Court ruled in favour of three HIV mothers who had been coerced into signing sterilisation consent forms (see also Section 8.2, or Case studies 32 and 33 in Section 8.4).<sup>lxxiii</sup> Twelve women living with HIV in South Africa also planned to take the government to court for being sterilised against their will.<sup>lxxiv</sup>

### 8.1.5 Access to and use of treatment

Access to and use of ART is critical to the reduction of AIDS-related deaths. Scale-up of ART has surpassed expectations, with the greatest advances made in the world’s most affected region, ESA (see Table 8.2).

**Table 8.2. PLWHIV on ARV treatment in 2010 and 2015**<sup>lxxv</sup>

Regions	PLWHIV on ART 2010	PLWHIV on ART 2015
Eastern and Southern Africa	4,087,500	10,252,400
Western and Central Africa	905,700	1,830,700
Middle East and North Africa	13,600	38,200

Africa is one of the regions where the success of ART has been particularly outstanding. In ESA countries like Botswana, Kenya and Namibia, the number of AIDS-related deaths has declined by over 50% since 2005 as a result of ART. Botswana is the country with the highest coverage of ART (over 95%) and South Africa has the largest number of people on ART (2,150,880) (see Table 8.3).<sup>lxxvi</sup> In South Africa, for example, the number of AIDS-related deaths has reduced significantly since 2007 thanks to the roll-out of ART, from 325,241 deaths in 2006 to 150,759 in 2016. Treatment coverage is overall higher among women than among men living with HIV, with 59% of women covered and 44% of men covered in the ESA region, and 34% and 21% in Western and Central Africa (see Table 8.4).<sup>lxxvii</sup> Despite these advances, there are still gaps in many countries, with ART continuing to be expensive and hard to access.

**Table 8.3. Access to ARV treatment and coverage in ESA in 2012**<sup>lxxviii</sup>

Countries	Estimated number of people needing ART	Estimated coverage (%)	Reported number of people on ART
Botswana	210,000	≥ 95	204,298
Namibia	13,000	90	116,687
South Africa	26,000,000	83	2,150,880
Swaziland	110,000	82	87,534
Zambia	590,000	81	480,925
Zimbabwe	720,000	79	565,675
Kenya	830,000	73	604,027
Malawi	580,000	70	404,905
Tanzania	710,000	61	432,293
Lesotho	170,000	56	92,747
Uganda	-	64	313,117
Mozambique	690,000	45	308,577
Angola	120,000	36	42,607
DRC	220,000	29	64,219

Note: Data not available for Comoros, Madagascar and Seychelles

**Table 8.4. Regional AIDS-related deaths and treatment coverage**<sup>lxxxix</sup>

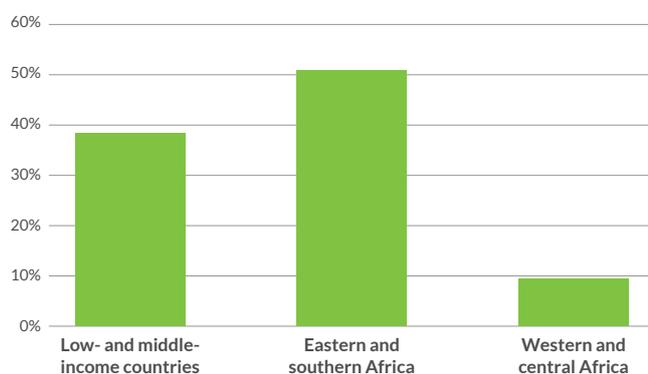
Regions	AIDS-related deaths	Total number of PLWHIV accessing ART	% of all PLWHIV accessing ART	Treatment coverage among women living with HIV	Treatment coverage among men living with HIV
Eastern and Southern Africa	420,000	11.7 million	60%	59%	44%
Western and Central Africa	310,000	2.1 million	35%	34%	21%
Middle East and North Africa	11,000	54 400	24%	-	-

The use of **pre-exposure prophylaxis (PrEP)**<sup>8</sup> is highly recommended to prevent HIV infection. There have been several successful trials in Africa, Asia and Europe and, since September 2015, WHO has recommended PrEP as part of comprehensive prevention. South Africa and Zimbabwe have implemented this complementary method with promising results.<sup>lxxx</sup> PrEPWATCH estimates a current PrEP user rate of 1,500–2,000 in Zimbabwe and 4,000–5,000 in South Africa.<sup>lxxxi</sup> Other prevention methods apart from PrEP and the female and male condom are voluntary medical male circumcision (VMMC) and post-exposure prophylaxis (PEP).<sup>9</sup>

### 8.1.6 Mother-to-child transmission

Mother-to-child transmission (MTCT) is the transmission of HIV from a mother to her child during pregnancy, labour, delivery or breast-feeding. MTCT is also referred to as 'vertical transmission' and is the cause of the majority of new HIV infections in children. MTCT is measured by the estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months. To calculate this, the estimated number of children newly infected with HIV as a result of MTCT among children born to HIV-positive women in the previous 12 months is divided by the estimated number of HIV-positive women who delivered in the previous 12 months. In 2013, ESA had the highest rates of children born to HIV-positive women testing positive for HIV within two months of birth; MTCT was lower in Western and Central Africa (see Figure 8.8).

**Figure 8.8. Children born to HIV-positive women tested for HIV within two months of birth, by region (%)**<sup>lxxxii</sup>



Without intervention, the transmission rates range from 15% to 45%. Effective interventions during pregnancy, labour, delivery and breast-feeding can reduce this to below 5%.<sup>lxxxiii</sup> Treatment consists of ART for the mother, a short course of ARV drugs for the baby and appropriate breast-feeding practices. Without treatment, about a third of children living with HIV die by their first birthday and half by their second.<sup>lxxxiv</sup> It is also important for HIV-negative pregnant women to remain negative; owing to their pregnancy, HIV-negative women are at a higher risk of acquiring HIV and transmission is increased as the viral load is high after being newly exposed.<sup>lxxxv</sup>

HIV-positive pregnant women can be exposed to discriminatory practices, such as receiving inaccurate information or inappropriate treatment. Failure to provide care during labour and forced or coerced sterilisation are also

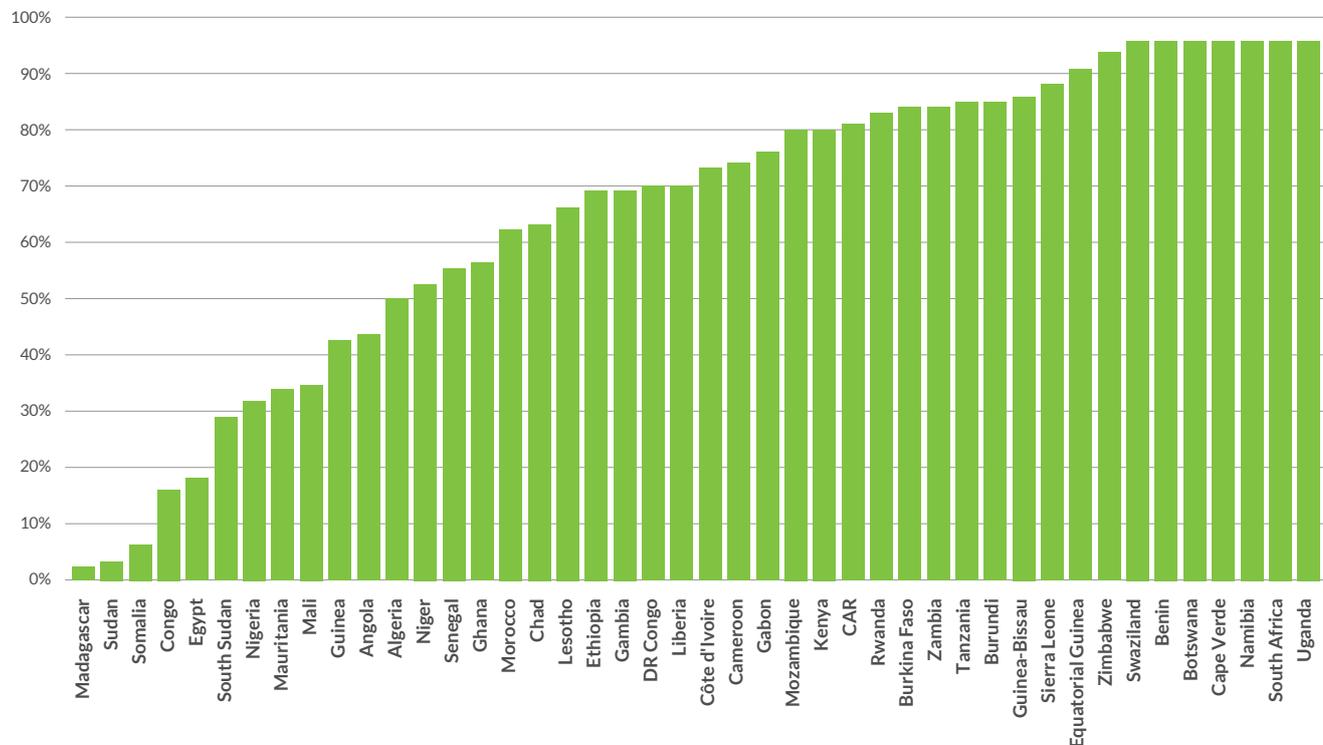
important concerns. In fact, 'Women who have faced HIV-related stigma and discrimination are less likely to access pre- and post-natal treatment and care.'<sup>lxxxvi</sup> These practices are detrimental to women's health as well as to efforts to eliminate MTCT.

<sup>8</sup> These are medicines that should be taken daily in order to prevent the virus from establishing a permanent infection. It is provided to people who do not have HIV but who are exposed to substantial risk of infection.

<sup>9</sup> For more on these methods please refer to WHO HIV/AIDS Fact Sheet: [www.who.int/mediacentre/factsheets/fs360/en/](http://www.who.int/mediacentre/factsheets/fs360/en/)

Impressive progress has been reported in 23 countries in which 88% of pregnant women living with HIV reside, under the Free Stay Free AIDS Free Framework to end AIDS among children, adolescents and young women by 2020.<sup>10</sup> In 2016, several of these countries reduced MTCT to under 5%. Five African countries have achieved 95% coverage of ARV treatment: Botswana, Namibia, South Africa, Swaziland and Uganda (see Figure 8.9).<sup>lxvii</sup>

**Figure 8.9. Pregnant women living with HIV receiving ARV medicines\* to prevent MTCT, 23 priority countries (%)<sup>lxviii</sup>**



Note: \* Either prophylaxis or lifelong therapy. \*\* Start Free Stay Free AIDS Free priority countries.

<sup>10</sup> This is an initiative of UNAIDS and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) with other partners, and is a super-fast-track framework for ending AIDS in children, adolescents and young women by 2020. <https://free.unaids.org/>

## 8.2 CONTINENTAL AND REGIONAL POLICY FRAMEWORKS

HIV and AIDS is addressed in the Constitutive Act of the AU (2000), where ‘the eradication of preventable diseases and the promotion of good health on the continent’ is explicitly stated as an objective (Obj. n). In 2004, the Solemn Declaration on Gender Equality in Africa underlined the gender-specific nature of the HIV pandemic, calling for accelerated ‘implementation of *gender specific* economic, social and legal measures aimed at combating the HIV/AIDS pandemic’ (Agreement 1, emphasis ours). It continues by stating that ‘Treatment and social services are available to women at the local level’, in such a way that they are responsive to the needs of families providing care. In addition, it calls to ‘enact legislation to end discrimination against women living with HIV/AIDS and for the protection and care for people living with HIV/AIDS, particularly women’. Finally, it calls to ensure ‘budgetary allocations in these sectors so as to alleviate women’s burden of care’. AIDS Watch Africa (AWA) is established as a unit within the Office of the Chairperson of the AUC, to publish annual reports on the HIV and AIDS situation on the continent and to ‘promote the local production of anti-retroviral drugs in our countries’ (Agreement 10).<sup>11</sup>

### 8.2.1 The Maputo Protocol and General Comment No. 1

The Maputo Protocol speaks to HIV and AIDS and women’s rights under Article 14 on Health and Reproductive Rights. The Maputo Protocol is the first internationally legally binding instrument that specifically deals with HIV and AIDS. Art. 14 asserts the need to protect and respect ‘the right to health of women, including sexual and reproductive health’.

#### Maputo Protocol – Art. 14.1 (d) and (e) and Art. 14.2

##### Article 14.1

(d) the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS

(e) the right to be informed of one’s health status and on the health status of one’s partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognized standards.

##### Article 14.2

(a) States Parties shall take all appropriate measures to provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas.

In 2012, the ACHPR adopted **General Comment No. 1 on Art. 14.1 (d) and (e)**, in order to guide full implementation of these Maputo Protocol provisions, which were considered to be framed in relatively open-ended and broad terms. The General Comment provides interpretative guidance on these provisions by articulating ‘the specific measures to be taken by States Parties in order to fulfill their obligations’. It also provides more detail on international standards and best practices for the effective implementation of the provisions of Art. 14.1 (d) and (e). The guidance provided is considered relevant not only in the context of the risk of non-compliance by state parties but also because of the risk of women’s human rights being violated through inaction and ignorance. The General Comment articulates two aspects: the normative content of the article in the Maputo Protocol and then the obligations of state parties in relation to those.

General Comment No. 1 underlines the importance of recognising and addressing the intersections between women’s human rights and HIV. It also underlines that women’s right to the highest attainable standard of health includes SRHR, and that women are unable to enjoy these rights in the context of high HIV prevalence and significant risk of exposure to and transmission of HIV. Moreover, women living with HIV have limited or no access to these rights, owing to HIV-related discrimination, stigma, prejudices and harmful customary practices. The General Comment therefore stresses that Art. 14.1 (d) and (e) ‘should not be read or understood in isolation from other provisions in the Protocol dealing with the intersecting aspects of women’s human rights, such as gender inequality, gender-based violence, harmful customary practices, and access to socio-economic rights’ (Introduction). Whereas General Comment No. 1 focuses on HIV and AIDS, in light of the disproportionate effect of HIV and AIDS on women’s health in Africa, it reasserts that Art. 14.1 (d) and (e) also applies to STIs.

<sup>11</sup> AWA was created at the Abuja 2001 Special Summit, and is an entity of the AU with the specific mandate to lead advocacy, accountability and resource mobilisation efforts to advance a robust African response to end AIDS, tuberculosis and malaria by 2030. Its work is grounded in the AU Heads of State and Governments’ political commitments to prioritise AIDS, tuberculosis and Malaria (Abuja Declarations) and the broader health and development agenda. [www.aidswatchafrica.net/index.php](http://www.aidswatchafrica.net/index.php)

## 8.2.2 The right to self-protection and to be protected from HIV and STIs

Art. 14.1 (d) provides for women and girls' right to self-protection and to be protected from HIV and STIs. General Comment No. 1 interprets this to refer to 'states' overall obligation to create an enabling, supportive, legal and social environment that empowers women to be in a position to fully and freely realise their right to self-protection and to be protected' (para. 10).

The right to self-protected and be protected 'includes the right to access information, education and sexual and reproductive health services'. It is also 'intrinsically linked to the right to equality and non-discrimination, life, dignity, health, self-determination, privacy and the right to be free from all forms of violence' (para. 11). General Comment No. 1 recognises that discrimination occurs in multiple forms and this prevents women and girls from realising their right to be self-protected and to be protected from HIV and STIs.

The right to self-protection and to be protected from HIV and STIs translates into several specific obligations for state parties. This first entails the obligation to guarantee *access to information and education* on sex, sexuality, HIV and sexual and reproductive rights. This information should cover HIV risk and transmission, prevention, testing, treatment, care and support and women's SRHR. It should be evidence-, facts- and rights-based, non-judgemental and understandable in content and language, and also address and deconstruct taboos, misconceptions and gender stereotypes. Chapter 7 discussed the features of comprehensive sexuality education (CSE) in more detail (in Section 7.2.2) –also in the context of the ESA Commitment, which has a strong reduction, and eventually elimination, in HIV prevalence among adolescents and youth as one of its key targets for 2020 (Case study 21 in Chapter 7).

Second, the right translates into access to *SRH services* (see also Chapter 7). General Comment No. 1 articulates a concern about limitations on and insufficient access to women's SRH services. It emphasises that these should be available to *all* women, and that this should not be based on a discriminatory assessment of risk (para. 30). In this context, women and girls' access to SRH services cannot be denied based on conscientious objection (para. 31).

Third, the enabling *legal and policy framework* should allow for women and girls 'to control their sexual and reproductive choices' and as such to strengthen their control over HIV prevention and protection choices (para. 33). This requires a non-discriminatory framework, as articulated in Art. 2 of the Maputo Protocol. This calls in particular for anti-discrimination legislation in relation to HIV and other STIs, and specifically to address related discrimination, stigma, prejudices and practices that heighten women's risk to HIV and related rights violations. Discrimination is noted to be based on various grounds, such as 'race, sex, sexuality, sexual orientation, age, pregnancy, marital status, HIV status, social and economic status, disability, harmful customary practices and/or religion' (para. 4). In cases where discriminatory laws and policies exist, states must take immediate action to remove these legal and policy barriers. Non-discrimination based on HIV is reiterated in General Comment No. 2 (discussed in Chapter 7, Section 7.2.3), which explicitly requires that HIV *testing* not be used as a condition for accessing contraception and safe abortion services. Moreover, it also mandates that positive test *results* 'must not serve as pretexts of the use of coercive practices or the suspension of service provision' (para. 59 of General Comment No. 2).

## 8.2.3 The right to be informed on one's health status and the health status of one's partner

The second specific article on HIV and STIs provides for the right to be **informed on one's health status**<sup>12</sup> and the health status of one's partner. This right, provided for in Art. 14.1 (e), encompasses a number of elements. First, it concerns the rights of women to 'access adequate, reliable, non-discriminatory and comprehensive information about their health'. This includes procedures, methods and technologies to determine one's health status, such as HIV testing, CD4 count, viral load, tuberculosis and cervical cancer screening (para. 13).<sup>13</sup> Second, the right to be informed also encompasses counselling, both pre-test (so decisions on testing can be based on informed consent) and post-test (e.g. on preventive measures or available treatment) (para. 14). Again, the applicability of these rights to all women is stressed in General Comment No. 1; this means 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 physical and mental disabilities (para. 15).

<sup>12</sup> Health status 'refers to the complete state of a person's physical, mental and social well-being and not merely the absence of disease or infirmity' (General Comment No. 1, para. 12).

<sup>13</sup> New methods and technologies for protecting against HIV infection that are currently being tested in clinical trials include HIV vaccines and the vaginal ring for HIV prevention.

The right to be informed on the **health status of one's partner** is stressed as vital for women to make informed decisions about their health, and can help avoid transmission of HIV and other STIs. General Comment No. 1 pays specific attention to the normative content of this right. It emphasises that informed consent is key in obtaining information on a partner's health status, and that such information cannot be obtained with coercion and should be aimed primarily at preventing harm to one's health. This calls for caution, especially when 'revealing of a partner's health status may result in negative consequences such as harassment, abandonment and violence' (paras 16 and 17). General Comment No. 1 further articulates that 'Information about a partner's health status may be obtained through **notification** by a third party (usually a health worker) or **disclosure**<sup>14</sup> (e.g. by the person him/herself)' (para. 18). Disclosure can be implicit.

General Comment No. 1 articulates a set of principles to guide health care workers in deciding whether to inform a patient's sexual partners of his or her HIV positive status (see Box 8.2). It is emphasised that, 'While disclosure should be encouraged, there should be no requirement to reveal one's HIV status or other information related to one's health status' (para. 19). Health workers should be authorised, without being obliged to decide on informing a patient's sexual partners, taking into account the nature of the situation and according to ethical considerations.

#### Box 8.2. Principles and guidelines for revealing of a person's health status by a third party (General Comment No. 1)

The revealing of a person's health status by a third party outside the ambit of the below-mentioned guidelines is unlawful and may lead to penal sanctions.

1. The HIV-positive person has been thoroughly counselled.
2. Counselling of the HIV-positive person has failed to achieve appropriate behavioural changes.
3. The HIV-positive person has refused to notify, or consent to the notification of, his/her partner(s).
4. A real risk of HIV transmission to the partner(s) exists.
5. The HIV-positive person is given reasonable advance notice.
6. The identity of the person is not revealed to the partner(s), if practicable, otherwise identity is revealed.
7. Follow-up is provided to ensure support to those involved, as necessary.
8. The person providing HIV treatment, care or counselling services has ensured that the person living with HIV is not at risk of physical violence resulting from the notification.

The right to be informed of one's health status and on the health status of one's partner translates into a set of obligations for states.

### 8.2.4 Obligations of states

When discussing both the right to self-protection and to be protected (Art. 14.1 d), and the right to be informed on one's health status and on the health status of one's partners (Art. 14.1 e), the specific obligations of states are addressed. This sub-section summarises these together with several overarching specific obligations, related to removing barriers, providing financial resources and setting up mechanisms for redress in case of violations (see Table 8.5). In addition to these specific obligations, General Comment No. 1 articulates *general* state obligations; these concern four sets of obligations on state parties—namely to respect, protect, promote and fulfil.

- To **respect**—requires states to refrain from interfering directly or indirectly with rights to self-protection, to be protected and to be informed on one's health status and the health status of one's partner.
- To **protect**—requires states to take measures that prevent third parties from interfering with these rights.
- To **promote**—requires states to create the legal, social and economic conditions that enable women to exercise their rights in relation to SRH.<sup>15</sup>
- To **fulfil**—requires states adopt all the necessary measures, including allocation of adequate resources, for the full realisation of these rights.

<sup>14</sup> 'Disclosure of one's health status is not always explicit. It may take various forms, including coded and implicit actions, by the person concerned. Coded or implicit actions may include disclosure that allows for the communication of a person's health status in a manner other than direct verbal dialogue. States must ensure that all forms of disclosure are recognized' (General Comment No. 1, para. 18)

<sup>15</sup> This involves engaging in sensitisation activities, community mobilisation and training of health care workers, religious, traditional and political leaders on the importance of the right to protection and to be informed on one's health status and the health status of one's partner.

**Table 8.5. Specific state obligations on Art. 14.1 (d) and (e), on women and girls' human right and HIV and AIDS**

General Comment No. 1 provides the interpretative guidance on the obligations of states on women and girls' human rights and HIV and AIDS, as reflected in Art. 14.1 (d) and (e).

Regarding Maputo Protocol Art. 14.1 (d)	
<b>Access to information and education</b>	<p>Guarantee information and education on sex, sexuality, HIV and sexual and reproductive rights to women, in particular adolescents and youths (evidence-, facts- and rights-based, non-judgemental and understandable; deconstructing taboos, misconceptions and gender stereotypes).</p> <p>Provide education programmes and access to information concerning HIV, including through sex education and public awareness campaigns,<sup>16</sup> on available health services responsible to <i>all</i> women's realities.<sup>17</sup> Include in curricula of educational institutions as well as in education that reaches women and girls in informal school systems, including faith-based schools.</p> <p>Provide appropriate pre-service and on-going in-service training to health providers and educators on health and human rights.</p>
<b>Access to SRH services</b>	<p>Ensure comprehensive, integrated, rights-based, women-centred and youth-friendly services that are free of coercion, discrimination and violence.</p> <p>Address limitations on and insufficient access to SRH services, especially HIV prevention and treatment. Guarantee available, accessible, affordable, comprehensive and quality women-centred HIV prevention methods (including female condoms, microbicides, prevention of MTCT (PMTCT) and PEP to <i>all women not based on a discriminatory assessment of risk</i>.</p> <p>Ensure health workers are not allowed, on the basis of religion or conscience, to deny access to SRH services.</p> <p>Integrate women-centred prevention methods in other services and promote access to such methods, including through planning, funding and distribution of new methods.</p>
<b>Enabling legal and policy framework</b>	<p>Create an enabling supportive, legal and social environment to allow women to control their sexual and reproductive choices, and thus to strengthen control over HIV prevention and protection choices.</p> <p>Ensure implementation of laws and policies through accountability mechanisms, implementing guidelines, a monitoring and evaluation framework and the provision of timely and effective redress mechanisms.</p> <p>Enact laws and policies to ensure women's access to health and legal services. Remove discriminatory legal and policy barriers. In particular, enact anti-discrimination legislation to address HIV and other STIs and related discrimination, stigma, prejudices and practices that perpetuate and heighten women's risk to HIV and related rights abuses.</p>
Regarding Maputo Protocol Art. 14.1 (e)	
<b>Access to information and education</b>	<p>Ensure access to information and education as highlighted above.</p> <p>Public health legislation should ensure pre- and post-test counselling is provided in all cases.</p> <p>Ensure information on one's health status held by authorities is subject to strict rules of data protection and confidentiality.</p>
<b>SRH procedures, technologies and services</b>	<p>Guarantee the availability, accessibility and affordability of comprehensive and quality procedures, evidence-based technologies and services for the medical monitoring of one's SRH, appropriate to the specific needs and contexts of women (including HIV testing, CD4 count, viral load, tuberculosis and cervical cancer screening)</p> <p>Provide training for health workers on, among others, non-discrimination, confidentiality, respect for dignity, autonomy and informed consent in the context of SRH services for women.</p> <p>Ensure testing is not used as a condition for access to other health services (including treatment, contraception, abortion, medical examination, ante- and post-natal services or any other reproductive health care). Also, positive test results should not be a basis for coercive practices, or the withholding of services.</p> <p>Ensure policies and programmes are sensitive to the needs of all women, and include youth-friendly services.</p> <p>Ensure procedures, technologies and services comply with ethical standards and are confidential, voluntary and obtained with informed consent.</p> <p>Create safe, enabling and positive conditions for informed disclosure and lawful notification on one's health status and the health status of one's partner</p>
Regarding both Arts 14.1 (d) and (e)	
<b>Barriers to SRHR</b>	<p>Take all appropriate measures to eliminate all barriers to women and girls' enjoyment of SRH.</p> <p>Take specific efforts to address gender disparities, harmful and traditional practices, patriarchal attitudes, discriminatory laws and policies.<sup>18</sup></p> <p>Take all appropriate measures to eliminate economic and geographic barriers of women in accessing health services and bring services closer to communities, especially to women in rural communities.</p>
<b>Provision of financial resources</b>	<p>Fund and empower public health authorities to provide a comprehensive range of services for the prevention and treatment of every person's SRH.<sup>19</sup></p>
<b>Redress for SRH violations</b>	<p>Ensure the availability and accessibility of redress and referral mechanisms such as legal and medical services in cases of violations of women sexual and reproductive rights, including non-discrimination, confidentiality, respect of autonomy and informed consent.</p> <p>Submit timely periodic reports on measures taken to implement the African Women's Rights Protocol in line with Art 26(1).<sup>20</sup></p>

<sup>16</sup> Information including HIV risk and transmission, prevention, testing, treatment, care and support and SRHR of women.

<sup>17</sup> All women, including young and adolescent women, older women, rural women, women who engage in sex work, women who use drugs, women living with HIV, migrant and refugee women, indigenous women, detained women and women with physical and mental disabilities (para. 15, General Comment No. 1).

## 8.3 NATIONAL LEGAL AND POLICY FRAMEWORKS

This section looks at the legal and policy frameworks at the national level regarding women's rights and HIV and AIDS. It tracks a selected number of legal and policy indicators at the national level to see the extent to which the Maputo Protocol provisions are being domesticated and implemented. These legal and policy indicators are complemented with a narrative analysis on the legal, policy and institutional changes in the countries. In the next and final section of this chapter, case studies shed light on strategies of change towards domestication and the realisation of women and girls' rights.

This section takes into account five legal and policy indicators on women and girls' rights and HIV and AIDS; these are presented in Table 8.6. Three indicators are of a legal nature and the other two are policy indicators. The first legal indicator concerns whether non-discrimination on the basis of HIV is guaranteed in the law. The second looks at the legal provisions regarding HIV testing and counselling. The scoring for this indicator can be that the legal provisions specify that testing is (a) voluntary or (b) mandatory. A third option here is that there are no legal provisions or guarantees regarding HIV testing; a fourth score is 'missing', for those countries where data such legal provisions could not be found.

The third legal indicator concerns the criminalisation of the wilful transmission of HIV. This captures whether a law to this extent is in place or not; such provisions can be in a penal code, sexual offences act, HIV policy or specific legislation. The indicator looks at the *wilful* transmission of HIV. Unlike all other indicators in this report, it is coded in yellow and blue, rather than red and green. This is to illustrate that criminalisation of wilful transmission is contested, and that, in theory, such legal provisions can both enhance and constrain women and girls' rights. Women and girls can be exposed to wilful transmission of HIV and suffer grievous bodily harm. But they can also be disproportionately and unrightly accused of wilfully transmitting HIV, and this can further marginalise minority groups, including sex workers. Yet the criminalisation can be counterproductive from a public health perspective, and can constitute a legal discriminatory barrier for women and girls living with HIV and AIDS.

The next two indicators are policy indicators. The fourth concerns whether there is a government programme providing access to ART. The fifth looks at the presence of government programming regarding MTCT. These indicators both look at whether or not such a policy and programmatic response is in place; the indicators themselves do not track the effectiveness of such programmes, or how many women and girls are reached by and benefit from these.

This section discusses trends, gaps and contestations on these five legal and policy indicators. This starts with a brief overview of these indicators for the African continent as a whole, and the main differences between regions. This is then followed by a more detailed discussion of countries, clustered in the five regions: Western, Eastern, Central, Southern and Northern.

**Table 8.6. 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 (can be a pilot)
	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
	M	Missing data: no data found on presence of government programmatic responses on MTCT

<sup>18</sup> In line with Arts 2 and 5 of the Protocol.

<sup>19</sup> In line with Art. 26(2) of the Protocol and para. 7 of the MPoA.

<sup>20</sup> In line with Art. 26(1) of the Protocol.

Table 8.7 presents an overview of legal and policy frameworks regarding women and girls' rights and HIV and AIDS. (For an explanation of the regional units used here, see Section 1.6.3 in Chapter 1.) Please note that the total for the continent has been recalculated, as some countries are included in more than one region.<sup>21</sup> The main trends are that the majority of countries (35) have legislation in place that ensures non-discrimination on the basis of HIV status. Sixteen countries lack such legislation, mostly in Eastern Africa (the Horn), Northern and Central Africa. For four, this could not be established (missing data). Most countries also 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).<sup>22</sup> In a notable minority of countries, HIV testing is mandatory for specific groups (Togo, for sex workers; Burundi and Uganda, for pregnant women; Angola and Chad, for medical procedures). In Eritrea, regulations ensuring voluntary HIV testing are absent.

The vast majority of countries have a programmatic response to access ART in place, and also have a programmatic response on MTCT 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, 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 the right to dignity and privacy. Criminalisation of non-disclosure, exposure and transmission of HIV as well as of sexual and HIV-related conduct pose a threat to VCT 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 from a public health perspective. The significance of these laws needs to be considered in the broader legal and policy frameworks regarding HIV and AIDS. When comparing trends in legal reform on non-discrimination and voluntary testing on the one hand, and criminalisation of wilful transmission of HIV on the other (see also comparison of Maps 6 and 7 in Chapter 2, Section 2.6.3), half of the 35 countries that criminalise wilful transmission of HIV also have legislation in place to ensure non-discrimination and voluntary testing. For the other half, these legal guarantees are not present: nine countries that criminalise wilful transmission of HIV lack guarantees for voluntary testing, three lack legislation on non-discrimination on the basis of HIV and five lack both. This means their legal frameworks lean more towards criminalisation than protecting and promoting the rights of women and girls living with HIV and AIDS.

Another set of laws that function as legal discriminatory barriers to accessing SRH services, including HIV testing and treatment, are those that criminalise and outlaw same-sex sexual acts. Three out of ten African countries criminalise and outlaw same-sex sexual acts;<sup>23</sup> in three countries same-sex sexual acts are punishable by death (Mauritania, Nigeria and Sudan). Twenty-one countries do not criminalise same-sex sexual acts; these include 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.<sup>24</sup> 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.<sup>25,26</sup> Stigmatisation and discriminatory attitudes and practices towards sexual orientation and gender diversity exist in virtually all African countries.

<sup>21</sup> A few countries are part of more than one of the regions used as analytical units here. For the continent 'total', these countries should be counted only once. (Angola and DRC are in both the Central and the Southern regional units, Rwanda and Burundi are in both Eastern and Central Africa and Tanzania is in both Eastern and Southern Africa).

<sup>22</sup> Algeria, Cape Verde, Equatorial Guinea, Gabon, Guinea, Guinea-Bissau, Mali, Mauritania, Niger and Western Sahara.

<sup>23</sup> 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.

<sup>24</sup> These 21 countries are all countries not listed in the previous footnote, minus South Africa, which has legalised same-sex partnership and marriage.

<sup>25</sup> Which is recognised in Mauritius' Equal Opportunities Act of 2008 and the Code of Ethics for Public Officers.

<sup>26</sup> 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.

Table 8.7. Continental and regional overview of legal and policy indicators, HIV and AIDS

HIV and AIDS	INDICATORS															
	Non-discrimination legislation based on HIV			Policy and/or legal regulations regarding voluntary HIV testing				Criminalisation of wilful transmission of HIV			Programmatic responses to access to ART			Programmatic response to MTCT		
	Y	N	M	VOL	MAN	ABS	M	Y	N	M	Y	N	M	Y	N	M
Western (15)	12	2	1	9	1	0	5	11	4	0	14	0	1	15	0	0
Central (11)	6	3	2	6	3	0	2	10	1	0	10	0	1	10	0	1
Eastern (11)	5	6	0	8	2	1	0	8	3	0	11	0	0	11	0	0
Southern (16)	15	1	0	15	1	0	0	10	6	0	16	0	0	15	0	1
Northern (7)	1	5	1	4	0	0	3	1	2	4	6	0	1	5	1	1
Total (55) <sup>27</sup>	35	16	4	39	5	1	10	35	16	4	52	0	3	51	1	3

<sup>27</sup> Excluding regional duplicates.

### 8.3.1 Western region

#### Trends, gaps and contestations

The national legal and policy frameworks in the Western region appear to be relatively strong regarding women and girls' rights and HIV and AIDS. Few countries have a mixed picture (Cape Verde, The Gambia, Guinea and Togo). Seven of the fifteen countries score positively on non-discrimination legislation, voluntary testing, programmatic responses to ART and MTCT. Two-thirds of the countries in the region have adopted laws that criminalise wilful transmission of HIV.

**Table 8.8. Key legal and policy indicators in Western Africa, HIV and AIDS**

Country	INDICATORS				
	Non-discrimination legislation based on HIV	Policy and/or legal regulations regarding voluntary HIV testing	Criminalisation of wilful transmission on HIV	Programmatic responses to access ART	Programmatic responses on MTCT
Benin	Yes	VOL	Yes	Yes	Yes
Burkina Faso	Yes	VOL <sup>28</sup>	Yes	Yes	Yes
Cape Verde	No	-	Yes	Yes	Yes
Côte d'Ivoire	Yes	VOL	No	Yes	Yes
The Gambia	-	VOL	No	-	Yes
Ghana	Yes	VOL <sup>29</sup>	No <sup>30</sup>	Yes	Yes
Guinea	No	-	Yes	Yes	Yes
Guinea-Bissau	Yes	-	Yes	Yes	Yes
Liberia	Yes	VOL	Yes	Yes	Yes
Mali	Yes	-	Yes	Yes	Yes
Nigeria	Yes	VOL	No <sup>31</sup>	Yes	Yes
Niger	Yes	-	Yes	Yes	Yes
Senegal	Yes <sup>32</sup>	VOL	Yes	Yes	Yes
Sierra Leone	Yes	VOL	Yes	Yes	Yes
Togo	Yes	MAN <sup>33</sup>	Yes	Yes	Yes

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

**Constitutional provisions:** None of the countries in Western Africa have constitutional provisions explicitly with respect to the rights of PLWHIV. The Constitution of Cape Verde expands on the right to health by specifying that it shall be achieved through an adequate network of health services and the gradual creation of economic, social and cultural conditions necessary to guarantee the improvement of quality of life of the populations.

**Statutory law regarding HIV and AIDS:** Benin, Burkina Faso, Côte d'Ivoire, Ghana, Guinea-Bissau, Liberia, Mali, Nigeria, Niger, Senegal, Sierra Leone and Togo have all adopted HIV-specific laws that include provisions on *non-discrimination based on HIV*.<sup>xxxix</sup> These laws cover the right of women with HIV to marry and have a family, and address discrimination and stigma linked to PLWHIV. They also address MTCT and access to and use of ART. Under the 2011 National HIV and AIDS Commission Act, the government of Sierra Leone pledges to take steps to ensure not only access to health care but also medicines at affordable prices for PLWHIV and those exposed to the risk of HIV infections. The legislation adopted in Benin and Nigeria is noteworthy as it places a specific emphasis on the rights of PLWHIV. The 2014 Nigerian Anti-Discrimination Act aims to eliminate all forms of discrimination based on HIV status, as well as giving effect to human rights guaranteed in Chapter 4 of the 1999 Constitution of the Federal Republic of Nigeria, but also recognises obligations under international and regional human rights and other instruments. Similarly, in Benin, Act No. 2005-31 of 10 April 2006 on the prevention, treatment and control of HIV and AIDS states that any person living with HIV shall enjoy without any discrimination his or her civil, political and social (housing, education, employment, health, social protection, etc.) rights.

<sup>28</sup> According to WHO, testing in Burkina Faso is voluntary and confidential and is mostly carried out by community-based organisations.

<sup>29</sup> According to Ghana's National HIV AIDS and STI Policy (2013), mandatory testing is required of persons charged with rape, defilement and incest.

<sup>30</sup> Although Ghana has not adopted legislation specifically on wilful transmission of HIV, it may be prosecuted under the Criminal Offences Act of 1960 and the Domestic Violence Act of 2007.

<sup>31</sup> According to AIDSmap.com, although there is no national HIV-specific law, the states of Enugu and Lagos passed HIV-specific laws that include provisions for prosecuting 'wilful' HIV transmission in 2005 and 2007, respectively. There are no reports of prosecutions. A draft national HIV-specific law focusing on human rights, with no criminalisation provisions, is proposed.

<sup>32</sup> Law 2010-03 of 9 April 2010, Art. 24, addresses discrimination against PLWHIV in the context of employment.

<sup>33</sup> Sex workers are subject to mandatory and periodic testing for HIV and STIs under Art. 50 of Law 2005-012.

With respect to laws that prohibit *wilful transmission of HIV*, 11 out of 15 countries in Western Africa have enacted such laws, based on the N'Djamena model law, developed in 2004 in N'Djamena by Action for West Africa Region-HIV & AIDS, in short (AWARE-HIV & AIDS).<sup>xc</sup> Côte d'Ivoire and The Gambia are currently discussing proposals on HIV-specific criminal laws. While Nigeria does not have national legislation that prohibits wilful transmission, two states—Enugu and Lagos—have passed HIV-specific laws criminalising 'wilful' HIV transmission. In Ghana, wilful transmission of HIV may be prosecuted under the Criminal Offences Act (1960) and the Domestic Violence Act (2007).

In nine of the countries in the Western Africa region, *HIV testing* is voluntary as stated in adopted legislation and/or policies. However, there are exceptions made, and in some cases and/or for certain groups testing is mandatory. In Togo, it is compulsory for sex workers to undergo periodic testing for HIV and STIs, under Article 50 of Law 2005-012.<sup>xci</sup> Additionally, legislation in Côte d'Ivoire and Senegal places age restrictions with respect to access to HIV testing. For example, for persons under 16 in Côte d'Ivoire and persons under 15 in Senegal, the consent of parents or legal representative is required for an HIV test. Under Ghana's National HIV AIDS and STI Policy (2013), mandatory testing is required of persons charged with rape, defilement and incest.

**Policy and institutional reforms:** All the countries in the Western Africa region have developed policies and strategic plans on HIV and AIDS. The areas covered in the policies reviewed include addressing discrimination and stigma linked to PLWHIV, investment in HIV and AIDS research, PMTCT and access to ART. Liberia has an HIV/AIDS Policy that focuses specially on the education sector (2010). Notably, Guinea has a National Strategy Framework on HIV & AIDS for 2008–17 that includes effective means of addressing the concerns of women and girls. Guinea-Bissau specifically recognises women as a priority group in its National Strategic Plan on HIV & AIDS 2007–11.

Almost all countries in West Africa have put in place a *national body* that focuses exclusively on HIV and AIDS, with the exception of Benin. Cape Verde, Liberia, Nigeria and Sierra Leone all have adopted a multi-sectoral approach in their policy and/or institutional reform. For example, in Sierra Leone, the National HIV & AIDS Secretariat is responsible for coordinating a multi-sectoral team to reduce the spread of HIV and AIDS and mitigate its impact. This commitment is also reflected in the country's National Strategic Plan on HIV & AIDS 2016–20.

All countries in Western Africa have adopted *programmatic responses to access to ART*. In most cases, this is done in connection to preventing MTCT, such as in Nigeria. In Liberia, as part of the National HIV and AIDS Strategic Plan 2015–20, HIV-positive mothers are to be placed on a lifelong ART.

In addition, all countries in Western Africa have adopted programmes specifically addressing *PMTCT*. The Gambia is one of the few countries to have adopted a specific strategic plan focusing on the elimination of mother-to-child transmission (eMTCT). For example, the Gambia's National Strategic Plan for eMTCT – HIV 2013–15 proposes to prioritise elimination activities in areas with high unmet needs, with innovative interventions such as the PMTCT fast track and mother support groups introduced and re-introduced, respectively. In Liberia, the eMTCT initiative is part of the National HIV and AIDS Strategic Plan 2015–20.

## Key gaps and contestations

With respect to HIV and AIDS and women's rights, the **absence of legislation on non-discrimination based on HIV** in six of the fifteen countries is a first critical gap, as these countries do not have legal protection for PLWHIV. A human rights-based approach would strengthen their protection. A second legal gap is that **voluntary HIV testing and counselling is not guaranteed** in six of the fifteen countries, with one country explicitly demanding mandatory testing for sex workers. A third legal gap related to HIV testing is that **age restrictions** are placed on HIV testing in two countries, and that young people can access these services only with third party consent. A fourth and related concern is that HIV test results of a minor can be **disclosed**: in Côte d'Ivoire it is not illegal for a doctor to share the status of a minor with his/her parents or legal representative, under Art. 15 of Law No. 2014-430. Guinea-Bissau also allows results to be shared with parents of a minor, a guardian in the case of orphans or persons deemed incapable or a judicial authority having legally asked for the test. A fifth critical issue are the many countries that have adopted, or are considering adopting, laws that **criminalise wilful transmission of HIV**. The effects of such laws on women and girls' rights merit specific attention and need to be investigated.

Another sixth gap and contestation relates to the **criminalisation of same-sex sexual acts and relations**. In Western Africa, same-sex sexual acts are legal in only half of the countries: Benin, Burkina Faso, Cape Verde, Côte d'Ivoire, Guinea-Bissau, Mali and Niger. In these countries, the Penal/Criminal Code does not specify provisions outlawing same-sex sexual relations. The Gambia, Guinea, Liberia, Nigeria and Senegal criminalise same-sex sexual activity between both men and women whereas in Ghana, Sierra Leone and Togo this law applies to men specifically. In Nigeria, same-sex sexual acts are **punishable by death** codified under *Sharia* law. The death penalty is implemented provincially in 12 Nigerian states. Besides, Nigeria's same-sex marriage (prohibition) act specifically prohibits 'registration of gay clubs, societies and organisations, their sustenance, processions and meetings'. In addition, a person can be sentenced to 10 year in prison if he or she 'registers, operates or participates in gay clubs, societies organization or "supports" the activities of such organisations'. This complicates work of NGOs on SOGIE issues and hampers the provision of essential health services for LGBT, including HIV and AIDS services.<sup>xcii</sup>

**Table 8.9. Countries that do and do not criminalise same-sex sexual acts, Western Africa**

Countries that criminalise same-sex sexual acts	Countries that do not criminalise same-sex sexual acts
The Gambia	Benin
Ghana	Burkina Faso
Guinea	Cape Verde
Liberia	Côte d'Ivoire
Nigeria*	Guinea-Bissau
Senegal	Mali
Sierra Leone	Niger
Togo	

\* same-sex sexual acts are punishable by death

With respect to policy and institutional reform, a seventh gap is that one in three countries do not have a programmatic response to **access ART**. Although all countries in the region address MTCT, there is an urgent need for policies/laws that would take into account the **specific need of women and girls living with HIV and AIDS** as well as their rights. Moreover, countries would gain from policies and programmes that include eMTCT strategies and providing continual access to treatment and care. A final gap is that there are few policy, programme and institutional mechanisms specially addressing the needs of **youth and adolescents with respect to HIV and AIDS**. Some countries have adopted multi-sectoral approaches at either policy or institutional level, thus it may be that the concerns of these groups are addressed.

### 8.3.2 Eastern region

#### Trends, gaps and contestations

The majority of countries in the Eastern region show a strong profile on four key indicators regarding women's rights and HIV and AIDS. Djibouti, Kenya and Tanzania all score positively on non-discrimination provisions on HIV, on guarantees for voluntary HIV testing and on programmatic responses to access ART and also MTCT. Burundi, Ethiopia, Rwanda, Somalia, South Sudan, Sudan and Uganda have three positive scores on these indicators. Eritrea stands out with positive scores on the policy indicators (access to ART and MTCT) but no legal provisions guaranteeing non-discrimination on the basis of HIV or VCT. Two-thirds of the countries in the region have adopted legislation that criminalises wilful transmission of HIV.

The EAC HIV Prevention and Management Act 2012 has been operational since December 2014 (see also Case study 28 in Section 8.4). Given the Constitution of the Community at the time, this happened following signature of the said Act 2014 by the then Tanzanian Head of State President Jakaya Kikwete.<sup>34</sup> South Sudan only recently joined the community and thus is yet to sign this Act.

**Table 8.10. Key legal and policy indicators in Eastern Africa, HIV and AIDS**

Country	INDICATORS				
	Non-discrimination legislation based on HIV	Policy and/or legal regulations regarding voluntary HIV testing	Criminalisation of wilful transmission on HIV	Programmatic responses to access ART	Programmatic responses on MTCT
Burundi	Yes <sup>35</sup>	MAN <sup>36</sup>	Yes	Yes	Yes
Djibouti	Yes	VOL	Yes	Yes	Yes
Ethiopia	No	VOL <sup>37</sup>	No	Yes	Yes
Eritrea	No	ABS	Yes	Yes	Yes
Kenya	Yes <sup>38</sup>	VOL <sup>39</sup>	Yes	Yes	Yes
Rwanda	No	VOL <sup>40</sup>	Yes	Yes	Yes
Somalia	No	VOL <sup>41</sup>	No	Yes	Yes
South Sudan	No	VOL	Yes	Yes	Yes
Sudan	No	VOL <sup>42</sup>	No	Yes	Yes
Tanzania	Yes	VOL <sup>43</sup>	Yes	Yes	Yes
Uganda	Yes	MAN	Yes	Yes	Yes

<sup>34</sup> In line with the EAC's regulations, an Act of the Community obtains this status once all member states have signed it.

<sup>35</sup> In addition to legislation on the legal protection of persons living with HIV, non-discrimination on the basis of HIV and AIDS status is also explicitly prohibited in the Constitution of Burundi in its non-discrimination clause in Art. 22.

<sup>36</sup> The prohibition of mandatory testing is too narrowly drafted such that mandatory testing is expressly prohibited only if it is carried out to allow or for continued stay in social or professional venues or activities.

<sup>37</sup> Under the PMTCT guidelines, testing of pregnant women is carried out under the provider initiated 'opt-out' HIV testing approach—that is, all pregnant women are provided with the test unless they expressly decline it.

<sup>38</sup> In addition to HIV-specific legislation, Kenya's Constitution prohibits discrimination on the basis of health status in its non-discrimination clause in Art. 27(4).

<sup>39</sup> Exception to prohibition of mandatory testing in the context of sexual offenders.

<sup>40</sup> The Reproductive Health Act provides for voluntary testing but mandatory testing may be required on request by competent organs in accordance with the law.

<sup>41</sup> PITC recommended under the National HIV Strategy 2014–19.

<sup>42</sup> PITC.

<sup>43</sup> Exception to prohibition of mandatory testing in the context of sexual offenders.

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

**Constitutional provisions:** Out of all the states in the Eastern region, Burundi's Constitution is explicit with respect to the rights of persons living with HIV and AIDS. Art. 22 asserts that all citizens are equal before the law and that no Burundian citizen is to be the subject of discrimination on the basis of, among others, sex and/or HIV and AIDS status. Kenya has an implied provision as it prohibits discrimination on the basis of health status in Art. 27(4) of the Constitution. All countries in the region have provisions that can be utilised to advance the rights of girls and women living with HIV and AIDS. Generally, these focus on the principles of non-discrimination and equality before the law, the right to health, the right to inherent dignity and physical integrity and the right to privacy.

**Statutory law on HIV and AIDS and women's rights:** Only five of the twelve states have specific laws dedicated to the *rights of PLWHIV*: Burundi, Djibouti, Kenya, Tanzania and Uganda. These laws cover testing and disclosure, addressing discrimination and stigma linked to PWLHIV, PMTCT and access to and use of ART. In Kenya, these laws also grant access for HIV testing for adolescents who are below the age of consent (18) in specified circumstances. Six other states (Eritrea, Ethiopia, Rwanda, Somalia, South Sudan and Sudan) have laws that touch on the rights of PLWHIV in other rights areas—for instance labour/worker rights and rights related to GVAW. Art. 3(d) of Uganda's Prohibition of FGM Act also specifically states that aggravated FGM is considered to have taken place where HIV is transmitted as a result.

In eight of the twelve countries, HIV counselling and testing is voluntary. Burundi has a provision that prohibits mandatory testing but this has so many restrictions and exceptions that it effectively renders testing mandatory. Uganda's HIV Prevention and Control Act 2014 allows for mandatory testing of pregnant women living with HIV and AIDS. This infringes on the right to privacy in the 1995 Constitution and also goes against the EAC HIV and AIDS Prevention and Management Act. Eritrea lacks a provision or regulation on the character of HIV testing and counselling.

Two-thirds of the countries in the region have provisions that prohibit *wilful transmission of HIV and AIDS*. These are found either in HIV and AIDS legislation or in the penal code. Such legislation is not found in Ethiopia, Somalia and Sudan.

**Policy and institutional reform:** All states have a policy that directly focuses on and/or alludes to HIV and AIDS. This is in the context of national health policies and/or strategic plans or policies that are exclusively dedicated to the rights of PLWHIV (Burundi, Djibouti, Ethiopia, Kenya, Somalia, South Sudan, Sudan, Tanzania and Uganda). With the exception of Sudan, all these policies acknowledge that the HIV and AIDS pandemic disproportionately affects women, including girls and youth. The areas covered in said policies cover scaling-up efforts with regard to testing and disclosure, addressing discrimination and stigma linked to PWLHIV, PMTCT and access to and use of ART. Kenya has a policy to specifically address HIV and AIDS among adolescents (the Fast-Track Plan to End HIV and AIDS among Adolescents and Young People 2015). Notably, all the reviewed states have either policy or programmatic interventions on ART and MTCT.

In addition, all states have an *institutional mechanism/body* that exclusively addresses the rights of PLWHIV. From the desktop research conducted, with the exception of Kenya, whose National AIDS Control Council has a Committee on Gender to ensure the state's plans are responsive to gendered concerns arising out of HIV and AIDS, it was not possible to ascertain the extent to which these bodies have units that exclusively address the rights of girls and women living with HIV and AIDS.

## Key gaps and contestations

The key gaps in legal and policy reform regarding women and girls' rights and HIV and AIDS in the Eastern region are, first, the **absence of non-discrimination** provisions in six countries to protect women and girls living with HIV from stigma and discrimination. These countries are Ethiopia, Eritrea, Rwanda, Somalia, South Sudan and Sudan. A second gap relates to **the lack of legal guarantees for voluntary HIV testing and counselling**, in Eritrea, and **mandatory HIV testing** for pregnant women in Burundi and Uganda.

A third gap entails provisions that allow for **disclosure of HIV and AIDS status to third parties** in Burundi and Uganda. According to Art. 28 of Law Decree 1/018(2005) in Burundi, doctors are in a position to reveal the HIV status of a PLWHIV to their partner or spouse if they are unable to or do not want to. In Uganda according to Section 18 of the HIV Prevention and Control Act [2014], the disclosure is framed very broadly, as HIV test results may be disclosed to 'any other person with whom an HIV infected person is on close or continuous contact including a sexual partner'. These exceptions raise serious questions as to confidentiality and undermine the right of girls and women to make decisions concerning their own bodies, as articulated in the Maputo Protocol and the constitutions of these states.

A key contestation concerns the adoption of laws on **wilful transmission of HIV and AIDS**. Views on the meaning of such laws for women and girls' rights are diverse. Of the eight countries that criminalise wilful transmission of HIV, five lack legal provisions that strengthen a human rights perspective. Of these eight, Rwanda and South Sudan have mandatory testing provisions, Burundi and Uganda lack legislation ensuring non-discrimination and Eritrea lacks non-discrimination legislation on the basis of HIV, and also lacks guarantees for voluntary HIV testing.

Another contestation relates to the criminalisation of same-sex sexual acts. Djibouti and Rwanda are the only two countries in Eastern Africa where consensual same-sex sexual relations are not criminalised by provisions in the Penal Code. Contrastingly, Burundi, Eritrea, Somalia, South Sudan, Sudan and Uganda **criminalise same-sex sexual acts** between both men and women. In Kenya and Tanzania the criminalisation applies only to men. In Sudan, the death penalty can be applied to some consensual same-sex sexual acts codified under *Sharia* law and implemented countrywide, making it virtually impossible for NGOs to work on SOGIE issues in the country. To a lesser extent, SOGIE-based NGOs in Tanzania and Uganda face legal barriers, as there are laws prohibiting registration of NGOs whose activities are 'not for public interest' or 'contrary to national written law'.<sup>xctiii</sup>

**Table 8.11. Countries that do and do not criminalise same-sex sexual acts, Eastern Africa**

Countries that criminalise same-sex sexual acts	Countries that do not criminalise same-sex sexual acts
Burundi	Djibouti
Eritrea	Rwanda
Ethiopia	
Kenya	
Somalia	
South Sudan	
Sudan*	
Tanzania	
Uganda	

\* same-sex sexual acts are punishable by death

With respect to policy and institutional reform, an important gap is that, with the exception of Kenya, all states need to institute mechanisms that specifically address gendered concerns, with regard to the rights of girls and women living with HIV and AIDS. Moreover, when acknowledging the disproportionate effect of HIV and AIDS on women and girls, it is necessary for states to institute action plans that are solely dedicated to addressing issues that girls and young women face, beyond PMTCT. Such explicit attention to women and girls is missing in many health policies and even HIV and AIDS policies. Yet HIV and AIDS interacts with various other factors, such as sex, gender, socio-economic status, age, marital status and access to reproductive health care, which result in women and girls being more disparately infected and affected. Therefore, failing to consider these intersecting factors while addressing other health-related matters amounts to an ineffective HIV response that does not respond to women and girls' lived realities.

### 8.3.3 Central region

#### Trends, gaps and contestations

The national legal and policy frameworks of the countries in the Central region show similarities. CAR, Congo Republic and DRC have non-discrimination legislation on the basis of HIV, and regulations for voluntary testing in place, as well as programmatic responses to access ART and on MTCT. Angola, Burundi and Chad differ in their profile, given that HIV testing in these countries is/can be mandatory for certain groups. São Tomé and Príncipe provides for voluntary testing, but no data was found regarding non-discrimination provisions regarding HIV status. Cameroon, Gabon and Rwanda stand out for lacking legal provisions on non-discrimination on the basis of HIV. All countries, except São Tomé and Príncipe, have legislation that criminalises wilful transmission of HIV. Data on the legal and policy framework of Guinea Equatorial could not be obtained.

**Table 8.12. Key legal and policy indicators in Central Africa, HIV and AIDS**

Country	INDICATORS				
	Non-discrimination legislation based on HIV	Policy and/or legal regulations regarding voluntary HIV testing	Criminalisation of wilful transmission on HIV	Programmatic responses to access ART	Programmatic responses on MTCT
Angola	Yes	MAN <sup>44</sup>	Yes	Yes	Yes
Burundi	Yes <sup>45</sup>	MAN <sup>46</sup>	Yes	Yes	Yes
Cameroon	No <sup>47</sup>	VOL	Yes	Yes	Yes
CAR	Yes	VOL	Yes	Yes	Yes
Chad	Yes	MAN <sup>48</sup>	Yes	Yes	Yes
Congo Republic	Yes	VOL	Yes	Yes	Yes
DRC	Yes	VOL <sup>49</sup>	Yes	Yes	Yes
Equatorial Guinea <sup>50</sup>	-	-	Yes	-	-
Gabon	No <sup>51</sup>	-	Yes	Yes	Yes
Rwanda	No	VOL <sup>52</sup>	Yes	Yes	Yes
São Tomé and Príncipe	-	VOL	No <sup>53</sup>	Yes	Yes

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

**Constitutional provisions:** Except for Burundi, which prohibits discrimination on the basis of HIV and AIDS infection, none of the constitutions has provisions on non-discrimination based on health status. General provisions in articles on discrimination, however, such as 'discrimination established by... other similar reasons' (Equatorial Guinea) or 'discrimination on the basis of sex or any other form of discrimination' (Rwanda) could be understood to include health status.

Some states explicitly include the duty of states to provide support to health promotion and adequate and resourced health services (e.g. Angola, CAR, Congo Republic, Equatorial Guinea, Rwanda). No states have explicit provisions on HIV and AIDS or STIs (prevention, protection, services) in their constitutions. Nine out of eleven constitutions in the region mention the right to health and health care or other related health rights. The constitutions of DRC and São Tomé and Príncipe specifically address youth rights, including protection from ill health. The Constitution of Gabon mentions protection of the health of vulnerable groups such as children, mothers, disabled persons and the elderly.

<sup>44</sup> This is a mixture of the two, as Law 8/04 on HIV and AIDS (2004) provides that persons deprived of freedom must not be subjected to compulsory tests to detect HIV infection, except for those whose judicial process or medical condition so demands.

<sup>45</sup> In addition to in legislation on the legal protection of persons living with HIV, non-discrimination on the basis of HIV and AIDS status is explicitly prohibited in the Constitution of Burundi in its non-discrimination clause in Art. 22.

<sup>46</sup> The prohibition on mandatory testing is too narrowly drafted, such that mandatory testing is expressly prohibited only if it is carried out to allow or for continued stay in social or professional venues or activities.

<sup>47</sup> The Penal Code 2016 prohibits discrimination in public spaces and on the workforce on the basis of health status.

<sup>48</sup> Art 4. Has provisions allowing for compulsory HIV testing when ordered by a court.

<sup>49</sup> Loi no 08/011 du 14 juillet 2008 portant protection des droits des personnes vivant avec le VIH/SIDA et des personnes affectées.

<sup>50</sup> Original documents for Guinea Equatorial were not found, therefore indicators could not be assessed.

<sup>51</sup> HIV legislation, including an article on discrimination and stigmatisation, was in the proposal stage in 2012.

<sup>52</sup> The Reproductive Health Act provides for voluntary testing but mandatory testing may be required on request by competent organs in accordance with the law.

<sup>53</sup> The Penal Code (Art. 182) aggravates punishment for sexual abuse when the perpetrator is a 'carrier of sexually transmitted disease, namely venereal or syphilitic disease' but does not address wilful transmission.

**Statutory law on HIV and AIDS:** Legal guarantees for PLWHIV are provided in HIV-specific laws or in reproductive health laws (e.g. Rwanda). Six out of eleven countries in the region have a HIV-specific law that includes rights to protection from *discrimination on the basis of HIV status* (Angola, Burundi, CAR, Chad, Congo Republic and DRC). In Cameroon, policies seem to compensate for the lack of a HIV-specific law: its National HIV and AIDS Strategy includes actions aimed at reducing stigmatisation and discrimination of PLWHIV or the requirement of voluntary testing. The Penal Code of Cameroon also criminalises discrimination on the basis of medical status in public spaces and on the workforce.

All (six) HIV-specific laws include articles on the *criminalisation of the wilful transmission of and exposure to HIV and AIDS*. Among francophone African countries, Congo Republic, in its specific HIV law, provides for most exceptions (seven in total) to criminal liability for wilful transmission.<sup>xcliv</sup> Four countries that do not have a HIV-specific law refer to the penal code for criminalisation of transmission (Cameroon, Gabon, Rwanda, São Tomé and Príncipe).

Nine out of eleven countries have legal provisions regarding *HIV testing and counselling*, six of them on voluntary testing and three with circumstances under which mandatory testing is permitted. Rwanda has a Reproductive Health Act that includes articles on HIV and AIDS. It provides the right to voluntary testing for all and confidentiality of results; however, it also includes a provision that mandatory testing may be demanded on request by competent organs in accordance with the law. The HIV-specific laws of CAR, Chad and Congo Republic have provisions explicitly ensuring confidentiality and protection against *disclosure* of HIV test results. In Gabon and São Tomé and Príncipe, the penal codes provide for non-disclosure of medical information by professionals.

**Policy and institutional reforms:** An analysis of the available national HIV and AIDS strategic plans reveals that the extent to which women's rights are addressed varies. Congo Republic has a gender-disaggregated analysis of vulnerable groups and identifies a broad range of vulnerable women: female sex workers, girl-mothers, girls in secondary and tertiary schools, female entrepreneurs, widows and female heads of households, female employees in the public and private sector and indigenous women. The strategic plan also includes a gender and power analysis of vulnerabilities and social determinants of health.

Rwanda's National Strategic Plan on HIV/AIDS 2009–12 is an exception in that it prioritises monitoring and protection of seropositive women, women's access to justice and economic empowerment. Targets in the results framework are also sex-disaggregated. The strategic plan of São Tomé and Príncipe, by contrast, does not recognise women and adolescents as vulnerable groups and does not analyse the social determinants of health. Most other strategic plans mention vulnerable groups such as youth and adolescents, police officers, prisoners, mobile populations such as truck drivers and traders, pregnant women, indigenous people and orphans and vulnerable children, but often without addressing gender differences.

Over the past few years, Central Africa has received increased attention from the HIV and AIDS donor community because of the rise in new HIV infection and AIDS morbidity rates. Several initiatives have been launched to accelerate the HIV and AIDS response in the region. Cameroon and DRC were among 25 countries<sup>54</sup> with high numbers of new HIV infections in adolescents and adults that participated in the development of the Prevention 2020 Road Map, together with UNAIDS. This provides the basis for a country-led movement to scale up HIV prevention programmes. The countries seek to fast-track a comprehensive response to meet global and national targets and commitments to end AIDS<sup>55</sup> as a public health threat by 2030. The roadmap also emphasises the empowerment of adolescent girls, young women and key populations at risk so they can protect themselves and stay free of infection.<sup>xcv</sup>

Another fast-track initiative has been launched focused on engaging large cities in the fight against HIV and AIDS (see Box 8.3). In 2006, members of the Economic Community of Central Africa, with support from Germany, initiated the *Projet prévention du VIH/Sida en Afrique centrale* (Project for the Prevention of HIV/AIDS in Central Africa), which targets young people between 15 and 24 years old. More recently, the *'test and treat' approach* (reducing delays in starting ART by offering it as soon as people are diagnosed HIV-positive) has been adopted and is being implemented in Cameroon, CAR, DRC and Gabon.<sup>xcvi</sup>

54 These countries are Angola, Brazil, Cameroon, China, Côte d'Ivoire, DRC, Ethiopia, Ghana, India, Indonesia, Kenya, Lesotho, Malawi, Mexico, Mozambique, Namibia, Nigeria, Pakistan, South Africa, Swaziland, Tanzania, Uganda, Ukraine, Zambia and Zimbabwe. See [www.unaids.org/sites/default/files/media\\_asset/hiv-prevention-2020-road-map\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/hiv-prevention-2020-road-map_en.pdf)

55 [www.fast-trackcities.org/about](http://www.fast-trackcities.org/about)

**Box 8.3. Fast-Track Cities Initiative in West and Central Africa**

Mayors of several cities worldwide have signed the Declaration on Fast-Track Cities: Ending the AIDS Epidemic, under which they commit to accelerate and scale up their local AIDS responses. The initiative was launched on World AIDS Day 2014 in Paris. The initiative is meant to build on, strengthen and leverage existing HIV-specific and -related programmes and resources to 1) attain the 90-90-90 targets, 2) increase use of combination HIV prevention services and 3) reduce to zero the negative impact of stigma and discrimination. The initiators, in their Declaration, propose a human rights-based approach and access for all. Young women, female sex workers and transgender people are mentioned as key target groups. The initiative is a global partnership between the City of Paris, the International Association of Providers of AIDS Care, UNAIDS and UN-Habitat, in collaboration with local, national, regional and international partners and stakeholders.

As part of their commitment, Fast-Track Cities are expected to develop a city-specific action plan to achieve the objectives. Cities are encouraged to produce quarterly internal reports and make them available to local stakeholders, particularly affected communities. The initiative provides a city-specific web-based dashboard for each city to map eight simple HIV indicators that will allow them to report their progress and to allow civil society actors and stakeholders to monitor activities and achievements toward attaining the 90-90-90 and zero discrimination and stigma targets.

As of April 2016, 60 local governments have signed the declaration, of which 30 are located in Sub-Saharan Africa and 18 in West and Central Africa in particular (Abidjan, Accra, Atakpamé, Bamako, Bamenda, Bangui, Cotonou, Dakar, Djouougou, Douala, Kinshasa, Lagos, Libreville, Lomé, Lubumbashi, Mbuji-Mayi, Ouesso, Yaoundé).

**Key gaps and contestations**

A first gap in the national legal and policy frameworks in the Central region are the countries that **lack legal provisions on non-discrimination on the basis of HIV**—notably Gabon and Rwanda—and lack of clarity on the presence of such provisions in Equatorial Guinea and **São Tomé and Príncipe**.

Second, there is weak translation of women and girls' human rights in legal, policy and institutional frameworks. Despite commitments of ministries of health to including human rights and gender perspectives in their strategic plans, these are rarely translated into specific actions. Although most HIV policies and strategic plans provide gender-disaggregated data that show higher HIV prevalence in women, they **rarely provide actions specifically targeting** women or underlying gender relations contributing to high prevalence (with the exception of Congo Republic and Rwanda).

A third weakness concerns the absence of, or the gender-blindness of, any approach to **youth or adolescent girls**. These groups are absent in some plans (e.g. Cameroon, Gabon). Where they are present, they are often not addressed in a gender-specific manner. In none of the plans that we had access to were adolescent girls (with high infection rates) recognised as a specific target group. This is a missed opportunity to design and deliver HIV services that meet their needs.

A fourth gap concerns the need for **parental consent** for HIV testing. Some countries provide an explicit age of consent for testing. CAR, Cameroon and DRC mention that consent is needed for minors under 18.<sup>xvii</sup> Congo and Rwanda have lowered the age of consent to, respectively, 16 and 15. The laws in Burundi, Chad, Equatorial Guinea, Gabon and São Tomé & Príncipe are silent on all aspects of HIV testing, counselling and treatment *for children, adolescents or minors*. The need for parental consent may constitute a barrier for adolescents getting tested. Adolescents who have parents who are reluctant to give their consent may remain undiagnosed and, if HIV-positive, may be deprived of appropriate care and treatment. Similarly, when policies are silent on the issue or unclear, health providers may be reluctant to provide HIV testing services to adolescents.<sup>56</sup>

**A fifth gap concerns mandatory HIV testing regulations in Angola, Burundi and Chad. A related contestation is the bias in HIV testing policies and programmes** towards pregnant women, or sex workers. Most policies emphasising counselling and testing for MTCT and testing for female sex workers. Also, ART is free for pregnant women in many countries. This emphasis means that women who are not pregnant or not sex workers are inadequately reached with HIV testing and counselling services. Similarly, men involvement programmes target married men, leaving out unmarried men.

<sup>56</sup> Fox, K., Ferguson, J., Ajose, W. et al. (2013). 'Adolescent Consent to Testing: A Review of Current Policies and Issues in Sub-Saharan Africa'. In *HIV and Adolescents: Guidance for HIV Testing and Counselling and Care for Adolescents Living with HIV: Recommendations for a Public Health Approach and Considerations for Policy-Makers and Managers*. Geneva: WHO. Annex 15.

The weak translation of women and girls' human rights in policies is also visible in HIV testing strategies. There is a strong need for **HIV testing modalities that support women's rights**. With increased attention to new and rapid testing modalities, women's concerns may be overlooked. In most countries, HIV testing for pregnant women is offered in antenatal care clinics in the context of PMTCT. Although most policy and legal regulations in the region require voluntary testing, consent and counselling of pregnant women, not all facilities have the resources and skills to respect these rights. Also, as a result of gender norms, social distance and power dynamics between pregnant women and medical professionals, women may be unlikely to decline testing.<sup>xcviii</sup> Women may have reasons to opt out of HIV testing because of the risks of disclosing a positive status, such as violence or the fear of violence, stigma and abandonment by their partner; yet women may agree to testing for fear of being perceived as challenging medical authorities, as has been observed in Cameroon.<sup>xcix</sup>

The risks around disclosure of HIV test results are rarely acknowledged in HIV and AIDS strategic plans. Few national HIV and AIDS strategies under review have taken into account providers' capacities to identify such risks and avoid coercive testing in PMTCT programmes. This gap may be exacerbated by initiatives to expand or accelerate testing, including through lay provider HIV testing, when such initiatives do not ensure consent, counselling and confidentiality. Provider-initiated testing has been launched in some countries in the region but is not yet being implemented.<sup>57</sup> Another critical contestation around HIV testing is that countries, for example DRC, may require HIV-positive serostatus **disclosure to sexual partners**, which can put women at risk.

A final contestation relates to **conflicting and contradictory legislation** regarding discrimination in relation to HIV. Some states have a strong commitment towards non-discrimination of PLWHIV, grounded in HIV-specific laws or other legislation and strategies. Yet they also have laws that criminalise, for instance, sex work or same-sex sexual acts. In Central Africa, Cameroon criminalises same-sex sexual acts between both men and women in its Penal Code, which states that same-sex sexual relations shall be punished with imprisonment from six months up to five years and a fine of FCFA 20,000 up to FCFA 200,00. Laws that criminalise same-sex sexual acts are also present in Angola and Burundi. There are no specific provisions that criminalise consensual same-sex relations in CAR, Chad, Congo Republic, Equatorial Guinea, Gabon and São Tomé and Príncipe. However, discriminatory environments with regard to sexual and gender diversity persist across these states. In Gabon, the level of reporting of incidents against LGBT persons is very low because of a highly discriminatory environment, while Equatorial Guinea reportedly continues to intimidate LGBT persons, and efforts meant to increase levels of acceptance of sexual and gender diversity have been rejected by the state.<sup>c</sup> Conflicting and contradicting legislation creates a paradox between criminalisation of the acts or work of marginalised groups on the one hand, and non-discrimination commitments on the other. A potential effect is that coverage of HIV services for these groups is very low, as health professionals, for example, may be reluctant to implement appropriate policies.<sup>ci</sup>

**Table 8.13. Countries that do and do not criminalise same-sex sexual acts, Central Africa**

Countries that criminalise same-sex sexual acts	Countries that do not criminalise same-sex sexual acts
Angola	CAR
Burundi	Chad
Cameroon	Congo
	DRC
	Equatorial Guinea
	Gabon
	Rwanda
	São Tomé and Príncipe

All countries in the region are directly or indirectly affected by **civil, political and armed violence and conflict**. The crisis in CAR has led to a deteriorating HIV situation, with disruptions to prevention and treatment services, loss to follow-up and high incidence of GVAW.<sup>cii</sup> CAR has the highest HIV prevalence in the region but one of the lowest ART coverage rates in the world (18%). As a response to this in the context of the crisis, CAR has integrated the HIV response into humanitarian action plans and enacted a decree (2014) exempting patients from payment during the crisis. However, this free care policy is limited to certain patient groups (primarily women and children) and to NGO-supported health facilities.<sup>ciii</sup>

<sup>57</sup> As of July 2017, the following countries from the region reported that lay provider HIV testing was not yet implemented: Burundi, Cameroon, CAR, Chad, Equatorial Guinea and Gabon. <http://www.who.int/hiv/pub/meetingreports/wca-hiv-testing-workshop/en/index2.html>

### 8.3.4 Southern region

#### *Trends, gaps and contestations*

The national legal and policy frameworks in the Southern region look very similar, with all countries having a programmatic response to access ART and regarding MTCT in place. However, missing data in Comoros means the latter is unclear for the country. Countries also have legal provisions on non-discrimination on the basis of HIV, except for Swaziland. Almost two-thirds of the countries have adopted legislation that criminalises transmission, exposure or non-disclosure of HIV. The *SADC HIV and AIDS Strategic Framework 2010-15* was developed to respond to the pandemic and guide country responses and initiatives. Taking note that SADC has the highest gender inequalities globally, it highlights patterns of male dominance in sexual decision-making, as well as high levels of sexual violence in many communities and cultural practices in some communities that are key drivers of HIV transmission. SADC through its Secretariat has emphasised development and harmonisation of policies and legislation in the region. While the Framework undertook to tackle areas of concern, such as the need to protect individuals and communities against HIV and AIDS-related stigma and discrimination; criminalisation of HIV transmission; and prevention, care and treatment for marginalised communities such as sex workers, prisoners, drug users and sexual minorities, these areas remain underdeveloped and contested in the region, owing to issues related to moral judgement or prejudice.

Through its Parliamentary Forum, SADC has promoted the domestication and monitoring of the *SADC Model Law on HIV*. This provides a framework to tackle stigma and discrimination in member states. It integrates issues of SRHR, protection against violence for women and girls, equality and non-discrimination and provides sanctions for breaches of confidentiality and unlawful disclosure. The 2017 Mahe Declaration, adopted at the Regional Women's Parliamentary Caucus of SADC-PF, also recognises unequal power relations between women and men and systemic gender-based discrimination, combined with lack of or inadequate SRHR and HIV and AIDS services, as key drivers of new HIV infections and unnecessary deaths in the region. The Mahe Declaration also points to harmful patriarchal norms and practices, and absence of an enabling legal and policy environment in member states, as preventing women and girls from exercising their rights and protecting themselves from HIV. Included within this is the need for other-party consent to access to HIV and SRH services and information, as well as practices of child marriage, marital rape and property-grabbing from widows, all of which remain legal and common practice in several countries. Other factors are inadequate health care infrastructure, lack of youth-friendly health services, poor linkages between HIV and SRHR and lack of birth control, family planning and MCH services. In addition, the *SADC Protocol on Health, HIV and AIDS Strategic Framework and Business Plan* sets out priority areas for action and key performance indicators in order to harmonise policies and strategies towards HIV elimination as member states strive to live up to their commitments.<sup>civ</sup>

Table 8.14. Key legal and policy indicators in Southern Africa, HIV and AIDS

Country	INDICATORS				
	Non-discrimination legislation based on HIV	Policy and/or legal regulations regarding voluntary HIV testing	Criminalisation of wilful transmission on HIV	Programmatic responses to access ART	Programmatic responses on MTCT
Angola	Yes	MAN <sup>58</sup>	Yes	Yes	Yes
Botswana	Yes	VOL <sup>59</sup>	Yes	Yes	Yes
Comoros	Yes	VOL	No	Yes	-
DRC	Yes	VOL <sup>60</sup>	Yes	Yes	Yes
Lesotho	Yes	VOL <sup>61</sup>	Yes <sup>62</sup>	Yes	Yes
Madagascar	Yes	VOL	Yes	Yes	Yes
Malawi	Yes	VOL <sup>63</sup>	Yes	Yes	Yes
Mauritius	Yes	VOL <sup>64</sup>	Yes	Yes	Yes
Mozambique	Yes	VOL	Yes	Yes	Yes
Namibia	Yes	VOL	No	Yes	Yes
Seychelles	Yes	VOL	No	Yes	Yes
South Africa	Yes	VOL	No	Yes	Yes
Swaziland	No	VOL <sup>65</sup>	No	Yes	Yes
Tanzania	Yes	VOL <sup>67</sup>	Yes	Yes	Yes
Zambia	Yes	VOL <sup>68</sup>	No	Yes	Yes
Zimbabwe	Yes	VOL <sup>69</sup>	Yes	Yes	Yes

58 This is a mixture of the two, as Law 8/04 on HIV and AIDS (2004) provides that persons deprived of freedom must not be subjected to compulsory tests to detect HIV infection, except for those whose judicial process or medical condition so demands.

59 The National HIV Policy 2012 provided that HIV testing was voluntary. However, it also provided that HIV testing prior to sentencing would be mandatory for all individuals convicted of a sexual crime. The Public Health Act 2013 requires mandatory testing in six circumstances.

60 Loi no 08/011 du 14 juillet 2008 portant protection des droits des personnes vivant avec le VIH/SIDA et des personnes affectées.

61 The National HIV and AIDS Policy 2006 provided for voluntary testing. However, it also provided that government establish guidelines and legislation for mandatory disclosure of the client's positive HIV status to sexual partner/s. Anecdotal information suggests that, by 2008, compulsory testing of pregnant women was government policy. See HRW. (2008). 'A Testing Challenge: The Experience of Lesotho's Universal HIV Counseling and Testing Campaign'.

62 Penal Code also criminalises non-disclosure

63 Mandatory testing in certain instances, e.g. rape, is required.

64 The People Living with HIV Stigma Index: Mauritius Report 2013 indicates that in 2013 there were reported incidences of forced testing at the hands of institutions; it is not clear whether this was a practice or a policy issue.

65 In general, mandatory testing is not policy, but the HIV Testing and Counselling National Guidelines 2006 provide that it can be considered in special circumstances, e.g. for blood donation and for rape perpetrators, only with a court order and only disclosed to the magistrate or judge handling the case.

66 However, the Sexual Offences and Domestic Violence Bill contains provision for aggravated punishment for convicted rapists who are HIV-positive.

67 Exception to prohibition of mandatory testing in the context of sexual offenders.

68 The Zambia Consolidated Guidelines for Prevention and Treatment of HIV Infection 2018 provide for routine testing with opt-out considerations. Partner notification is voluntary.

69 In general, mandatory testing is not allowed, but the National Guidelines on HIV Testing 2005 provide that it can be considered in special circumstances, e.g. for blood donation and for rape perpetrators, only with a court order and only disclosed to the magistrate or judge handling the case.

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

**Constitutional provisions on HIV and AIDS:** All countries in SADC have provisions on non-discrimination, which could be extrapolated to protect PLWHIV. Fourteen countries' constitutions provide for gender equality (Angola, Comoros, DRC, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia, Zimbabwe). No country's constitution forbids discrimination based on HIV or health status but the constitutions of Seychelles and South Africa forbid discrimination on any grounds. Six countries in SADC do not provide for the right to health specifically as an inherent right (Botswana, Lesotho, Mauritius, Namibia, Tanzania, Zimbabwe).

**Statutory law on HIV and AIDS:** Fifteen countries have laws on *non-discrimination against PLWHIV* (Angola, Botswana, Comoros, DRC, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Tanzania, Zambia and Zimbabwe). Many of these laws focus on discrimination in the workplace. Despite this, in 2007, a nine-country study in the region on HIV and human rights found weaknesses in the response to HIV in terms of human rights.<sup>cv</sup> Some countries have laws relating to health care standards and services (Botswana, Lesotho, Madagascar, Seychelles, South Africa and Zambia). In Comoros, laws also grant access for HIV testing for adolescents who are below the age of consent (18) in specified circumstances. All countries except, DRC have policies on voluntary testing. However, alongside such provisions, it is possible to find in the same policy provisions making exception to such voluntary testing. This is the case in countries like Botswana, Lesotho, Malawi, Mauritius, Zambia and Zimbabwe.

Nine countries in the region have adopted legislation that criminalises HIV non-disclosure, exposure and transmission: Angola, Botswana, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Zambia and Zimbabwe. More countries are considering this course of action. The criminalisation occurs through specific laws, penal codes and laws against wilful exposure and transmission of HIV and AIDS. Some crimes against sexual violence increase the punishment of offenders based on HIV status. This is the case for Lesotho's 2003 Sexual Offences Act and Namibia's Combating of Rape Act 2000.

**Policy and institutional reform on HIV and AIDS:** All countries in the region have developed diverse and multi-sectoral responses and frameworks; all have national policies on HIV and AIDS and national strategic plans.<sup>cvi</sup> Country policy responses all over the region are *making the link between combating HIV and gender inequalities*. The Malawi National HIV and AIDS Strategic Plan 2011–16, extended to 2020, emphasises the need to address gender dimensions of the epidemic; eliminate discrimination and marginalisation; and involve those most at risk, particularly women and young people. The Swaziland HIV Policy 2012 identified gender inequalities and sexual violence as drivers of HIV, stating that many cultural norms and values shape negative gender relations that constrain women's autonomy. The Seychelles National Strategic Framework 2012–16 for HIV and AIDS and STIs took stock of women and men in vulnerable situations with special emphasis on GVAW, social and economic vulnerabilities and disadvantages and disenfranchised sub-groups.

The major area in which countries have targeted service delivery for women living with HIV is with regard to PMTCT. PMTCT programmes exist in all countries (although information for Comoros was not found) and provide much-needed services to enable women living with HIV to attain reproductive health services. Mauritius has achieved 97% coverage of PMTCT, for example. ART is also availed to pregnant women in all countries as part of PMTCT programmes, although not all women access these much-needed services. Countries are also moving towards e-MTCT programming, as is the case with Mauritius, South Africa and Zambia. In South Africa, ARV prices have been halved to increase affordability, while Botswana, South Africa and Zambia have either abolished or slashed the costs of user fees for HIV treatment in order to increase access to treatment. This is beneficial especially for indigent and vulnerable women.

It is notable that all SADC countries now offer *comprehensive treatment* including PEP to survivors of violence, and that some countries have integrated PrEP into their programmes (Botswana, Malawi, South Africa, Zambia and Zimbabwe) to provide for sex workers and partners in sero-discordant couples.<sup>cvi</sup> This is beneficial especially for vulnerable women. Despite this, not all women can obtain these services, given challenges in health care coverage, shortage of ART supplies and societal attitudes that stigmatise and marginalise women suffering from HIV or seeking related services.

## Key gaps and contestations

A first gap is the **absence of non-discrimination provisions** regarding HIV status in Swaziland. A second gap relates to **mandatory testing** laws in six countries in the region, as stated above. Even countries that have policies on VCT have enacted laws that **criminalise non-disclosure**, which raises the risk of the public avoiding voluntary testing, so they can later use the defence that they were unaware of their HIV status because they did not get tested for HIV.

A critical trend with regard to HIV testing and disclosure is that the traditional VCT model of addressing HIV from a preventive and treatment-based perspective is under threat. The trend towards increased **criminalisation of HIV non-disclosure, exposure and transmission** has raised controversy in the region. Such laws serve to further stigmatise PLWHIV and their sexuality as well as violating their rights to dignity and privacy, among others. Further, in cases where HIV status is a factor in elements of a criminal charge, conducting forced testing and disclosing results against the wishes of the accused person violates the right to privacy. This is a hotly contested area of rights as debates are polarised around victim rights *vis-à-vis* the rights of PLWHIV.

Another contestation relates to the **criminalisation of same-sex sexual acts**. Same-sex sexual acts are legal in DRC, Lesotho, Madagascar, Mozambique, Seychelles and South Africa. South Africa is the only African state to include a *provision prohibiting discrimination* based on sexual orientation in its constitution. It is also the only state in which partnership and marriage between same-sex couples is allowed, under the Civil Union Act of 2006. In Angola, Botswana, Comoros, Malawi and Zambia, same-sex sexual between both men and women are criminalised; in Mauritius, Namibia, Swaziland and Zimbabwe the law applies only to men. Criminalisation of same-sex sexual acts in Mauritius is contradicted by recognition of the right to non-discrimination on the basis of sexual orientation in the *Equal Opportunities Act* of 2008 and the *Code of Ethics for Public Officers*. Malawian NGOs focusing on SOGIE issues reported being challenged by backlash after raising SOGIE issues on a political level. The government has reportedly threatened to close CSOs working on these issues.<sup>cvi</sup>

**Table 8.15. Countries that do and do not criminalise same-sex sexual acts, Southern Africa**

Countries that criminalise same-sex sexual acts	Countries that do not criminalise same-sex sexual acts
Angola	DRC
Botswana	Lesotho
Malawi	Madagascar
Mauritius	Mozambique
Namibia	Seychelles
Swaziland	South Africa
Tanzania	
Zambia	
Zimbabwe	
Comoros	

### 8.3.5 Northern region

#### Trends, gaps and contestations

The countries in the Northern African region show fairly similar profiles regarding their HIV and AIDS legal and policy frameworks. Egypt, Libya and Morocco all have guarantees for voluntary HIV testing, and a programmatic response to access ART and MTCT, but lack legislation on non-discrimination on the basis of HIV. Algeria only has a programmatic response in place, for both ART and MTCT. Tunisia has guarantees for voluntary testing and a programmatic response on ART but lacks non-discrimination legislation and does not have a programmatic response on MTCT. Mauritania's legal and policy framework looks different, as the only country of this region with non-discrimination legislation on HIV and the only one that criminalises wilful transmission of HIV.

**Table 8.16. Key legal and policy indicators in Northern Africa, HIV and AIDS**

Country	INDICATORS				
	Non-discrimination legislation based on HIV	Policy and/or legal regulations regarding voluntary HIV testing	Criminalisation of wilful transmission on HIV	Programmatic responses to access to ART	Programmatic responses on MTCT
Algeria	No	-	-	Yes	Yes
Egypt	No	VOL	No	Yes	Yes
Libya	No	VOL <sup>70</sup>	- <sup>71</sup>	Yes	Yes
Mauritania	Yes <sup>72</sup>	-	Yes <sup>73</sup>	Yes	Yes
Morocco	No	VOL	-	Yes	Yes
Tunisia	No	VOL <sup>74</sup>	No	Yes	No
Western Sahara	-	-	-	-	-

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

**Constitutional provisions on HIV and AIDS:** None of the countries in the Northern region has constitutional provisions that directly and explicitly address HIV and AIDS. Most of the states reviewed have constitutional provisions that can be utilised to make the case for non-discrimination against PLWHIV as well as for access to HIV prevention and treatment programmes. For instance, the constitutions of Egypt, Libya, Morocco and Tunisia include the right to health. States reviewed also have guarantees of equality and non-discrimination on the basis of sex, gender or other reasons, which provides a basis for protection for PLWHIV. These states include Algeria, Libya, Egypt, Mauritania, Morocco and Tunisia.

**Statutory law on HIV and AIDS:** In Mauritania, the law on HIV and AIDS is related to the prevention, management and control of HIV and AIDS in general and against the stigmatisation of PLHIV. It also criminalises wilful transmission of HIV.

Four states have guarantees for voluntary HIV testing. Where states have an exception to *voluntary testing*, this is mostly the case for blood and organ donors (Libya, Morocco, Tunisia). In Libya, however, HIV testing is reported to be mandatory in practice, such as for pregnant women during pregnancy and before labour and for issuance of health certificates related to employment and marriage.<sup>cix</sup>

**Policy and institutional reform:** All states have a policy that directly focuses on and/or alludes to HIV and AIDS. These are in the form of national strategies, action plans or guidelines to providers. With the exception of Mauritania, policies are exclusively dedicated to the rights of PLWHIV. In Mauritania, HIV is addressed in the context of the National Action Plan for Birth Spacing and covers reduction of maternal, child and adolescent mortality. National policies and strategies include reduction of HIV transmission, voluntary testing, ART and PMTCT. Notably, all the reviewed states have either policy or programmatic interventions on ART. In addition, others have interventions with regard to PMTCT (Algeria, Egypt, Mauritania and Morocco).

In its Strategic Plan, Morocco commits to reducing new infections among key and vulnerable populations.

<sup>70</sup> The 2010 HIV Voluntary Counselling and Testing Services: A Guideline for Service Providers requires mandatory testing only for blood transfusions. Despite the guidelines for voluntary testing, mandatory testing happens in practice. (GARPR. 2015. 'Country Progress Report-Libya'. June.)

<sup>71</sup> On 7 February 2000, six Bulgarians were tried in Tripoli on charges of deliberately infecting children with HIV. Under Art. 305 of the Penal Code, they were charged with causing an epidemic through spreading a harmful virus, leading to the death of persons.

<sup>72</sup> Law 042/2007 is related to the fight against HIV and AIDS in general and against the stigmatisation of PLHIV.

<sup>73</sup> A HIV-specific law was adopted in 2007 based on the AWARE-HIV and AIDS Model Law: <https://www.aidsmap.com/resources/law/Western-Africa/page/1444873/#Modellaw>

<sup>74</sup> The only exception for voluntary testing is for blood and organ donors.

In addition, some of the states reviewed have an institutional mechanism or body that exclusively or as part of its mandate addresses the rights of PLWHIV (Algeria, Mauritania, Morocco). With the exception of Algeria, it could not be ascertained whether these bodies specifically addressed the gendered concerns of women and girls living with HIV and AIDS. In Algeria, the Ministry of Religious Affairs has trained imams and murchidates on the principles of equality and justice and developed modules on Islam and women, Islam and HIV and AIDS and GVAW.<sup>cx</sup>

### Key gaps and contestations

A key gap and contestation around HIV and AIDS in the Northern region relates to **social stigma and discrimination**. At just 0.1%, the MENA region has among the lowest HIV prevalence rates in the world. Yet infections are on the rise, and deaths resulting from HIV are also steadily increasing.<sup>cxv</sup> Some of these new infections have a gendered angle, with women disproportionately affected. For instance, in Algeria, it is estimated that over half of new infections in 2014 were of women;<sup>cxvii</sup> their limited role in decision-making and control of resources is a risk factor here.<sup>75</sup> One of the reasons for this downward spiral is that the region is plagued by intense HIV-related stigma and discrimination. The continuous repression of the subject and discrimination against those living with HIV has now been linked with an alarming increase in the HIV spread in these countries, particularly in Egypt. On a positive note related to this challenge, in 2016 a court in Egypt issued a landmark ruling for the country and the region prohibiting HIV discrimination in the workplace.<sup>cxviii</sup> Efforts such as this as well as institutional and social change could possibly alleviate stigma and discrimination.

Yet, even where these countries have set up treatment centres and offer free treatment, high stigmatisation prevents those infected from seeking **treatment**: less than a quarter of those infected are on treatment and almost half of those infected are not even aware of their status.<sup>cxix</sup> Even where persons living with HIV are willing to seek treatment, they risk being **denied services**. The HIV Stigma Index reports that 'More than half of people living with HIV in Egypt have been denied treatment in healthcare facilities.'<sup>cxv</sup> In Algeria, stigmatisation has also been noted as a major deterrent to addressing HIV: in a culture of silence, women tend to be blamed for spreading the virus, whereas they may be equally vulnerable to catching HIV from their husbands. Constitutional human rights guarantees and HIV policy measures are seemingly ineffective against the tide of stigma and discrimination of persons living with HIV in Northern Africa.

A next gap is the **inadequate protection of key populations**. Female sex workers in the MENA region are particularly vulnerable owing to the criminalisation of their behaviour and work, which contributes to strong sociocultural disapproval, combined with other gender issues that women in the region face. Little value is placed on their protection from HIV and they suffer hindered or low access to HIV prevention programmes.<sup>cxvi</sup> In Mauritania, there is a concern that vulnerable groups at risk of HIV and AIDS are discriminated against, which could **prevent them from accessing treatment**. This exclusion fuels their pre-existing vulnerability to infection. For instance, in Algeria, national incidence of HIV was rated at 0.1%, but with a prevalence of 10.25% among sex workers in 2016.

**Sexual minorities**, especially MSM, also face heightened stigma and hindered access to HIV prevention programmes. This is all the more significant as the increase in HIV prevalence in the region has been linked to increased prevalence among key populations, as reported in Egypt, Morocco and Tunisia.<sup>cxvii</sup> In Morocco in particular, two-thirds of new infections have occurred among female sex workers, their clients, MSM and injecting drug users, or among the stable sexual partners of these populations.<sup>cxviii</sup> Algeria, Mauritania, Morocco, Libya and Tunisia **criminalise** same-sex sexual acts between both men and women. Mauritania has even codified the death penalty for same-sex sexual acts in *Sharia* law. It is, however, reportedly not implemented for same-sex sexual behaviours, with lesser penalties preferred. Egypt is the only North African state where same-sex sexual relations are not criminalised. Besides criminalisation of same-sex sexual relations in law, other restrictive laws on association and foundation of non-profit organisations are found across all North African states except Tunisia, making the registration and work of NGOs on SOGIE issues difficult or even impossible. Also, high levels of hostility towards LGBT persons persist, forcing individuals to flee, as is reported in Libya.<sup>cxix</sup>

75 Young persons require parental consent to seek SRH services (Executive Board of UNDP and UNFPA. 2006. DP/FPA/CPD/DZA/4).

Table 8.17. Countries that do and do not criminalise same-sex sexual acts, Northern Africa

Countries that criminalise same-sex sexual acts	Countries that do not criminalise same-sex sexual acts
Algeria	Egypt
Libya	
Mauritania*	
Morocco	
Tunisia	

\* same-sex sexual acts are punishable by death

The **conflict and post-conflict** environment in Libya has hampered the HIV response. While there was a focus on HIV prevention and treatment services in 2010, all plans for establishing VCT services, monitoring and evaluation systems and PMTCT halted with the breakout of conflict in 2011.<sup>cxix</sup> Libya has a number of policies around HIV from a VCT perspective. However, the post-conflict situation has created several additional factors with the potential to fuel the epidemic. During the conflict, a nationwide stock-out of ARV drugs, infection control and blood safety systems occurred, alongside a rise in GVAW related to the conflict. In 2014, there was no national HIV strategy and HIV and AIDS responses were addressed within a health and disease framework with a focus on treatment.<sup>cxix</sup>

## 8.4 CASE STUDIES

The section presents six case studies on initiatives to realise the rights of women and girls with respect to HIV and AIDS. They range from local-level initiatives with groups of women and girls living with HIV and AIDS (WLHIV) (Case studies 30 and 31) to national litigation cases (Case studies 32 and 33) as well as regional and continental initiatives (Case studies 28 and 29). Together, the cases present a range of interventions that are each relevant for women and girls who are living with HIV and AIDS or vulnerable to infection: an enabling legal environment (Case study 28), prevention of vertical transmission (Case study 29), care and support (Case study 30), treatment (Case study 31) and access to justice (Case studies 32 and 33).

What the initiatives have in common is that they are built on in-depth knowledge of the lived realities and particular circumstances of WLHIV. **Knowledge, information and evidence** are the basis for further action and are generated either by (participatory) research by WLHIV themselves or by research institutes that investigate particular issues. For example, the two cases on forced sterilisation started off from a research report presenting figures on the prevalence of this phenomenon. Evidence has been used as a tool to communicate on controversial issues and to trigger a public debate on women and girls' rights.

Four case studies focus on enhancing women's **empowerment** and on access to justice for WLHIV. This is particularly meaningful given that, generally, WLHIV and their associations have insufficient opportunities for training and access to legal support. These cases also have in common that they try to challenge social norms and taboos relating to sexuality, HIV and AIDS and fertility that often create a culture of silence. Breaking this silence is important in many of the strategies documented in these case studies, and often requires the creation and nurturing of safe spaces where WLHIV can come together and share experiences and challenges. The initiatives also recognise that women and girls are different, have different needs and experience different levels of discrimination. The initiatives in Mali and Malawi provide space for sharing stories among women of different ages, localities and classes and prepare WLHIV to voice their concerns as a collective. The Malawian initiative takes an intersectional approach in that it emphasises the right to quality treatment for all women and girls and opposes the preferential treatment of pregnant women based on the bias in policies regarding women's reproductive role.

The cases of forced and coerced sterilisation illustrate the prevalence of abuse in health care against WLHIV in many countries. The use of **litigation** is a first step to address this but additional measures are needed; while these actions have created public awareness, and changes in professional codes of conduct and behaviour, they have not yet resulted in further legal or policy change to protect WLHIV from discrimination, violence and abuse. Most initiatives target either women or institutions (government, NGOs) but the Malawian case shows the importance of addressing the environment and the structural challenges WLHIV face. Through **strategic alliance-building** with different groups of WLHIV, faith-based organisations, CSOs and a range of other stakeholders, the initiatives have been able to promote a rights-based HIV and AIDS agenda, promoting attention for gender equality and women's SRHR beyond increased access to HIV treatment and care.

## Case study 28. East African Community HIV Prevention and Management Act

In 2012, the EAC Legislative Assembly passed the HIV and AIDS Prevention and Management Act ('the HIV Act'). This Act seeks to harmonise the response to and management of HIV in the East African region. The development and enactment of the Act entailed intensive collaboration between political, administrative and civil society actors, and involved comprehensive analysis.

As part of its legal framework, the EAC has in place an EAC HIV and AIDS Prevention and Management Act ('the HIV Act'). This was passed in 2012, and is a regional response in the management of HIV across the EAC countries. The Act serves to ensure a harmonised approach in the region by addressing gaps, discrepancies and inconsistencies that may be found in national approaches to preventing and managing HIV and AIDS.

The enactment of this regional law was the result of concerted efforts by the EAC, particularly its Secretariat, and civil society stakeholders. On the part of the EAC Secretariat, comprehensive analysis of the various pieces of HIV legislation in the region was undertaken in preparation for enactment and implementation of the Act. This strategy was innovative because consultations were undertaken simultaneously with the legislative process. This proved effective in that, by the time the HIV Act was ready and had been fully signed by the EAC countries, the issues that needed to be addressed had already been part of a discourse with governments at the national level. This eased implementation of the HIV Act itself. Moreover, there was also room for an assessment towards the end of the process; this was useful because the HIV Act took so long to become law that the assessment was able to ascertain that the Act was still in line with the situation on the ground. In this way, the resultant Act was responsive and up-to-date.

Advocacy of civil society actors significantly contributed to enactment of the HIV Act. The East African Civil Society Organisations Forum (EACSOF) undertook an advocacy campaign, through its member organisation, the Eastern African National Network of AIDS Service Organisations (EANNASO). These civil society actors were part of the development of the draft Act, including consultations as well as other processes up until enactment. Their campaign relied on multiple approaches, and on close collaboration between EACSOF/EANNASO and the EAC Secretariat. The campaign lobbied members of the East African Legislative Assembly (EALA), which eventually passed the Act. It identified champions within EALA and in governments, such as ministers, former ministers and ambassadors, to also advocate for enactment. In addition, civil society actors played a critical role in terms of sharing information with other organisations in the EAC.

The development and enactment of the EAC HIV Act demonstrate how policy-makers such as the EAC Secretariat and civil society actors can join forces. Both sets of actors were in a unique position to shape the legal and policy environment and, in turn, the rights culture among states to the benefit of rights-holders—that is, the citizens in those countries.

## Case study 29. Free To Shine campaign

The *Free to Shine* campaign is a recently launched advocacy campaign driven by African First Ladies and focused on eliminating MTCT of HIV. The campaign leverages the unique position of First Ladies, as mothers of the nation, *vis-à-vis* the general public in their countries, as well as high-level policy-makers and politicians at national, continental and international levels. The campaign aims to end childhood HIV and to keep mothers healthy.

Significant progress has been made towards the global commitment to end the AIDS epidemic by 2030.<sup>cxvii</sup> In order to end AIDS in Africa, it is imperative to prioritise children and their mothers, as well as adolescent girls, to ensure these vulnerable groups also benefit from the progress achieved in the wider population.

Of the 2.1 million children living with HIV globally, the majority are in Africa, with 1.4 million of these children in Sub-Saharan Africa. In 2015, an estimated 110,000 children living in 21 Sub-Saharan Africa were newly infected with HIV.<sup>cxviii</sup> Most new cases of HIV in children under 15 years old are caused by MTCT.<sup>cxix</sup> The majority of these infections occur during the breastfeeding period.

Young women of child-bearing age account for a quarter of all adults newly infected with HIV, placing themselves and their future offspring at risk. In 2015, there were 250,000 new infections in adolescents, and 160,000 of them were among adolescent girls (aged 10–19); three out of four of these occur in Sub-Saharan Africa.<sup>76</sup> Among young people aged 15–24, young women bear a disproportionate burden of new HIV infections, accounting for up to 66% in Sub-Saharan Africa. Yet only 15% of young women are aware of their HIV status. These young women hence lack critical access to counselling and testing services, as well as SRH services and HIV treatment and care.

African countries need to accelerate efforts to reduce new HIV infections among women of reproductive age. There is also a need for more concerted and systematic efforts to keep women in HIV care, and to enable good adherence to HIV treatment until the risk of HIV transmission to the baby ends fully. Similarly, early infant diagnosis (EID) needs to be scaled up to diagnose infants living with HIV and enrol them in treatment as soon as possible. While WHO recommends that all HIV-exposed infants are tested within two months of birth, only half had access to EID screening in 2015. Furthermore, almost 50% of infants who were tested for HIV never received the results.<sup>cxv</sup>

The *Free to Shine* campaign, recently launched by the Organisation of African First Ladies against HIV/AIDS (OAFLA) and the AU, responds to these gaps in the elimination of MTCT of HIV (eMTCT).<sup>cxvi</sup> The advocacy campaign aims to reduce new infections among women of reproductive age and ensure no child has AIDS. Africa's First Ladies drive critically important changes in their respective countries in the area of HIV and AIDS, and women and girls' health more generally. First Ladies, as mothers of the nation, can positively influence citizens' behaviours through awareness-raising, in a way that crosses divides and touches all citizens. Similarly, they leverage their reputation, their visibility and their access to high-level political leaders to influence decision-makers at policy level.

The *Free To Shine* campaign contributes to ongoing efforts to end childhood AIDS in Africa by 2030 and keep mothers healthy. It intends to drive advocacy by the First Ladies and other stakeholders at national and regional levels on the targets and commitments adopted in key regional and global commitments and frameworks.<sup>77</sup> These targets and commitments include the 2016 UN Political Declaration on Ending AIDS, the Maputo Protocol, the Maputo Plan of Action, the UNAIDS 90-90-90 Targets and the *Start Free, Stay Free, AIDS Free* framework. In particular, the campaign will contribute to:

- Eliminating new HIV infections among children by reducing the number of children newly infected to less than 40,000 by 2018 and 20,000 by 2020;
- Reaching and sustaining 95% of pregnant women living with HIV with lifelong HIV treatment by 2018;
- Reducing the number of new HIV infections among adolescents and young women to less than 100,000 by 2020.

*Free To Shine* highlights the need to remove barriers that prevent women and mothers engaging with HIV and AIDS-related health services for themselves and their children. It seeks to raise awareness of the HIV epidemic in children and the need to prioritise children and mothers, to ensure that successes achieved in reducing infections are extended to this vulnerable group. Furthermore, the campaign intends to increase understanding on how to prevent HIV and AIDS in childhood by keeping mothers healthy, preventing MTCT and ensuring fast and effective identification and treatment of HIV-infected children. *Free to Shine* advocates for the mobilisation of resources and the prioritisation of the delivery of effective and sustainable HIV and AIDS health services that are accessible to all who need them.

76 Start Free Stay Free AIDS Free: A Super-Fast Track Framework for ending AIDS among Children, Adolescents and Young Women by 2020. <https://free.unaids.org/>

77 *Free To Shine* is widely supported by organisations that are leading the work to end AIDS, including UNAIDS, WHO, the Elizabeth Glaser Pediatric AIDS Foundation, UNICEF, Abbott, UNDP and AIDS Accountability International.

The key strategies for this campaign are as follows:

1. To promote advocacy for domestic and global resource mobilisation to strengthen paediatric AIDS programmes in Africa;
2. To build networks and support and maintain coordinated partnerships at all levels to strengthen paediatric AIDS programmes;
3. To sensitise AU governance structures such as the Permanent Representatives Council, the Executive Council and the Assembly, AU Organs (the Pan-African Parliament, New Partnership for Africa's Development and African Peer Review Mechanism) and Regional Economic Communities and Regional Health Organisations on key issues related to paediatric AIDS;
4. To leverage high-level international forums (such as UN General Assembly and its special sessions and the G7 and G20 summits) and high-level advocacy missions in global advocacy hubs to mobilise support for paediatric AIDS in Africa;
5. To raise awareness among general populations within and outside Africa through mass media, publications, websites, colloquiums and other means;
6. To leverage the assets and competencies of the private sector to mobilise resources and to design a digital campaign; and
7. To engage and empower WLHIV to be able to create networks of support for each other and to reach other women in their communities with support through pregnancy and breastfeeding.

### Case study 30. 'Gundo-So': The Bambara Chamber of Confidences—empowering women living with HIV regarding serostatus disclosure

Gundo-So is an initiative to equip and empower women to cope with their serostatus by providing a safe space to share experiences. The strategy uses cultural norms of engagement and decision-making in groups whereby women define the rules and topics and manage their own discussion space. The initiative is implemented by an NGO with reputed experience and legitimacy.

Mali has one of the lowest HIV prevalence rates in the West Africa region; however, new HIV infections have increased by 11% and AIDS-related deaths have decreased by 11% since 2010, according to UNAIDS.<sup>cxxvii</sup> Organisations such as the Association for Research, Communication and Home Support for People Living with HIV/AIDS (ARCAD-Sida) have been working alongside the government on prevention and the provision of treatment, care and support for PLWHIV.

ARCAD-Sida was created on 29 November 1994 by a group of doctors to provide medical and psychosocial support to AIDS patients. It is one of the leading and oldest associations fighting HIV and AIDS in Mali, working alongside the Malian government. It has established screening and treatment sites and provides psychosocial support to PLWHIV throughout the country. In 1996, it created the Centre for Listening, Care, Animation and Counselling to develop community-based care for people living with the disease virus.<sup>cxxviii</sup>

Mali is a deeply patriarchal society, with the roles and responsibilities assigned to women largely confined to the domestic and reproductive sphere. Socio-cultural barriers constrain women's roles in broader society, and these constraints increase with HIV infection. Women living with HIV are particularly vulnerable to stigmatisation, divorce, repudiation, child deprivation and neglect in the country, especially as they are often economically and socially dependent on their husbands. In this context, to reveal or not their seropositive status becomes for them a vital stake. Fear of being stigmatised makes it even harder for most women to disclose their serostatus.<sup>cxxix</sup>

In 2010, ARCAD-Sida launched the Gundo-So project, as it was concerned with the specific issues that WLHIV faced. 'Gundo-So' is a name in Bambara, a national language in Mali: *gundo* means 'confidentiality' and *so* means 'room' or 'box'. The name refers to the meetings women were holding in their communities to discuss their HIV issues—that is, *chambres des confidences*, and the project was inspired to further support these. The women chose the name to adapt the programme to reflect their own realities.<sup>cxix</sup>

Gundo-So seeks to better equip and empower women living with HIV regarding their serostatus disclosure management, thus contributing to improving their quality of life. The aim is to promote and encourage reflection and exchanges between women on the issue of serostatus and the weight of secrecy. The project provides women with a platform to discuss issues related to sexuality and other problems they encounter in their life as PLWHIV. Many women see it as providing a safe space to discuss and share fears and worries with other women in a similar situation.<sup>cxix</sup>

The project includes an assessment interview as well as 10 weekly meetings and an optional group session for participants. Many tools specific to Malian culture are used—pebbles to estimate the weight of secrecy, wooden sticks to weigh the pros and cons, etc. It has been deployed in six sites in Bamako and one site in the region of Kayes, in the west of the country. The goal is to generate a framework the women can own with a particular operating model, rules and sanctions. For example, if someone is late, they must tell a funny story for the group to forgive them.<sup>cxix</sup> During the different discussions, women choose a name for their group—for example 'the Village of Peace' (Hèrèbougou) or 'the Village of Happiness' (La-fiabougou)—and elect a 'village chief' (*dogoutigui*). Every woman chooses a nickname; this can be Benjaminine (Laguarè) for the younger person in the group, or 'Tanty' for older women—a sign of respect in African culture.<sup>cxix</sup> The names signify a hierarchy as well as a relationship of mutual support between women of different ages.

The project has had a positive impact on the lives of the women. They report feeling less burdened by secrecy and better able to plan and implement strategies to unveil or not their status according to different contexts. The project has allowed them to connect and exchange with other women and feel supported by them without being discriminated against. The project also appears to have had beneficial effects on treatment adherence and given women a greater sense of control over their lives.<sup>cxix</sup> The following are testimonies from some of the women in the project (translated from French to English).<sup>cxix</sup>

'Before the project, I used to cry the whole time, and now this is no longer the case, because I have now people with whom I can say everything and without rejection' (WLHIV, widow, 45 years).

'The strength of the project is that we are with other women. We even have a tontine, we get together and we keep in touch although we are not in the same neighbourhood' (WLHIV, widow, 34 years).

'The thing that has struck me the most in the project is the fact of being able to interact with others without fear of being rejected or discriminated against' (WLHIV, married, 44 years).

### Case study 31. Social accountability in Malawi and women living with HIV: Our Bodies, Our Lives campaign for better ARVs in Malawi<sup>78</sup>

The 'Our Bodies, Our Lives' movement is an initiative focused on access to better-quality ARVs for women. The initiative has grown through and uses a combination of strategies, with movement building at the centre. These strategies have addressed intersecting inequalities (HIV status, pregnant women, poor women) in access to ARVs and used political momentum to amplify their concerns at multiple levels.

Since 2007, Just Associates (JASS) has supported WLHIV to strengthen their demand for social justice as a collective and to identify common objectives and priorities in order to achieve their goals. Of particular importance has been the movement-building strategy JASS uses, which supports the strengthening of women's voice, agency and collective power with a view to ensuring their demands are met and gains secured. One of the key features of this movement-building strategy is finding an entry point, an issue for WLHIV to cohere around; in this case, this happened around the inability to access quality HIV treatment as a result of gender inequalities, power and poverty.

The Our Bodies, Our Lives movement-building initiative enabled 1,200 WLHIV to address the 'structural drivers of discrimination, inequality and violence' with a view to imbuing women at an individual and collective level with voice and agency.<sup>79</sup> JASS together with women leaders took stock of the structural and intersecting barriers for WLHIV in realising access to services. They recognised that through reawakening women's power and agency, WLHIV could claim freedom from marginalisation and exclusion individually and as a social group, and accordingly demand access to social goods, services and resources.

Using the approach of dialogue, self-reflection and workshops, JASS conducted a needs assessment in three regions and nationally in Malawi, where WLHIV were encouraged to talk about their personal and daily realities. Conceptual tools for mapping and analysing power helped women make the link between incidents of inequality and discriminatory norms and institutions. They also assisted in identifying targets and spaces for change, such as village chiefs, committees and families, affecting WLHIV in the private and public sphere. These reflective processes allowed women to take stock of their personal and individual struggles and to collectively identify and analyse common barriers with a view to overcoming them, through story-telling, among other activities. Women, within a supportive environment, were encouraged to imagine and live new realities based on a rediscovery of the inherent power they possessed. The processes eventually enabled WLHIV to identify and overcome fear, shame and isolation, and helped build trust and community. They were also important for women to appreciate their power as reflected in their survival and coping strategies, and to use that power to solve problems and improve their lives together and in solidarity with others. The major challenges identified during the conversations related to discriminatory attitudes and behaviours contributing to the feminisation of HIV and AIDS, HIV-positive women's marginalisation within social justice movements and society at large and disconnects among various WLHIV based on age, location, class and sexuality.

Initially, 25 community-based WLHIV leaders were selected to serve as political facilitators to work with JASS to strengthen and support community-level organising. The JASS team visited these women leaders in their communities to discuss progress reached on priorities and action plans as agreed on during the workshops. JASS partnered with the Malawi Network of Religious Leaders Living with HIV/AIDS (MANERELA+), with its network of faith-based leaders and activists, given the centrality of religion in Malawi, and with the Coalition of Women Living with HIV/AIDS (COWLHA) to expand the constituency and organisational infrastructure and ensure ongoing training and outreach for the WLHIV.

In the course of the movement-building and community-based outreach, the WLHIV undertook participatory action research to build the evidence base for a concerted campaign to demand access to better quality ARVs. More than 60 activist leaders were trained on research design and interviewing skills and collaborated in creating survey tools. This resulted in 856 WLHIV from 13 districts in the North, Central and South regions being interviewed. This was followed by a National Dialogue on ART held in Lilongwe, where the Our Bodies, Our Lives campaign was launched, with duty-bearers and power-holders engaged to fulfil their roles towards WLHIV. Press briefings, feature articles in two national newspapers, daily news clips on national news as well as a 20-minute in-depth news special on national television were instrumental in generating broader interest, and as such in shifting hidden and invisible power.

<sup>78</sup> This case study write-up is based on two JASS publications, with the permission of JASS Malawi: Essof, S. and Khan, A. (2015). 'The Our Bodies, Our Lives Campaign for Better ARVs in Malawi: Enacting Social Accountability Through Women's Activism and Organising'; JASS. (2013). 'Making Change Happen: Power-Movements-Change: Malawi'.

<sup>79</sup> Essof, S. and Khan, A. (2015). 'The Our Bodies, Our Lives Campaign for Better ARVs in Malawi: Enacting Social Accountability Through Women's Activism and Organising'.

A total of 160 women from the 3 regions convened around the dialogue with key stakeholders and decision-makers, including the Malawi Human Rights Commission, the Malawi Health Equity Network and MANERELA+, to map out demands for quality ARVs. The women drafted a communiqué listing their demands to the minister of health (also the vice president of Malawi) and also participated in the March to SAVE Children and Their Mothers from HIV Infections, Stigma & Preventable Deaths. Key messages were sent out to President Joyce Banda and government officials on the devastating impact of Stavudine<sup>80</sup> on women's bodies, on stigma and discrimination against WLHIV and on the linkage between women's access to quality ARVs and their access to other critical resources, including fertiliser and savings loans, to promote healthy living.

The combination of strategies elicited results. In 2013, the government announced that it would accelerate its rollout plan, eliminating the phased approach that had previously made the less toxic ARV regimens available only to pregnant and breastfeeding women and those with higher viral loads. The announcement was a swift victory for WLHIV, although the challenges of sustained funding for and delivery of the new drug regimen to women persisted. After the campaign launch in September 2012, district focal points and campaign committees were established throughout the country in order to monitor rollout of Tenofovir-based ARV regimens and to help women deal with barriers to access. MANERELA+ makes routine visits to districts to collect data from activists and compare these with treatment data compiled by the Ministry of Health.

In August 2017, the campaign presence covered all 28 districts, and was 6,000 WLHIV-strong. Significantly, the campaign has evidenced a reversal of side-effects among women who have started the new drug regimen. Success has been registered in accelerated rollout of the WHO-recommended first-line ARV drug regimens to replace the lower-cost, more toxic alternatives women previously received, monitored by WLHIV. In villages where WLHIV are organising other WLHIV, there is 100% conversion to second-line regimens. There is also evidence of improved relations between WLHIV and health officers, leading to better access to multiple drug regimens, essential medicines and mobile health services. Women from the campaign work closely with district health centres, which see them as a resource. The campaign has also begun a rollout of women-centred treatment literacy, based on set treatment literacy modules developed specifically for this purpose. In addition, the campaign leaders have extended their advocacy efforts to Malawi's Global Fund Country Coordinating Mechanism around predictable funding for AIDS treatment and are extending their quest to broader goals, including increased access to livelihood support and the setting-up of savings clubs.

<sup>80</sup> Stavudine is an ARV medication that can have serious and life-threatening side-effects owing to its toxicity. WHO has recommended discontinuing and phasing out its use. [www.who.int/hiv/pub/guidelines/arv2013/arv2013supplement\\_to\\_chapter09.pdf](http://www.who.int/hiv/pub/guidelines/arv2013/arv2013supplement_to_chapter09.pdf)

### Case study 32. Namibian court rules against forced sterilisation of people living with HIV and AIDS

In 2014, the Supreme Court in Namibia issued a landmark ruling on the forced sterilisation of WLHIV, recognising the right to personality, to human dignity and to found a family. This led to a better respect of ethical procedures by health professionals in the case of sterilisation.

Three women living with HIV sued the government of Namibia, alleging that they had been sterilised without their informed consent. They asserted that this violated women's constitutional rights to life, liberty and human dignity and the right to found a family. In addition to arguing that their sterilisation was unlawful, the women contended that they had been discriminated against as a result of their HIV status, which amounted to a breach of their constitutional rights. At the heart of this case was the contention that the sterilisation procedures lacked the victims' consent—nor were they given information about the risks and consequences of such a procedure. The landmark Supreme Court ruling of 3 November 2014 agreed that the right to SRH for WLHIV in Namibia had been compromised through the practice of forced sterilisation.

In 2008, the Namibian Women's Health Network, a chapter of the International Community of Women Living with HIV (ICW), uncovered the alleged practice of hospitals forcefully sterilising HIV-positive women.<sup>xxxvi</sup> At an advocacy training event of the ICW, it emerged that at least three women present had been sterilised without prior informed consent.<sup>xxxvii</sup> Women alleged various violations, including that they had been forcibly sterilised; others reportedly were shunning hospital services for fear of forced sterilisation and pressure to use injectable contraceptives.<sup>xxxviii</sup> One 26-year-old woman who had gone to give birth naturally but underwent a caesarean operation during labour was given forms to sign in that state, only to learn later when seeking contraception that she had been sterilised during the operation.

On following up on the claims, ICW noted a pattern of forced sterilisation confronting HIV-positive women who sought reproductive health services. Out of a sample of 230 women, at least 40 women claimed to have been forcibly sterilised. ICW referred 13 cases for litigation to the Legal Assistance Centre (LAC) and presented all 40 cases to the deputy minister of health and social services.<sup>xxxix</sup>

LAC initiated summons proceedings for 18 cases separately and individually, all around the same time. The LAC lawyers and government attorneys agreed to proceed to trial with only three (the other cases had been instituted with the Court and were only stayed pending the outcome of the three cases). Since these were landmark cases, LAC sought to leave room to amend particulars of the other 15 cases in the event that the Court did not find merit in the 3 initial cases. Luckily this was not to be necessary for the remaining 15 cases; the pleadings required no changes.

In July 2012, the High Court of Namibia determined that all three women litigants were indeed sterilised without their informed consent in violation of the law. Although the judges rejected the discrimination claim, the ruling was nonetheless a major victory for the victims. When the government appealed the High Court's decision, the primary legal issue was whether the women had given their *informed* consent to be sterilised. In all three cases, the women signed consent forms while they were in labour, but argued that their signatures were coerced and that they were not provided adequate information to make an informed decision. The government argued that this was irrelevant, contending that the only question the High Court needed to consider was whether the women were aware that sterilisation leads to sterility.

In November 2014, the Supreme Court of Namibia upheld the ruling of the High Court against the forced sterilisation of three HIV-positive women in public hospitals in the case of *Namibia v LM and Others*.<sup>81</sup> This is the first ruling of its kind in Africa that addresses intersectional discrimination faced by women. However, the issue of whether they had been discriminated against on the basis of their HIV status was not resolved in the women's favour, although the Court noted that 'the tenor of the women's evidence strongly suggests that they believe that their HIV positive status was the primary reason for their sterilization'.

The Supreme Court referred to the Ethical Guidelines for Health Professionals published by the Health Professionals Council of Namibia, which state that 'everyone has the right to be given full information about the nature of his or her illnesses, diagnostic procedures, the proposed treatment and the costs involved'. The Court noted in its general remarks that 'Informed consent implies an understanding and appreciation of one's rights and the risks, consequences and available alternatives to the patient.' The judgement also stated that, in the context of a sterilisation, the woman must in fact be in a position to comprehend the nature and consequences of the operation to be performed on her, and obtaining the consent of a pregnant woman while she is in labour does not meet this threshold.

81 LM and Others v. the Government of the Republic of Namibia (I 1603/2008, I 3518/2008, I 3007/2008) [2012] NAHC 211 (30 July 2012). [www.saflii.org/na/cases/NAHC/2012/211.html](http://www.saflii.org/na/cases/NAHC/2012/211.html)

Changes in the practice of health professionals have emerged, with more caution taken to comply with proof of informed consent. After the case was determined, medical personnel in public hospitals have required women seeking sterilisation to provide police affidavits to that effect. However, activists are concerned that this shifts the burden to women seeking to realise their reproductive rights rather than the duty-bearers. Fear remains that, even after the Supreme Court judgement, the situation is not resolved for the majority of WLHIV in Namibia.<sup>cxl</sup> This is particularly related to the failure of government to establish policies to ensure the practice will not be repeated for any women living with HIV.

The Abortion and Sterilisation Act is still silent on the need for informed consent for sterilisation procedures, and policy changes have not been evidenced to protect WLHIV from further violations of their reproductive rights. Despite this, the Supreme Court judgement (case law) changes the status quo and the Act should be read in conjunction with this decision. Notwithstanding the absence of policies, it will be against the law for any life-changing procedures to omit to follow the requirements as set out in the forced sterilisation cases because case law is law in Namibia. The Supreme Court's decision is binding and subject to adherence by all state health facilities.

### Case study 33. HIV-related forced sterilisation in Kenya

**This case led to increased attention to the abuse of WLHIV in health facilities. The initiators used evidence on forced and coerced sterilisation of WLHIV to mobilise public opinion and call health providers and the government to account in Court for discriminatory treatment and violation of the right to bodily autonomy and informed consent.**

In 2012, the African Gender and Media Initiative (GEM) published a report titled 'Robbed of Choice', which presented evidence on a continuing silent violation of rights against WLHIV. This involved forced or coerced sterilisation of 40 women living with HIV as well as women living with disabilities, particularly those from peri-urban settlements with little to no education.<sup>cxli</sup> Forced and coerced sterilisation of women living with HIV has been documented in at least six countries in Africa: Kenya, Lesotho, Namibia, South Africa, Swaziland and Uganda. Among these states, Namibia remains the only one where litigation has successfully been advanced on the issue (see Case study 32).

In response to the report and inspired by the litigation case in Namibia, the Kenya Legal and Ethical Issues Network on HIV & AIDS (KELIN) developed a dual strategy that entailed both a legal and an advocacy response. The first response was to take legal action in order to secure justice for the aggrieved women. The second response involved advocacy towards raising awareness on forced sterilisation.

Kenya is the second country on the continent to have challenged the issue through court processes. This has been done through two sets of ongoing cases fronted by KELIN—namely, Petitions 605 and 606 of 2014,<sup>cxlii</sup> against Médecins Sans Frontières, Marie Stopes International and the government through the Ministry of Health, for forced and coerced sterilisation of women living with HIV.<sup>82</sup> The cases demand accountability for the discriminatory treatment of women living with HIV between the years 2005 and 2010, when numerous women were forcibly sterilised. The cases advance Art. 14 of the Maputo Protocol, which provides for the right to bodily autonomy and to integrity, dignity, privacy, health and life. The cases further reinforce the norms and guidelines established by General Comment No. 2 of the ACHPR, which elaborates on SRHR.

Although these cases are still ongoing, they have involved unique strategies in that there have been several trainings undertaken in the country with the objective of creating awareness among women that forced sterilisation is a human rights violation and one for which duty-bearers must be held accountable. The trainings have also served as platforms for the identification of additional victims. The national and international media attention that the cases have received has led them to have a visible impact, including breaking the silence and stigma associated with infertility in an African setting, and thereafter many more claimants sharing their stories.

KELIN is hopeful that, beyond breaking the silence, the cases will be able to ensure the government and private health care facilities are held accountable for the violations. Moreover, this case will present an opportunity for the Court to interrogate the constitutional obligation of the state to provide the highest attainable standard of reproductive health based on both a national and an international obligation. The case will also present the court with an opportunity to address discrimination of women and the inter-sectionality of issues such as poverty, HIV and illiteracy. Finally, KELIN is hopeful that the cases will compel the Ministry of Health to issue a circular clarifying that it is not the policy of the state to sterilise women.

<sup>82</sup> The affidavits and responses by the government are available at [www.kelinkenya.org/wp-content/uploads/2017/12/PETITION-NO.-606-of-2014-.pdf](http://www.kelinkenya.org/wp-content/uploads/2017/12/PETITION-NO.-606-of-2014-.pdf)

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