

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.¹

- 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 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.

¹ 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 31.²

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

² 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
Reference to women and girls' rights or gender equality in REC treaty	Enhancement of the economic, social and cultural conditions of women; full participation of women	Good governance, gender equality, human rights; mainstreaming of gender; participation; addressing discrimination	<ul style="list-style-type: none"> No reference in Agreement Establishing IGAD Currently drafted IGAD Treaty refers to role of women in development 	Mainstreaming gender; prohibits discrimination, including on sex or gender	Full participation of women; eliminate discrimination against women
Normative framework of REC on gender equality/women and girls' rights	Supplementary Act on Equality of Rights between Women and Men (2015): 53 rights articles, including on family rights, marginalised groups, education and training, GVAW, health and HIV and AIDS, peace and security	EAC Gender Equality and Development Bill (2016) awaiting assent from EAC Heads of State: <ul style="list-style-type: none"> Non-discrimination Harmonisation of gender equality commitments across the sub-region Women's rights, including GVAW, health, peace and security, marginalised groups 	IGAD Gender Policy Framework (2012–20): <ul style="list-style-type: none"> Including Gender & Health: SRHR, HIV and AIDS, GVAW, harmful practices including gender, peace and security 	SADC Protocol on Gender and Development (2008; amended and updated in 2016): 14 thematic areas, including GVAW, health (SRH and reproductive rights), HIV and AIDS, education and training, peace-building and conflict resolution	Revised Gender Policy (2016): <ul style="list-style-type: none"> Human rights as one of the 7 guiding principles 17 priority areas, including SRHR, HIV and AIDS, adolescent SRH, child marriage, human trafficking
Monitoring mechanisms	-	-	-	<ul style="list-style-type: none"> MERF (2017) SADC Gender and Development Monitor 	<ul style="list-style-type: none"> Annual progress reports Gender Policy implementation plan and monitoring tracking matrix forthcoming
Other commitments on women and girls' rights areas central in Right By Her report	<ul style="list-style-type: none"> Dakar Declaration on the Implementation of UNSCR 1325 ECOWAS Gender Policy ECOWAS Regional Action Plan for combatting obstetric fistula in West Africa Vision 2020 	HIV and AIDS Prevention and Management Act	Regional Action Plan for Implementation of UNSCRs 1325 and 1820		<ul style="list-style-type: none"> Social Charter Framework for the Multi-Sectoral Programme on HIV & AIDS (2012–15); HIV AIDS Policy and tracking plan
Gender infrastructure in REC	<ul style="list-style-type: none"> ECOWAS Gender Development Centre Gender Commission ECOWAS Secretariat Gender Management Team 	Gender Department	Gender Affairs Programme	Gender Unit	<ul style="list-style-type: none"> COMESA Technical Committee on Gender Directorate on Gender and Social Affairs
Regional advocacy networks at REC level	<ul style="list-style-type: none"> NOPSWECO ROAJELF ECOFEP MARWOPNET 	<ul style="list-style-type: none"> EASSI EALS EACSO EAHP EANNASO 	Underdeveloped networks with CSOs	SADC Gender Protocol Alliance	Limited involvement of CSOs <ul style="list-style-type: none"> FEMCOM
Other aspects	<ul style="list-style-type: none"> ECOWAS Court of Justice 50 Million African Women Speak campaign 	<ul style="list-style-type: none"> EAC Consultative Dialogue Framework (on participation of civil society) EAC Court of Justice 50 Million African Women Speak campaign EAC Gender Equality and Development Barometer 	IGAD Women and Peace Forum (government and civil society members)	<ul style="list-style-type: none"> SADC Gender Protocol Barometer SADC Court suspended 	50 Million African Women Speak campaign

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.³

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.

³ 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**.⁴
- 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.

⁴ 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.⁵ 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.⁶ The most prominent weakness in the Central region is the lack of criminalisation of marital rape,⁷ 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,⁸ 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.⁹ 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.

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

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

⁷ In particular in Angola, Burundi, Cameroon, CAR, Chad, Gabon and Equatorial Guinea.

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

⁹ 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.¹⁰
- 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.

¹⁰ 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.¹¹ Seven countries have provisions in statutory law regarding harmful practices, all of them in the Southern region.¹² 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.¹³ 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.¹⁴
- 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.¹⁵
- 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.¹⁶

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.

¹¹ Ghana, Ethiopia, Malawi, Somalia, South Sudan, Sudan, Swaziland and Uganda.

¹² Botswana, Lesotho, Malawi, Mauritius, Namibia, Swaziland and Zimbabwe.

¹³ These 12 countries either score no on these indicators or have missing data.

¹⁴ 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).

¹⁵ 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.

¹⁶ 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 18¹⁷ 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.

¹⁷ 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**.¹⁸ 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.¹⁹

¹⁸ 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).

¹⁹ 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)²⁰
4. Government funding for health higher than 15% of general government expenditure (also based on AU Scorecard on Domestic Financing for Health)²¹
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**.²² 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.

²⁰ Score card published by Africa AIDS Watch: www.aidswatchafrica.net/index.php/africa-scorecard-on-domestic-financing-for-health

²¹ Ibid.

²² 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.²⁴ The majority of countries have launched a chapter of the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA).²⁵
- 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.²⁶ 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.²⁷
- 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.²⁸
- 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).

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

²⁵ 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.

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

²⁷ Four countries have missing data on this indicator.

²⁸ 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 expenditure²³

Legend

- Government funding for health > 15% of general government expenditure, target achieved/on track.
- Government funding for health 10-15% of general government expenditure, achievement of target in progress.
- Government funding for health < 10% of general government expenditure, more effort required to achieve target.
- No data available.

²³ Score card published by Africa AIDS Watch: 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),²⁹ 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 of with a law on the age of consent to SRH services set at 12 years; in South Africa a child may consent to his or her medical treatment without parental consent.
- The contested nature of the issue of **adolescent pregnancies and access to education** in many countries and regions: in a few countries, pregnant girls or adolescent mothers are denied access to school and face barriers to continuing and completing their education (Equatorial Guinea and Tanzania)
- Provision of good quality, integrated and fully compulsory **comprehensive sexuality education** is not yet realised, and continues to be contested, despite progress made. In countries making progress in the implementation of the ESA Commitment, not all schools are being reached, neither are all out-of-school youth, and the quality and comprehensive of the CSE varies.
- Many countries lack clear legislation on age of consent to sexual activity. When in place, **sexual consent of youth** is often constructed in reference to sexual defilement or rape. This framing protects girls and young women from forced sex, sexual abuse and exploitation, but can also restrict her right to express her sexuality.³⁰ 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 then 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).

²⁹ 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).

³⁰ 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,³¹ they are in the rise in others.³² New infections tend to concentrate in specific countries.³³
- 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' to protect themselves from HIV infection. **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.³⁴

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.

³¹ For example Burundi, Guinea-Bissau, Mozambique, Nigeria, Senegal, Uganda, Zimbabwe.

³² For example Congo Republic, Ethiopia, Ghana, Liberia, Madagascar.

³³ Including Kenya, Malawi, Mozambique, Nigeria, South Africa, Tanzania, Uganda, Zimbabwe.

³⁴ 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**³⁵ 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.

³⁵ 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



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 HIV³⁶
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),³⁷ five in Northern Africa,³⁸ five in Central Africa,³⁹ three in Western Africa,⁴⁰ and only one in Southern Africa.⁴¹
- 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).⁴² 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.⁴³ Another 18 countries of these 26 do criminalise wilful HIV transmission (marked yellow on Map 7).

³⁶ 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.

³⁷ Eritrea, Ethiopia, Rwanda, Somalia, South Sudan and Sudan.

³⁸ Algeria, Egypt, Libya, Morocco and Tunisia.

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

⁴⁰ Cape Verde and Guinea, and missing data for The Gambia.

⁴¹ Swaziland.

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

⁴³ 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.⁴⁴ 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 HIV⁴⁵ and eight lack such legislation.^{46,47} 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.⁴⁸ 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**⁴⁹; 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.⁵⁰ 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.^{51,52} 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.

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

⁴⁵ Cameroon, Rwanda and South Sudan.

⁴⁶ Egypt, Ethiopia, The Gambia, São Tomé and Príncipe, Somalia, Sudan, Swaziland and Tunisia.

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

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

⁴⁹ 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.

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

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

⁵² 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.