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ADVANCING SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN AFRICA

CONSTRAINTS AND OPPORTUNITIES

Edited by
Ebenezer Durojaye, Gladys Mirugi-Mukundi and Charles Ngwena

Advancing Sexual and Reproductive Health and Rights in Africa

This book explores recent developments, constraints and opportunities relating to the advancement of sexual and reproductive health and rights in Africa.

Despite many positive developments in relation to sexual and reproductive health in recent years, many Africans still encounter challenges, for instance in poor maternity services, living with HIV, and discrimination on the basis of age, gender, sexual orientation or identity. Covering topics such as abortion, gender identity, adolescent sexuality and homosexuality, the chapters in this book discuss the impact of culture, morality and social beliefs on the enjoyment of sexual and reproductive health and rights across the continent, particularly in relation to vulnerable and marginalized groups. The book also explores the role of litigation, national human rights institutions and regional human rights bodies in advancing the realization of sexual and reproductive health and rights in the region. Throughout, the contributions highlight the relevance of a rights-based framework in addressing topical and contentious issues on sexual and reproductive health and rights within Sub-Saharan Africa.

This book will be of interest to researchers of sexuality, civil rights and health in Africa.

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Constraints and Opportunities

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Acronyms and abbreviations

ACHPR:	African Charter on Human and Peoples' Rights
African Commission:	African Commission on Human and Peoples' Rights
ACtHPR:	African Court on Human and Peoples' Rights
ACRWC:	African Charter on the Rights and Welfare of the Child
ACERWC:	African Committee of Experts on the Rights and Welfare of the Child
AU:	African Union
CEDAW:	Convention on the Elimination of Discrimination against Women
CSE:	Comprehensive Sexuality Education
ICCPR:	International Covenant on Civil and Political Rights
ICESCR:	International Covenant on Economic, Social and Cultural Rights
CRPD:	Convention on the Rights of Persons with Disabilities
CERD:	Convention on the Elimination of Racial Discrimination
FGC/M:	Female Genital Cutting/Mutilation
KNCHRC:	Kenyan National Commission on Human Rights
Maputo Protocol:	Protocol to the African Charter on the Rights of Women
NHRIs:	National Human Rights Institutions
IAComHR:	Inter-American Commission of Human Rights
IACtHR:	Inter-American Court of Human Rights
HRC:	Human Rights Committee
SDGs:	Sustainable Development Goals
STIs:	Sexually Transmitted Infections

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Foreword

Over the years, significant steps have been made towards the realization of Sexual and Reproductive Health Rights (SRHR) across the globe. Following the International Conference on Population and Development (ICPD) that resulted in the ICPD Programme of Action in Cairo, 1994, and the Beijing Declaration and Platform for Action, 1995, several countries globally committed to, and have taken concrete steps towards, the realization of SRHR at the state and global levels. However, although steps have been taken towards achieving this goal, the comprehensive realization of SRHR still remains a challenge. The Committee on Economic, Social and Cultural Rights in General Comment No. 14 also defines the obligations that State parties have to fulfil in order to implement the right to health at the national level.

In Africa, due to androcentric social-political systems rooted in coloniality, apartheid, xenophobia, Afrophobia, transphobia, homophobia, ableism, sexism and racism, many African countries still lag behind with regard to their obligations to protect, promote and advance SRHR.

Systems designed to discriminately provide access to power, resources, and opportunities perpetuate inequality at both the structural and individual levels of society, thereby entrenching the power imbalance. Therefore to comprehensively realize SRHR, an intersectional approach that appreciates how multiple systems of oppression interact simultaneously to determine an individual's SRHR must be adopted.

The right to health contains both freedoms and entitlements. Freedoms include the right to control one's health, including the right to be free from non-consensual medical treatment and experimentation. Entitlements include the right to a system of health protection (i.e. health care and the underlying social determinants of health) that provides equality of opportunity for people to enjoy the highest attainable standard of health.

The realization of SRHR requires us to challenge the unequal distribution of power in society and to strive to restore peoples dignity which is a pivotal principle permeating the right to health. Contextual changes that are needed so as to remove obstacles, oppressive systems and conditions that make people vulnerable to SRHR violations must also be identified and actualized.

Thus decolonization, anti-racism work and intersectional frameworks must be employed in reshaping, researching and analysing the global health architecture.

As per the mandate of the Special Rapporteur, SRHR are integral elements of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The mandate recognizes that many obstacles stand between individuals and their enjoyment to sexual and reproductive health. These obstacles are interrelated and entrenched, operating at different levels: in clinical care, at the level of health systems, and in the underlying determinants of health. In addition to biological factors, social, economic and other conditions bear upon a woman's sexual and reproductive health.

The importance of a 'policy approach' to the right to health, especially in relation to sexual and reproductive health, and in poverty reduction, cannot be overemphasised.

It is therefore incumbent on state to ensure that laws, policies and practices do not lead to rights abuses or violations. Laws, policies and practices determine who has access to the benefits of SRHR services, the quality of SRHR services people will receive, and how SRHR systems are structured and governed. For instance, in many African countries, SRHR related laws and policies are applied to adolescents in a manner that depicts them as emotionally and intellectually weak. This approach not only disempowers them by undermining their sexual agency and bodily autonomy but also denies them access to SRHR information and services. Additionally, in most African countries, the hegemonic conceptualization of sexuality as being strictly heteronormative has led to the criminalization of persons of non-heteronormative and diverse sexualities, which infringes on individuals' right to equality and non-discrimination, privacy and inherent dignity. It is especially important to ensure access to services and information for those in vulnerable situations or historically subjected to discrimination, such as adolescent girls, migrant women, women with disabilities, urban, slum dwellers, refugees, LGBTIQA+ and gender diverse persons and communities.

The right to health is an inclusive right, extending not only to timely and appropriate health care, but also to the underlying determinants of health. Access to health-related education and information, including on sexual and reproductive health is also recognized as important. This volume, *Advancing sexual and reproductive health and rights in Africa: constraints and opportunities*, which is edited by Ebenezer Durojaye, Gladys Mirugi-Mukundi and Charles Ngwena is a powerful and timely resource that will definitely be useful in the advancement of SRHR in Africa. It captures recent developments across Africa that may have an impact on the enjoyment of SRHR and will go a long way in stimulating discourse on various integral facets of SRHR. Moreover, the book will be instrumental in helping people understand the role national human rights institutions and regional human rights bodies play in advancing the realization of SRHR in the region. It is a useful resource to researchers, academics, policymakers, civil society organizations, students and other persons interested in the subject of SRHR. It addresses contemporary issues relating to SRHR

in Africa giving priority to both sexual health and rights as well as reproductive health and rights. We must work together to attain the United Nations Sustainable Development Goals on gender equality and health and well-being – particularly those aimed at ensuring universal access to sexual and reproductive health rights and reducing maternal mortality.

The book is instructive not only from the standpoint of engaging in debate and exploring the role of national human rights institutions and regional human rights bodies in advancing the realization of sexual and reproductive health and rights in the region. It also underscores the importance of litigation as a means of remedying human rights violations and advancing sexual and reproductive health and rights.

Whether before, during or after a public health crisis or any other situation that places people in vulnerable situations, sexual and reproductive health rights must be protected as an integral element of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health must be protected and promoted.

I highly commend this book to scholars, researchers, practitioners, human rights activists, advocates for law reform, civil society groups, lawyers, and policymakers and analysts from across Africa and beyond.

Dr. Tlaleng Mofokeng
UN Special Rapporteur on the right to the highest attainable standard of physical and mental health

Preface

The idea for this book was conceived during the Colloquium on Advancing Sexual and Reproductive Health and Rights organized by the Dullah Omar Institute (DOI), University of the Western Cape in conjunction with Kenya Legal & Ethical Issues Network on HIV and AIDS (KELIN) in August of 2018. The Colloquium was part of a project on 'Advancing Sexual and Reproductive Health and Rights in East and Southern Africa', funded by AmplifyChange and jointly implemented by KELIN, Initiatives for Strategic Litigation in Africa (ISLA) and the Dullah Omar Institute. The Colloquium was attended by 30 participants across Africa with diverse backgrounds including academics, activists, personnel of national human rights institutions, officials of regional human rights bodies and civil society groups. At that Colloquium, papers on various aspects of sexual and reproductive health and rights were presented. Some of the papers presented form part of this book while other papers were sourced from contributors who could not attend the Colloquium.

One of the motivations for this book is based on recent developments across the region on sexual and reproductive health and rights. While on one hand, religious and cultural practices have continued to pose serious threats to the realization of sexual and reproductive health and rights in the region, on the other hand, recent jurisprudence from the regional bodies such as the African Commission on Human and Peoples' Rights and national courts offer a glimpse of hope for the region. These latter developments reinstate the point that opportunities exist to ensure the realization of SRHR. To this extent, this book offers an interesting contribution to knowledge and debate on SRHR in Africa. It addresses important issues, some of which are often enmeshed in controversy. For instance, despite the unacceptably high incidence of maternal death often as a result of unsafe abortion, many countries in the region still adopt highly restrictive laws and practices on abortion. It should be noted that the Maputo Protocol is the first human rights instruments to grant women the right to abortion on certain grounds. It is indeed ironic that the region with the most progressive instrument on abortion also has one of the worst statistics on deaths resulting from unsafe abortion. This calls for drastic actions on the part of African leaders. African governments must recommit themselves to addressing challenges hindering access to sexual and reproductive health care

services for all on a non-discriminatory basis. This entails addressing the special needs of vulnerable and marginalized groups

All hands must be on deck to ensure that African countries achieve Sustainable Development Goal 3, reinforced by AU Agenda 2063 and Continental Framework for the Operationalisation of Sexual and Reproductive health and Rights (Maputo Plan of Action 2016–2030), to improve the health and well-being of all. Policymakers, government departments/ministries civil society groups, religious bodies, research institutions and other stakeholders need to join hands to ensure universal access to sexual and reproductive health care services for all. As agreed during the Abuja Declaration, African leaders must provide resources to realize access to sexual and reproductive health care services for all. In this regard, no one, regardless of his or her gender, age, social status, race, ethnicity, sexual orientation, identity or other associational status, must be left behind.

Ebenezer Durojaye
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Charles Ngwena

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1 Introduction

Ebenezer Durojaye, Gladys Mirugi-Mukundi and Charles Ngwena

1 Introduction

Almost 25 years after the historic International Conference on Population Development (ICPD) in Cairo in 1994 and the Beijing Declaration of 1995, the world has witnessed some major developments regarding the promotion and protection of sexual and reproductive health as human rights. Issues relating to sexual and reproductive health and rights (SRHR) have been receiving more attention from governments across the world, including African governments. Despite these positive developments, however, challenges remain. Sub-Saharan Africa still accounts for the highest number of people living with HIV in the world. Teenage pregnancies and unsafe abortions have resulted in avoidable deaths among women of reproductive age. Moreover, Africa remains one of the most dangerous places in the world for a woman to give birth. The maternal mortality ratios (MMR) in many African countries remain very high. For instance, the MMR in Nigeria is 814 deaths per 100,000 live births (one of the highest in the world).[1] The average number of deliveries attended by a skilled health care worker in Africa is put at about 47% lower than the world's average of 60% and 88% in Southern and Eastern Asia, respectively.[2] Contraceptive use among young women remains very low. About two-thirds of all births are still to young women aged 20–25.

Other regional challenges include negative attitudes towards non-conforming sexuality on the basis of age, gender, sexual orientation or identity. Existing rights in international and regional human rights instruments can be invoked to apply to sexual and reproductive health. These include the rights to life, dignity, privacy, non-discrimination, equality, liberty, freedom from inhuman and degrading treatment, health, scientific benefit and family. At the ICPD in Cairo, the international community defined reproductive rights to include:

> [T]he right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice of regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.[3]

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A meeting convened by the World Health Organization defined sexual rights to include the right of all persons, free of coercion, discrimination and violence, to:[4]

- Seek, receive and impart information related to sexuality;
- Sexuality education;
- Respect for bodily integrity;
- Choose their partner;
- Decide to be sexually active or not;
- Consensual sexual relations;
- Consensual marriage;
- Decide whether or not, and when, to have children; and
- Pursue a satisfying, safe and pleasurable sexual life

2 Overview of sexual and reproductive rights issues and challenges

While the international community has made remarkable progress in advancing SRHR, some major challenges remain with regard to realizing these rights. Since ICPD and the Beijing Declaration, the world has seen more attention given to issues that affect the rights and well-being of women. For instance, the rate of maternal mortality has decreased considerably from about half a million deaths annually in the 1990s to about 230,000.[5] Despite this remarkable progress, many of the African countries failed to achieve the Millennium Development Goal 5, which was to reduce the number of maternal deaths by 75% by 2015, but the rate of maternal deaths remains unacceptably high.[6] Many factors account for this, including lack of political will, poor allocation of resources to maternal health, a high rate of unsafe abortions and lack of access to skilled health care providers during birth, especially for women in rural areas or disadvantaged communities.[7]

In the same vein, progress has been made with regard to providing life-saving medications in the context of HIV/AIDS. At the end of 2018, an estimated 23 million out of 37 million people living with HIV were said to be on treatment[8] a remarkable improvement from 2010 when it was around 17 million people on treatment. This has led to a dramatic decrease in HIV-related deaths from 1.7 million in 2004 to 770,000 at the end of 2018.[9] Further, the rate of mother-to-child transmission of HIV has reduced considerably.[10] Indeed, many of the countries that are worst affected by the HIV epidemic in Africa are now providing medications to reduce transmission from pregnant women to the unborn child and for the treatment for children, with the number of people receiving treatment eaching 940,000 at the end of 2018.[11] However, this still falls short of the 1.7 million children in need of HIV treatment, and disparities still exist among the regions.

Furthermore, evidence has shown that there has been an increase in the number of women using one form of contraception or another in many parts of the world, including Africa.[12] This is significant, as access to contraception is crucial

for the prevention of unwanted pregnancy and unsafe abortions. However, unmet need for contraception remains high in many countries in the region. Hence, the fertility rates for many African countries are still very high. While the average fertility rate in sub-Saharan Africa is 4.5, it can be as high as 5.4 in Nigeria and 5.9 in Mali.[13] Lack of access to sexual and reproductive health information and services, and cultural practices such as child marriage, power imbalances and lack of information account for the high fertility rate in the region. Lack of respect for the agency of young women coupled with cultural and religious factors continue to limit access to sexual and reproductive health services, including access to contraception to those in the region.[14] It is known that fertility rate influences maternal mortality and the well-being of a woman, as the higher the fertility rate, the higher the risk to the woman's health.

While progress has been made to address the impact of harmful cultural practices affecting the enjoyment of sexual and reproductive health and rights of women in the region, these practices have continued. Over the last few years, many African countries have taken drastic measures including the enactment of laws prohibiting or criminalizing child marriage and female genital cutting/mutilation (FGC/M). These measures have been propelled by continental-wide efforts such as the African Union Campaign to end child marriage.[15] This campaign aimed to promote the rights of women and girls in Africa by advocating for the eradication of child marriage in the continent. The campaign received the support of many African countries and led to law reforms in some countries to address gender inequality and raise the marriageable age at a national level.[16] However, the number of child marriages taking place in Africa is still high and of great concern. Reports have shown that in Africa, 35% of women have been married before reaching 18 compared to 30% in South Asia.[17] A similar situation applies to FGC/M. While many countries in the region have experienced progress in combating this cultural practice through legislative reforms and public awareness campaigns, the practice has continued unabated.[18] Of the over 200 million girls that have undergone FGC/M, about 70% of them live in Africa. Indeed, about eight African countries have recorded over 80% FGC/M prevalence.[19] Strong religious and cultural views on this practice have led to its continuance in many parts of the region. There is a need for political will, education and continued engagement with communities where this practice takes place.

In many African countries, discrimination and human rights abuse of sexual minorities have continued. Individuals and states have continued to exhibit homophobic tendencies against persons of different gender identities or sexual orientations across the region. Reports have documented violent attacks on individuals based on their perceived or real gender identity or sexual orientation.[20] In addition, a significant number of African countries have enacted laws or policies criminalizing consensual same-sex sexual relationships.[21] Even in countries where same-sex relationships are lawful, violent attacks based on gender identity or sexual orientation are common.[22] Violence against and human rights abuse of individuals based on gender identity or sexual

orientation not only undermines the enjoyment of human rights, it also hinders programmes and efforts at addressing HIV and other sexual and reproductive health challenges. However, there seems to be a glimmer of hope, as the African Commission on Human and Peoples' Rights, hitherto silent, has recently taken a progressive stance on this issue.[23]

3 Opportunities

Treaty human rights bodies such as the Committee on Economic, Social and Cultural Rights (CESCR), the Committee on the Rights of the Child (CRC), the Committee on the Elimination of All forms Discrimination against Women (CEDAW) and the Human Rights Committee have all issued very useful General Comments/recommendations and concluding observations that have further clarified the meaning and content of sexual and reproductive health and rights. For instance, in its general comments 14 and 22, the CESCR noted that states are obligated to ensure availability, accessibility, acceptability, quantity of sexual and reproductive health care services.[24] It further noted that states must respect, protect and fulfil sexual and reproductive health and rights of all, especially vulnerable and marginalized groups. The Committee noted that denial of sexual and reproductive health services to an individual based on gender, sexual orientation or identity, refugee or asylum status, health status or age will amount to a breach of the state's obligation under the Covenant.[25]

On the other hand, the CEDAW Committee has affirmed that failure by states to ensure access to health care services particular to women's needs will amount to an act of discrimination contrary to the provisions of the Convention.[26] It has recently affirmed that acts of violence, including harmful practices, homophobic attacks and forced sterilization amount to violation of women's fundamental rights and freedom.[27] In the same vein, the Committee on Rights of the Child has issued different general comments to clarify the sexual and reproductive health and rights of children and adolescents.[28] The Committee has emphasized the need for states to respect the rights of children and adolescents to sexual and reproductive health services without parental consent. It has further noted that states are to ensure the removal of all forms of barriers, including legal, religious, cultural and social, to sexual and reproductive health services for children and adolescents.[29]

In September 2015, the United Nations General Assembly adopted the Sustainable Developments Goals (SDGs), which contain 17 goals.[30] The overarching goal of the SDGs is to ensure that no one is left behind in the fight to eradicate poverty worldwide. The SDGs contain some important targets relating to sexual and reproductive health. In particular, goals 3 on healthy living and 5 on gender equality are very relevant to addressing some of the sexual and reproductive health challenges facing Africans. SDG 3 aims specifically to reduce maternal mortality ratios to 70 deaths per 100,000 by 2030.[31] The indicators to monitor progress for this include, among others, proportion

of births attended by skilled medical personnel, contraceptive prevalence use, adolescent birth rate, antenatal care coverage and ensuring universal access to family planning services. These positive developments can propel governments and policymakers in Africa to live up to their obligations under these different human rights instruments.

At the regional level, the African Commission on Human and Peoples' Rights has continued to play an important role in developing norms and standards to advance sexual and reproductive health as human rights. These include its adoption of thematic resolutions, general comments, concluding observations and other promotional activities. Of the recent developments on SRHR in Africa, some points are worthy of note—the adoption of general comments 1 and 2 on Article 14 of the Maputo Protocol, the adoption of Resolution 275 and the joint general comment on child marriage and other harmful practices.

In 2012, the African Commission adopted its first General Comment to clarify the provision of Article 14 (1) (d) and (e) of the Maputo Protocol, which is the first provision to explicitly address HIV as a human rights issue.[32] The Commission has clarified that among the steps to be taken by states to meet the obligations under this provision, included the creation of an enabling legal environment that is respectful of the fundamental rights of all, including people living with HIV or at risk of the epidemic.[33] General Comment 2 of the Commission addresses various aspects of sexual and reproductive health, including access to safe abortion services, contraceptive services and sexuality education for young people.[34] It urges African governments to ensure that barriers to sexual and reproductive health services are removed.[35] States are further enjoined to ensure the provision of youth-friendly services to meet the sexual and reproductive health needs of young people.[36] It particularly urges states to ensure access to safe abortion services to all women in the region in accordance with the Maputo Protocol.[37] These general comments are historic in the sense that they broke the silence on some contentious sexual and reproductive health issues that are often treated with kid gloves.

Perhaps one of the most significant contributions of the African Commission to the development of sexual and reproductive health and rights is the affirmation of the rights of sexual minorities in the landmark Resolution 275.[38] In this Resolution, the African Commission condemns all forms of violence against persons based on real or perceived sexual orientation or gender identity.[39] It invokes the provisions of the African Charter on equality and non-discrimination, dignity and freedom from torture, inhuman and degrading treatment, and calls all African states to address all forms of violence against persons based on sexual orientation or identity. The Resolution came in the wake of violent attacks on people perceived to be of different sexual orientation and identity and the enactment of draconian laws to punish homosexual activities in countries such as Nigeria and Uganda.[40] While in recent years some countries have intensified homophobic tendencies to the issue of non-conforming sexuality, the African Commission has taken a bold step in protecting the rights of all

individuals from violence regardless of their gender identity or sexual orientation. This is a milestone in the annals of the Commission's history and portrays a positive development in the recognition of the rights of sexual minorities in the region

In its first ever Joint General Comment, the African Commission and the Expert Committee on the Rights and Welfare of the Child in Africa addressed the human rights violations in the context of child marriage and other harmful cultural practices.[41] This Joint General Comment is significant in that it addresses a very serious and sensitive issue. Child marriage has remained a source of concern to human rights advocates and policy makers in the region. Despite several efforts made to curtail this practice, it has withstood resistance from communities and regions where it is practised mainly on religious and cultural reasons.

The Joint General Comment expresses concerns about the prevalence of child/early marriage in the region and its human rights implications. It specifically notes that this practice undermines various rights in the African Charter, Maputo Protocol and the African Children's Charter.[42] Beyond condemning child marriage a human rights violation of the girl-child, the Joint General Comment makes concrete culturally appropriate recommendations addressing this serious human rights concern.[43] These include the need to ensure verification of birth and the issuance of birth certificates, full implementation of laws and imposition of sanctions, education and awareness campaigns and institutional measures to guarantee access to justice and rehabilitation of the girl-child already involved in child marriage.[44]

In 2017, the African Commission adopted a very progressive document to combat sexual violence and its consequences in Africa. This document-Guidelines to Combat Sexual Violence and its Consequences in Africa-remains one of the most important documents by the African Commission on this issue.[45] Drawing on existing international norms and standards regarding sexual violence, the Commission adopts a broad and progressive definition of violence against women. The document further provides comprehensive examples of sexual violence to include, among others, rape, including marital rape, sexual harassment, female genital mutilation, virginity testing, child marriage, forced pregnancy, forced abortion, nudity and forced sterilization.[46] This is a progressive approach by the Commission, which complements the provisions of the Maputo Protocol on violence against women. The guidelines take into consideration the lived experiences of African women regarding all forms of sexual violence they daily encounter.

The various efforts of the regional human rights bodies have been consolidated by the adoption of the continental framework known as the revised Maputo Plan of Action 2016–2030 on universal access to sexual and reproductive health care services in Africa.[47] The Plan of Action aims at reaffirming commitments made during the ICPD in 1994 and the SDGs 2015, and contains detailed and costed actions towards realization of universal access to SRHR by African governments[48]. It addresses key SRHR issues affecting the region and

outlines policies and programmes that African governments should adopt with a view to ensuring universal access to SRHR in the region. It is an ambitious fourteen-year plan that proposes to address some of the sexual and reproductive ill-health facing many Africans and improve their living conditions and well-being. For instance, it proposes an integration of SRHR services with HIV/AIDS, STIs, maternal health and new-born and family planning services. It recommends the involvement of men, families and communities, civil society groups, private and public sectors, and South-south cooperation towards the realization of universal SRHR services in the region.[49]

In addition to these significant developments at the regional level, some national courts have begun to provide important jurisprudence bordering on the promotion and protection of the rights to sexual and reproductive health. For instance, courts in Kenya, Uganda, South Africa, Malawi and Zimbabwe have handed down judgments that advance the sexual and reproductive health and rights of individuals. Some of the cases adjudicated included forced detention for inability to pay maternity fees,[50] respect for adolescent sexual development and expression,[51] promotion of rights of sex workers in the context of mandatory HIV testing[52] and declaration of child marriage as unconstitutional.[53]

These developments in the region provide opportunities for accountability on the part of African governments to live up to their obligations and to realize SRHR under international law and the African regional human rights system. The above developments clearly indicate that there are sufficient norms and standards in the region not only to hold states accountable, but also to advance the SRHR of vulnerable and marginalized groups. This calls for renewed commitment and political will on the part of African governments. More importantly, it calls for the involvement of other stakeholders such as civil society groups and national human rights institutions to act as watchdogs to the governments by ensuring accountability and creating awareness on SRHR issues.

4 Objectives

The main objective of this book is to explore recent developments, constraints and opportunities relating to the advancement of sexual and reproductive health and rights in Africa. It aims to highlight the relevance of a rights-based framework to addressing topical and contentious issues on sexual and reproductive health and rights in the region. Other objectives are:

- To stimulate debate on the impact of culture, morality and social beliefs on the enjoyment of sexual and reproductive health and rights, particularly in relation to vulnerable and marginalized groups;
- To explore the role of national human rights institutions and regional human rights bodies in advancing the realization of sexual and reproductive health and rights in the region;
- To discuss the importance of litigation as a means of advancing sexual and reproductive health and rights.

5 Significance of this book

Attempts have been made to explore the subject of sexual and reproductive health and rights in Africa from different perspectives and by different authors. Some of these publications have explored the application of human rights to sexual and reproductive health challenges in Africa. Others have examined the impact of socio-cultural practices on the enjoyment of sexual and reproductive health and rights. However, none captures the recent developments on this issue within the African region. The edited volume, *Strengthening sexual and reproductive health as human rights in Africa*, by Ngwena and Durojaye[54] published in 2014 seeks to address the application of human rights to the enjoyment of sexual and reproductive health in the region. It contains very interesting chapters addressing different issues, including HIV/AIDS, adolescents' sexuality, maternal mortality, child marriage, unsafe abortion and protection of women in armed conflict. The volume, however, does not address some contentious issues on sexual and reproductive health in the region such as homosexuality, conscientious objection to abortion services, the potential role of litigation in advancing SRHR and the role of national and regional human rights bodies in advancing SRHR.

The book *Protecting human rights of sexual minorities in Africa*[55] which was published in 2017 focuses entirely on the human rights challenges facing sexual minorities in Africa. It addresses the various acts of violence and human rights abuses perpetrated against sexual minorities across Africa. While the book focuses on sexual rights issues as experienced by sexual minorities, it does not deal with broader social, cultural and religious issues that affect sexual and reproductive health in the region.

This book addresses contemporary issues relating to SRHR in Africa. It attends to both sexual health and rights issues and reproductive health and rights issues. It captures developments that are more recent across Africa and their impact on the enjoyment of SRHR. The book further explores the role of national courts in advancing sexual and reproductive health and rights across the region. Important case-law from some African countries is discussed to emphasize the need to hold states accountable for the violation of sexual and reproductive health and rights.

In line with the views of other commentators, this book affirms that addressing the sexual and reproductive health and rights of Africans, particularly vulnerable and marginalized groups, is a matter of life and death that deserves urgent interventions from governments.[56] It recognizes that religious and cultural practices may sometimes interfere with the enjoyment of sexual and reproductive rights of the people. More importantly, the book makes the link between the SDGs and the right to health, including sexual and reproductive health and rights.

It suggests that applying a rights-based approach to issues of sexual and reproductive health would have great potential to improve the living conditions of the people in general and advancing the rights of vulnerable and

marginalized groups in particular. It further claims that the existing norms and standards on the right to sexual and reproductive health provide an impetus for its realization in the region. Therefore, the inability by a state to ensure that all individuals, regardless of their gender, age, sexual orientation or identity, enjoy to the fullest their sexual and reproductive health, amounts to failure to meet its human rights obligations.[57]

6 Relevance

This book will be useful to researchers, students, academics, people working in civil society organizations, government departments/institutions, judiciary, international organizations, human rights institutions/bodies and individuals interested in the issue of sexual and reproductive health and rights.

7 Structure

This book is divided into three parts and contains 14 chapters addressing diverse issues on SRHR, with contributions from academia, human rights activists and members of regional human rights bodies and national human rights institutions. Part I addresses issues relating to reproductive health and rights. Part II deals with sexual health and rights, while Part III features chapters addressing mechanisms for the realization of sexual and reproductive health and rights. Due to language barriers, the book covers situations in Anglophone countries in the region. The summary of the chapters is presented below.

7.1 Part I – Reproductive health and rights

In Chapter 2, Satang Nabaneh examines the lack of regulation regarding the scope of conscientious objection to abortion in South Africa. The chapter seeks to clarify the essential conditions needed to ensure that women who seek access to abortion services are treated with respect for their reproductive autonomy and human dignity. It concludes by reflecting on how the right to freedom of conscience should be balanced with women's right to legal abortion services and care.

The focus of Chapter 3 by Ibrahim Obadina is on the nexus between unsafe abortion and maternal mortality in Nigeria. The chapter proposes that asking the 'woman question', and more particularly the 'Nigerian woman question', should guide policies, laws and judicial decisions relating to women's sexual and reproductive health and rights, including abortion services in Nigeria. It notes that asking the 'Nigerian woman question' means examining how the peculiar experiences of Nigerian women have been ignored by laws rooted in patriarchy across the country. Although criminal statutes have incorporated exceptions to the lifesaving requirement, the chapter argues that the country can draw inspiration from the Protocol on the Rights of Women in Africa (Maputo Protocol), which has recognized the rights of a woman to seek

abortion on certain grounds, in consonance with women's reality and experience in Africa.

Chapter 4 by Robert D. Nanima examines how the abortion question can be mainstreamed into the discussion on the right to health of women in Uganda. He argues that the restrictive regime on abortion exacerbates the marginalization of women and deepens already existing polarities. In his view, these polarities tend to pit the woman against the community, thereby undermining the right to health and well-being of Ugandan women. The chapter then engages in a discussion of the international and regional norms and standards applicable to the realization of safe abortion services for women and how this can be applied to Ugandan women. It particularly discusses the importance of the provision of the Maputo Protocol on abortion and the implications of the reservation entered by the Ugandan government. The chapter makes some recommendations to the Ugandan government on how to deal with the polarization of abortion in the country.

In Chapter 5, Michelle Rufaro Maziwisa examines the obligations of the government to promote, protect and fulfil human rights in the context of adolescent girls' reproductive health and rights using Zimbabwe as a case study. The chapter specifically notes that the right to contraception constitutes a critical part of the realization of this. The chapter further argues that constraints such as lack of information, socio-cultural factors and need for parental consent often limit access to contraception for adolescents in the country. Existing international and regional norms on SRHR impose obligations on the Zimbabwean government to ensure access to contraception services for adolescents in rural areas. The chapter concludes by urging the Zimbabwean government to take more proactive measures, consistent with its obligations under international law, with a view to ensuring access to contraception for adolescents in rural areas.

Chapter 6 by Sibusiso Mkwananzi discusses an important but often ignored issue of men's involvement in the realization of the SRHR of women. Using South Africa as a case study, the chapter examines the various challenges women and girls face in realizing their SRHR and proposes that the involvement of men in SRHR of women has the potential to advance the rights of women. It highlights some of the benefits and constraints of involving men in the promotion and protection of SRHR of women and girls in the country. The chapter makes useful recommendations of how men can effectively be involved in the realization of the SRHR of women and girls.

7.2 Part II – Sexual health and rights

Godfrey Dalitso Kangaude discusses the human rights issues in relation to sexuality of adolescents in Malawi in Chapter 7. He argues that most parents have difficulties recognizing their children as sexual. Parents react negatively to childhood sexual development by prohibiting sexual conduct rather than promoting positive sexual behaviours. Using Malawi as a case study, the chapter argues that addressing gender inequitable norms that begin to exert influence

in early adolescence requires recognizing children and adolescents as possessing an evolving sexual agency, and supporting them to develop positive sexual behaviours and practices as they begin to pursue romantic and sexual interests. The chapter recommends a rights-based approach to addressing the sexual and reproductive health of adolescents in Malawi in ways consistent with gender equality norms and in line with the country's obligations under international law.

In Chapter 8, Ebenezer Durojaye and Satang Nabaneh examine the effectiveness of criminalization of FGC/M in The Gambia. The chapter discusses the nexus between FGC/M and human rights as well as the reasons often adduced to support the use of criminal law to address FGC/M. Furthermore, it focuses on the amendment to the Women's Act in The Gambia, which prohibits FGC/M. The paper evaluates the utility of the approach adopted by the Gambian government vis-a-vis its obligation under the Protocol to the African Charter on the Rights of Women (African Women's Protocol). The chapter concludes by recommending that beyond criminalization, states should complement this approach with other strategies such as education and awareness programmes.

Chapter 9 by Adetoun T Adebanjo examines the role of culture and religion in the criminalization of homosexuality in Nigeria and proposes a middle ground where the rights of gay people can be respected, notwithstanding Nigerian cultural, moral and religious beliefs. The chapter discusses the relevant provisions of Nigeria's Criminal and Penal Codes, and Shari'a law, which had criminalized homosexuality long before the introduction of the Same-Sex Marriage (Prohibition) Act of 2013. It further argues that Nigeria's anti-gay laws contradict provisions of the Nigerian Constitution and principles of fundamental human rights enshrined in international and regional human rights instruments. Taking into consideration the particular situation of Nigeria, the chapter recommends short and long-term measures that the Nigerian government should adopt with a view to ensuring securing the rights of homosexuals in the country. These include relaxing some of the stringent measures and provisions of the Same-Sex Act and ultimately working towards decriminalization in the future.

The focus of Chapter 10 by Kutlwano Pearl Magashula is on the rights of transgender people in Botswana. The chapter explores the implication of the *Gender marker* case on the lives of transgender persons in Botswana. It argues for more inclusive approaches to legal gender recognition in order to build a pluralistic society that safeguards the rights of all its members. It calls for a reflection on the array of human experience and influence, as well as compliance with international human rights standards in relation to legal gender recognition. The chapter concludes by proposing alternative approaches to legal gender recognition informed by learnings from progressive national laws and advancements in comparative jurisprudence. It considers the implication and benefits of less restrictive approaches to legal gender recognition and registration and how they could be applied in Botswana.

Chapter 11 by Berry D. Nibogora discusses the challenges with the promotion and protection of the rights of sexual minorities under the African human rights system. In particular, the chapter examines Resolution 275 adopted by the African Commission on Human and Peoples' Rights. It discusses the provision of international regional human rights instruments in relation to sexual minorities and human rights abuses they encounter. The chapter traces the various activities and strategies that culminated in the adoption of the very progressive Resolution 275. It then examines the content of the resolution and makes recommendations to African governments towards its implementation.

7.3 Part III – Mechanisms for realizing SRHR

The focus of Chapter 12 by Tambudzai Gonese-Manjonjo and Ebenezer Durojaye is on the relevance of litigation to advance SRHR in the region. The chapter draws on the experiences of the Southern African Litigation Centre, an organization that focuses on strategic litigation as a tool for realizing the SRHR of individuals in southern African countries. It then discusses some of the challenges, gains and opportunities of strategic litigation in ensuring accountability and redressing violations experienced by vulnerable and marginalized groups within the region. Using three cases as examples, the chapter discusses how engaging with the courts at the national level can elicit positive results in society as regards the realization of SRHR. The chapter concludes by admitting that despite the positive impact of strategic litigation, there are some challenges that need to be taken into consideration before deciding to embark on strategic litigation.

In Chapter 13, Shatikha S. Chivusia examines the role of national human rights institutions (NHRIs) in advancing SRHR at the national level. Using the Kenyan National Human Rights Institution as a case study, the chapter discusses the findings of the Kenya National Commission on Human Rights (KNCHR) from its Public Inquiry into Violations of Sexual and Reproductive Health Rights in Kenya that was conducted in 2012 and from its work around the 2017 election period with regard to sexual and gender-based violence (SGBV) cases. The chapter concludes by making concrete recommendations on how the Kenyan NHRI can play a more proactive role in realizing the SRHR of women and girls in the country.

Chapter 14 by Ayalew Getachew Assefa examines the role of the Expert Committee on the Rights of the Child in Africa in realizing the SRHR of children and adolescents in the region. The chapter highlights international and regional norms in relation to the SRHR of adolescents and considers the relevant principles on children's rights on this issue. It further considers the mandate of the Expert Committee and how this could help in advancing the SRHR of children and adolescents in the region. The chapter discusses the various mechanisms of the Expert Committee, including the state report system, communication system and the investigation system. It further examines the strengths and weaknesses of these mechanisms and concludes by

recommending how they can be more effective in advancing the SRHR of children and adolescents in the region.

Notes

1 WHO et al *Trends in maternal mortality 1990–2015* (2018).
2 As above.
3 See International Conference on Population and Development (ICPD) in Cairo, Egypt, on 5–13 September 1994 para 7.6 of The Programme of Action.
4 WHO *Expert meeting on sexual and reproductive health and rights* (2002).
5 See World Health Organization et al *Trends in maternal mortality: 2000 to 2017: Estimates* (2019).
6 As above.
7 As above. See also, O Afulukwe-Eruchalu & E Durojaye 'Developing norms and standards on maternal mortality in Africa: Lessons from UN human rights bodies' (2017) 1 *African Human Rights Yearbook* 82–106; R Cook et al *Reproductive health and human rights: Integrating medicines, ethics and Law* (2003) 161.
8 UNIADS *Global AIDS update 2018* (2019).
9 As above.
10 As above.
11 As above.
12 See World Health Organization (WHO) *Ensuring human rights in the provision of contraceptive information and services: Guidance and recommendation* (2014) 4.
13 World Bank Report *Fertility rate total (births per woman) sub-Saharan Africa* (2018) available at https://data.worldbank.org/indicator/SP.DYN.TFRT.IN (accessed 18 November 2020).
14 See E Durojaye 'Access to contraception for adolescents in Africa: A human rights challenge' (2011) 44(1) *Comparative and International Law Journal of Southern Africa* 1–29.
15 See for instance, African Union document on Campaign to end child marriage in Africa: A call to action available at https://au.int/en/sa/cecm (accessed 10 March 2021).
16 See for instance, the 14 February 2017 Amendment to the Malawian Constitution, which removes the contradiction regarding marriageable age. Prior to the Amendment, the Marriage, Divorce and Family Relation Act of 2015 prohibited marriage of a girl under 18, however, the Constitution has provided that with parental consent, a girl under 18 could get married. See also the Women's Act of 2010.
17 See UNICEF *Child Marriage* (April 2020) available at https://data.unicef.org/topic/child-protection/child-marriage (accessed 23 June 2020).
18 See S Nabaneh & A Muula 'Female genital mutilation/cutting: A complex legal and ethical landscape' (2019) 145(2) *International Journal of Gynecology & Obstetrics* 253–257; see also E Durojaye & PM Sonne 'A holistic approach to addressing female genital cutting (FGC) in Africa: The relevance of the Protocol to the African Charter on the Rights of Women' (2011) *Akungba Law Review* 240–259.
19 United Nations Children's Fund *Female genital mutilation/cutting: A global concern* (2016).
20 See International Lesbian, Gay, Bisexual, Trans & Intersex Association et al *State sponsored homophobia 2017: A world survey of sexual orientation laws: Criminalisation, protection and recognition* (2017) 81; see also Report by AMSHeR & Coalition of African Lesbians *Violence based on perceived or real sexual orientation and gender identity* (2013) 11.
21 See for instance, PM Eba 'HIV-specific legislation in sub-Saharan Africa: A comprehensive human rights analysis' (2015) 15 *African Human Rights Law Journal* 224–262.
22 AMSHER & Coalition of African Lesbians (n. 20) 18.
23 See African Commission on Human and Peoples' Rights *Resolution on protection against violence and other human rights violations against persons on the basis of their real or imputed*

sexual orientation or gender identity available at http://www.achpr.org/sessions/55th/resolutions/275.

24 See General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant) (2000) § 2, 8; UN Committee on Economic, Social and Cultural Rights 'General Comment No. 22, Right to Sexual and Reproductive Health' (2016) UN Doc. E/C.12/GC/22.
25 Genreral Comment 14 para 12.
26 See CEDAW Committee, General Recommendation No. 24: Article 12 of the Convention (women and health). See also UN Committee on the Elimination of Discrimination against Women 'Statement of the on Sexual and Reproductive Health and Rights: Beyond 2014 ICPD Review' (2014) UN Doc. CEDAW/C/2014/I/CRP.
27 CEDAW Committee General Recommendation No. 35 on gender-based violence against women, updating General Recommendation No. 19 adopted 14 July 2017.
28 See for instance, General Comments 3, 4, 14 and 15 of the Committee on CRC.
29 See for instance, General Comments 4 of the Committee on CRC on Adolescents and Health.
30 United Nations General Assembly the Sustainable Developments Goals (SDGs).
31 As above.
32 On 6 November 2012, the African Commission adopted the first ever General Comment 1 on Article 14(1) (d) and (e) of the Protocol to the African Charter on Human and Peoples' Rights on the rights of women in Africa available at http://www.achpr.org/instruments/general-comments-rights-women/ (accessed 14 February 2020).
33 General Comment 1 para 20.
34 General Comment No 2 on Art 14.1 (a), (b), (c) and (f) of the Protocol to the African Charter on the Rights of Women available at http://www.achpr.org/files/instruments/general-comments-rights-women/achpr_instr_general_comment2_rights_of_women_in_africa_eng.pdf.
35 General Comment 1 para 16.
36 General Comment 2 para 29.
37 General Comment 2 para 37–40.
38 African Commission on Human and Peoples' Rights *Resolution on protection against violence and other human rights violations against persons on the basis of their real or imputed sexual orientation or gender identity* available at http://www.achpr.org/sessions/55th/resolutions/275.
39 See para 1.
40 International Lesbian, Gay, Bisexual, Trans & Intersex Association et al (n. 20); see also AMSHER Report (n. 20) 20.
41 Joint general comment of the African Commission on Human and Peoples' Rights (ACHPR) and the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) on ending child marriage adopted by the African Commission on Human and Peoples' Rights (ACHPR) and the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) 2017.
42 Joint General Comment on Child Marriage para 12.
43 Joint General Comment on Child Marriage paras 30–37.
44 As above.
45 *The Guidelines to Combat Sexual Violence and Its Consequences in Africa* was adopted during the 60th Ordinary Session of the African Commission on Human and Peoples' Rights held from 8 to 22 May 2017 in Niamey, Niger.
46 As above.
47 The revised Maputo Plan of Action on SRHR was adopted by African Minsters of Health during the … to replace the 2007–2015 Plan on Action.
48 As above.
49 As above.

50 See *Millicent Awuor Omuya alias Maimuna Awuor & Another v. The Attorney General & 4 Others* (2015), Petition No. 562 of 2012 Kenya, High Court, Constitutional and Human Rights Division.
51 See *Teddy Bear Clinic for Abused Children and Another v. Minister of Justice and Constitutional Development and Another* CCT 12/13, [2013] ZACC 35.
52 Southern Africa Litigation Center 'News Release: Malawi High Court says mandatory HIV testing violates Constitutional Rights' available at https://www.southernafricalitigationcentre.org/2015/05/20/news-release-malawi-high-court-declares-mandatory-hiv-testing-unconstitutional/ (accessed 26 June 2020).
53 See for instance, *Mudzuru & Another v. Ministry of Justice, Legal & Parliamentary Affairs (N.O.) & Others* Const. Application No. 79/14 [2015] ZWCC 12.
54 `C Ngwena & E Durojaye (eds) *Strengthening sexual and reproductive health as human rights in Africa* (2014).
55 S Nawanse & A Jjuuko (eds) *Protecting human rights of sexual minorities in Africa* (2017).
56 See for instance, A Glasier et al 'Sexual and reproductive health: A matter of life and death' (2006) 368 *Lancet* 1595–607.
57 See General Comment 22 of the Committee on ESCR 2016.

2 Abortion and 'conscientious objection' in South Africa

The need for regulation

Satang Nabaneh

1 Introduction

South Africa's Choice on Termination of Pregnancy (CTOP) Act is a groundbreaking law for women's sexual and reproductive health and rights in South Africa and serves as a benchmark for law reform globally.[1] The Act was part of a package of rights extrapolated from South Africa's 1996 Constitution that recognizes the right to bodily and psychological integrity including the right to make decisions concerning reproduction and the right to health care, including reproductive health. The Act was partly a result of feminist political action,[2] and a response to prevent the death of South African women through backstreet terminations.[3] The Act is a complete departure from the 1975 Sterilization Act, which had stringent grounds for permitting abortion that were compounded by cumbersome administrative procedures.[4]

The Act provides for abortion on demand up to 12 weeks of pregnancy. Between 13 to 20 weeks, women[5] can obtain abortion on the following grounds: physical or mental health, foetal anomaly, if the pregnancy is a result of rape or incest and on grounds of socio-economic circumstances. After 20 weeks of gestation, a woman can only terminate her pregnancy if determined by a medical practitioner that it poses a serious danger to the woman's health or life, or if the foetus will 'suffer from a severe physical or mental abnormality'.

The CTOP Act recognizes that in the first trimester, in addition to doctors, midwives who have undergone prescribed training could perform an abortion. With a view to enhancing accessibility to abortion services, an amendment to the CTOP Act in 2008 included the training of registered nurses to conduct the procedure during the first trimester. Broadening the role of healthcare workers including nurses to deliver services is viewed as a significant way for the realization of access to termination of pregnancy care.[6]

Despite the very liberal nature of the law, the Act does not directly address conscientious objection.[7] Conscientious objection has been defined as 'the refusal to participate in an activity that an individual considers incompatible with his/her religious, moral, philosophical, or ethical beliefs'. The hope was that the omission of a conscience clause in the Act would circumvent controversy and legal challenges.[8] Instead, it has the effect of serving as a major barrier to the implementation of the law in practice.[9]

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Given the unregulated practice of conscientious objection in South Africa, there is no clear answer as to what extent the CTOP Act allows healthcare providers to conscientiously object to performing abortions. This chapter investigates the lack of regulation regarding the scope of conscientious objection to abortion in South Africa. The chapter aims to clarify the essential conditions needed to ensure that women who seek access to abortion services are treated with respect for their reproductive autonomy and human dignity.

The chapter proceeds in four parts. Part I briefly considers the conceptualization of conscientious objection. Part II of the chapter maps both the international and national framework on conscientious objection. Part III examines the impact of the conscientious objection on the rights of women. Part IV illustrates the ethical and legal challenges. The chapter concludes by reflecting on how the right to freedom of conscience should be balanced with women's right to legal abortion services and care.

2 Conceptualizing conscientious objection

The concept of conscientious objection has been historically associated with the right to refuse to take part in the military or in a war due to religious or moral reasons.[10] This has been co-opted in the healthcare arena. Recent developments have shown that freedom of conscience continues to be accepted as a limitation to reproductive healthcare, including women's right to termination of pregnancy.[11] The Global Doctors for Choice in their White Paper examining the prevalence and impact of conscientious objection, conclusively demonstrate an increase in the practice of healthcare providers' refusal to provide abortion services.[12] Health care providers continue to invoke 'conscientious objection' to deny services including emergency contraception and other forms of contraception, sterilization and infertility treatment.[13] As this chapter focuses on abortion care, conscience claims are mainly made on refusal to provide abortion care.

Conscientious objection is a complex issue of competing rights: women's rights to safe, legal abortion and the healthcare providers' claimed right to refuse.[14] As abortion remains a contentious moral issue, women's legal right to access health services is sometimes in opposition to the provider's right to refuse duty of care. In justifying the right to conscientious objection, John Rawls, for instance, sees the practice of conscientious objection as an exception to the *prima facie* duty to obey the law based on one's personal conscience.[15] Within the context of health care, Bernard Dickens has argued that the right to conscientious objection precedes the legalization of abortion.[16]

Various scholars have discussed freedom of conscience in health care following Mark Wicclair's comprehensive analysis of the three emerging approaches: conscience absolutism, the incompatibility thesis and compromise.[17] On the one hand, according to absolutism or the maximum accommodation paradigm, a provider's conscientious conviction is privileged over that of the patients, in which there is no obligation to disclose or refer.[18] The argument in favour of conscientious objection is that it violates healthcare providers' right to freedom

of conscience. On the other hand, the incompatibility thesis means disallowing the exercise of conscientious objection as it is contrary to professional obligations.[19] Thus, healthcare providers should not have a right to refuse.[20]

In critically analysing the two aforementioned extreme positions, Wicclair argues for the compromise or balance approach, which involves a reasonable accommodation provided by the employer, but which also entails provider duties including referral.[21] This, however, remains a lofty goal that is difficult to achieve in practice. It has also been illustrated that although it is possible to allow conscientious objection to abortion and still ensure women's access to services, in most cases, it does not sufficiently protect women's reproductive right.[22] Wendy Chavkin et al have also noted that the balancing act between the competing rights becomes very difficult when there is a thin line between conscience based on religion and political position.[23] The emergence of two main defences: that the exercise of conscientious objection should be allowed and that recommendations on how refusal can be managed to prevent the harms that it can create are premised on a call for respect of the moral integrity of healthcare providers.[24]

Laura Harris et al., note that conscientious objection is 'the only way to refuse to provide abortions that are permitted by law'.[25] Those who are against the idea of conscientious objection have argued that unlike in the military, conscientious objection does not have a place in reproductive healthcare.[26] Joyce Arthur and Christian Fiala label conscientious objection as a 'dishonourable disobedience'[27] to laws and ethical code and call for its ban due to its violation of patients' rights.[28] Another argument against conscientious objection is that the right to refuse jeopardizes women's health and human rights, as it unfairly privileges a doctor's conscience over that of their patients.[29] Conscientious objection, they contend, weakens the full realization of reproductive rights and women's equality.[30]

Against this background, the recognition of the right to freedom of religion, conscience and thought, and state's obligation to respect that right, is well established. This chapter works on the premise that there is a right to conscientious objection. However, this is not an absolute right as it should not unduly disadvantage or deny women access to health services which they have a legal right to receive. Ultimately, there should be an explicit law that regulates conscientious objection and limits healthcare provider's personal right of conscience. Freedom of conscience is recognized as a fundamental right at the international, regional and domestic levels.

3 International and regional human rights standards

Historically, objections based on the freedom of thought, conscience and religion have been invoked in relation to compulsory military service. The recognition of freedom of conscience is a component in a democratic and pluralist society. This right is guaranteed in international, regional and national

human rights instruments and guarantees a right to conscience. South Africa, as a member of both the United Nations (UN) and the African Union (AU), has signed and ratified these core international human rights treaties.

This section examines international and regional frameworks on the right to freedom of conscience. The purpose of this analysis is to show the standards that South Africa has agreed to abide by under international and regional human rights instruments.

3.1 United Nations level

Freedom of conscience is guaranteed in international human rights instruments. Article 18 of the Universal Declaration of Human Rights (UDHR) states 'Everyone has the right to freedom of thought, conscience and religion: this right include freedom to… manifest his religion or belief in teaching, practice, worship and observance'. This article is replicated in Article 18(1) of the International Covenant on Civil and Political Rights (ICCPR). The Human Rights Committee in General Comment 22 on Article 18 notes that while the right to conscientious objection is not explicitly stated in the Covenant, it believes that such a right could be read into Article 18. However, the recognition of the right to conscientious objection by the Committee was within the context of individual claims on the right to refuse to perform military service. Article 18(3) of ICCPR further goes on to place limitation on the manifestation of one's religion or belief as this may affect other people, as well as the state. Thus, the right to conscientious objection is not absolute. International and regional human rights treaty bodies have found that the freedom to manifest one's religion or belief can be subjected to restrictions.[31]

UN Human rights treaty monitoring bodies have also called on states to ensure that the exercise of conscientious objection does not hinder the access to reproductive health services. The Committee on the Elimination of all Forms of Discrimination against Women (CEDAW Committee) responsible for compliance of the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) issued General Recommendation No. 24 on Article 12 on Women and Health noting that refusal to provide certain reproductive health care for women is discriminatory. Additionally, it obligates states to take steps to guarantee access to services when providers are permitted to refuse to provide such services.

In General Comment No 36 on the right to life, the Human Rights Committee notes that state parties have a duty to ensure that women and girls are able to effectively access safe and legal abortion by removing barriers that are a result of the exercise of conscientious objection by healthcare professionals.

The UN Committee on Economic, Social and Cultural Rights (Committee on ESCR), which monitors the implementation of the International Covenant

on Economic, Social and Cultural Rights (CESCR) issued General Comment No. 22 on the Right to Sexual and Reproductive Health, which noted that the obligation to protect the right to health includes state obligations to take measures to prevent private actors from imposing barriers to services including conscience claims to refuse to provide abortion.

The treaty monitoring bodies have likewise raised the issue of conscientious objection in their concluding observations on state party reports. Within the South African context, the Committee on ESCR, in its concluding observation on South Africa's initial report in November 2018, recommended that health professionals 'who invoke conscientious objection provide referrals within their own facility or to a nearby facility so that their objection does not impede women's access to abortion services'.

3.2 African regional level

At the regional level, the African Charter on Human and Peoples' Rights (African Charter) provides for freedom of conscience under Article 8. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) is unique as it expressly recognizes abortion as a right. Article 14 of the Protocol obligates states to permit abortion where pregnancy poses a risk to the life or health of the woman or to the life of the foetus, or where pregnancy is a result of sexual assault, rape or incest. As of January 2019, more than 75 per cent of African states have ratified the Maputo Protocol.[32] This is an indication of the favourable reception that the Protocol enjoys in the continent as the foremost legal instrument on women's rights.[33] However, it is important to note that some African countries have entered reservation to the provision on abortion upon ratification including Cameroon, Kenya, Uganda and Rwanda.[34] However, it is argued that reservations cannot be construed as serving to restrict international and regional human rights obligations.

Article 26 of the Protocol enjoins state parties to adopt budgetary measures, to fulfil the rights guaranteed in the Protocol. While ratification is desirable, implementation of the Maputo Protocol is absolutely imperative in order to impact the lives of women. Implementation has been admittedly slow as women continue to face barriers to access abortion services even in countries where abortion has been liberalized. An estimated 6.2 million women have unsafe abortion in the African region.[35] Women from sub-Saharan African constitute the highest incidence of deaths at 62 per cent (29,000) from unsafe abortion.[36]

The African Commission on Human and Peoples' Rights (African Commission) has also taken steps to provide interpretive guidance to women in Africa by elaborating on specific rights while assisting states to fulfil their obligations under the Maputo Protocol. Towards this end, the African Commission adopted General Comment No 2 in 2014 on Article 14(1) (a), (b), (c) and (f) and Article 14(2) (a) and(c) of the Protocol on reproductive health rights on

28 November 2014. The General Comment focuses on measures to promote and protect sexual and reproductive rights of women and girls including access to safe abortion.[37] Article 14 (2) obligates state parties to take all appropriate measures to ensure medical abortion.

Unprecedentedly, the Commission addressed states' duty to adequately regulate the practice of conscientious objection in the reproductive health sphere. As the General Comment notes, healthcare providers directly involved in providing abortions services may invoke conscientious objection but not in emergency situations. Premised on their obligations under the Maputo Protocol, states are obliged to:

> ensure that health services and healthcare providers do not deny women access to contraception/family planning and safe abortion information and services because of, for example, requirements of third persons or reasons of conscientious objection.[38]

In addition, the General Comment further notes that state obligations relating to enabling and political framework also entail ensuring healthcare providers do not deny women access to safe abortion information and services.[39] General Comment No 2 is a critical resource for ensuring access to safe and timely legal abortion. In particular, the African Commission sends a clear message to African states that permit conscientious objection, that they must establish and implement effective regulatory framework so as to guarantee that such refusals do not undermine women's access to legal abortion services.

The African Commission, which can receive communications alleging violations on the African Charter and its subsequent protocols, and the African Court on Human and Peoples' Rights (African Court) have not yet had the opportunity to develop their jurisprudence on the scope of the right of conscientious objection within the sexual and reproductive health services sphere.

The other regional human rights systems also recognize an individual's right to freedom of religion, conscience and thought. At the European level, the right to freedom of thought, conscience and religion is provided in Article 9 of the European Convention for the Protection of Human Rights and Fundamental Freedoms. It further requires the exercise of the right to be 'subject to such limitations as are prescribed by law and as are necessary in a democratic society in the interests of public safety, for the protection of public […] health, or the protection of the rights and freedoms of others'.[40] Limitation on the exercise of conscientious objection has been reaffirmed by the European Court of Human Rights in several cases in the context of reproductive healthcare. In the inter-American human rights system, the American Convention on Human Rights also guarantees freedom of thought, conscience and religion with limitations (Article 12). Both the International American Commission on Human Rights (IACHR) and the Inter-American Court have not explicitly addressed the subject of conscientious objection in the context of reproductive healthcare.

4 The legal scope of conscientious objection in South Africa

According to the World Health Organization (WHO)'s Global Abortion Policies Database, more than 70 countries allow health care providers to refuse to provide abortion care, invoking conscientious objection.[41] Conscientious objection is widely practised around the world and has been enshrined in law in countries such as the United Kingdom, Australia, France and the United States.[42]

4.1 The Constitution of South Africa

The South African Constitution recognizes reproductive autonomy. Section 12(2) of the Constitution guarantees a 'right to make decisions concerning reproduction'. Section 27(1) of the Constitution also provides for the right of access to healthcare services including reproductive healthcare. Section 27 further implies that the state is not only obligated to refrain from unfairly interfering with the individual's right to pursue reproductive healthcare services, but also to provide care where the individual is incapable of paying. The obligation arising from this section would imply that the state and or other entities or individuals should refrain from obstructing access to healthcare services including abortion without justifications.[43] A refusal of care would be deemed to be unjustifiable and thus constitute an infringement of section 27(1)(a) of the Constitution.

Given that the South African Constitution is value-based, the right to reproductive autonomy and access to reproductive healthcare are intimately linked to the rule of law and to the enjoyment of other rights including equality and respect for human dignity. Respect for human dignity is a foundational value that is crucial for addressing conflicting interests.[44] The UN Working Group on the Issue of Discrimination against Women in Law and in Practice shares this same reasoning when it stated:

> The right of a woman or girl to make autonomous decisions about her own body and reproductive functions is at the very core of her fundamental right to equality and privacy, involving intimidate matters of physical and psychological integrity, and is a precondition for the enjoyment of other rights.[45]

The Constitution recognizes the implied right to conscientious objection. According to section 15 (1) of the Constitution, 'everyone has the right to freedom of conscience, religion, thought, belief and opinion'. The Constitutional Court on respecting diversity has acknowledged that 'the essence of equality lies not in treating everyone in the same way, but in treating everyone with equal concern and respect'. Like other constitutional rights, this right is not absolute.

4.1.1 Limitation clause

It is important to note that fundamental rights under the Constitution are not absolute and are subject to the limitation clause under section 36(1). The

limitation clause takes as its premise, that fundamental rights cannot be enjoyed in such a way that does not pay attention to the rights of others or the wider societal interests. Thus, conscientious objection cannot be exercised in such a way that permits healthcare works to impose their anti-abortion views on women seeking abortion. While healthcare providers have a freedom to choose to refuse to participate in an abortion procedure, the rights of the pregnant woman and the interests of the society must be taken into account.[46]

Section 36 limits the right to conscientious objection and imposes a duty to a minimum, to provide the pregnant client with information about where she can obtain an abortion. Section 36 of the Constitution supports the limitation of the right to conscientious objection where maternal life or health is in serious danger or there is a medical emergency. A health care worker can therefore not legally or ethically object to the rendering of care in cases of life- or health-endangering emergencies associated with abortion procedures.

4.2 Choice on termination of Pregnancy Act

The Act, which took effect in 1997 'promotes reproductive rights and extends freedom of choice by affording every woman the right to choose whether to have an early, safe and legal termination of pregnancy according to her individual beliefs'.

As alluded to earlier, there is no express provision regulating conscientious objection in the CTOP Act. However, Ngwena noted that an earlier draft of the Bill contained a conscience clause that provided as follows:[47]

(1) Subject to subsection (2), no person shall be under a legal duty, whether by contract or any statutory or any other legal requirement, to participate in the termination of pregnancy if he or she has a conscientious objection to termination of pregnancy.
(2) The provisions of subsection (1) shall not affect any duty to participate in treatment which is necessary to save the life or to prevent serious injury to the health of the woman, or to alleviate pain.
(3) Any person having an objection referred to in subsection (1) shall be obliged to refer a woman who wants her pregnancy to be terminated to a medical practitioner or a registered midwife, as the case may be, who shall terminate the pregnancy.

The Act does not explicitly mention a right to 'conscientious objection' for health care providers, but it is clear on the professional obligations of providers. Refusal to provide abortion only applies to the actual procedure, this means that those that are directly not involved do not have the right to refuse. A similar approach was adopted in the decision of the UK Supreme Court in the *Greater Glasgow Health Board v Doogan*. The Court held that:[48]

> It is unlikely that, in enacting the conscience clause, Parliament had in mind the host of ancillary, administrative and managerial tasks that might

> be associated with those acts. Parliament will not have had in mind the hospital managers who decide to offer an abortion service, the administrators who decide how best that service can be organised within the hospital, the caterers who provide the patients with food and cleaners…

Accordingly, healthcare providers are under a legal and ethical obligation to provide care to patients suffering from complications of abortion. However, these regulations in the CTOP Act are not fully adhered to or implemented.

However, the South African case of not having a conscientious objection clause is not unique, as in most African countries and elsewhere it is not addressed and hence, remains largely unregulated.[49] In the African context, one of the exceptions to the rule is the Zambian Termination of Pregnancy Act of 1972 which allows for a limited scope of the exercise of conscientious objection. This has been supplemented by guidelines.[50] A sharp contrast to this is the Zimbabwean Termination of Pregnancy Act of 1972 that is not limited in scope and does not adhere to international and regional human rights standards.[51]

The CTOP Act makes it an offence if any person 'prevents the lawful termination of a pregnancy or obstructs access to facility for the termination of pregnancy'. The penalty is a fine or imprisonment for up to ten years. It could be argued that healthcare providers, including nurses and midwives, who refuse or omit to refer a patient to another doctor who is prepared to terminate pregnancies lawfully or a facility where abortion may be done, are preventing lawful termination of pregnancy or obstructing access to a facility for the termination of pregnancy. This section is rationally connected to the following: (i) the right to freedom of conscience is not absolute especially in relation to the medical profession; (ii) the constitutional and legal rights of women are protected as they are not obstructed from exercising such right; and (iii) it is reasonable, as it can be interpreted to mean that it does not compel health care providers in non-emergency cases to participate actively in abortion procedures.

The Act further provides that a woman who requests an abortion from a medical practitioner or registered midwife 'shall be informed of her rights under [the] Act by the person concerned'. The provision creates a duty on healthcare providers which is a reasonable and justifiable limitation on their right to freedom of conscience. Despite a healthcare provider's opposition to abortion on grounds of conscience, he or she is obliged to give a woman information about the law that enables her to exercise her constitutional and legal rights. Effective information when abortion is legal is 'directly relevant for the exercise of personal autonomy.'

Despite the lack of defined scope of obligations incurred by healthcare providers as a result of the absence of an expressed conscientious clause in the Act, this does not mean the complete absence of regulatory laws. Since the Constitution is the supreme law, it follows that section 15 on freedom of conscience and section 36 on general limitation of rights apply to this Act. In South Africa, as opposed to other jurisdictions such as in some Scandinavian

and Eastern European countries, health care providers have a constitutional right to conscientious objection.[52]

It is noteworthy that courts in South Africa have not yet clarified the issue of conscientious objection. The case of *Charles and Others v Gauteng Department of Health* (Kopanong Hospital) was about a nurse's refusal to prepare patients for follow-up treatment following a termination due to her religious beliefs at the Kopanong Hospital in Vereeniging which led to her reassignment by the director to another department. She eventually quit in May 2004.[53] On the basis of the Promotion of Equality and Prevention of Unfair Discrimination Act, she sued the then Minister of Health and the hospital for unfair discrimination on the grounds of religion and conscience. In 2007, the Labour Appeal Court of South Africa in Braamfontein transferred her case of a healthcare professional's refusal to provide care to the Commission for Conciliation, Mediation and Arbitration (CCMA).

The other known case was in 2010 when through an arbitration, a physician who was dismissed for protesting against termination of pregnancies was reinstated by the Free State Health Department on the basis that the dismissal was unfair.[54] The anti-abortion discourses materializing in these two cases show a subtler means of deploying power. For instance, the pro-life movement utilizes labour laws grounded on non-discrimination and the exercise of the constitutional right to freedom of conscience, religion, thought, belief and opinion to slowly chip away at abortion access across the country. Opening the issue as one of a worker's right to non-discrimination and utilizing labour laws would mean setting legal precedent that would claw back on a liberal abortion law.

As the debate between women's rights to safe and legal abortion versus the protection of healthcare provider's moral integrity rages on, this line of strategy provides a discursive opportunity that facilitates the use of 'freedom of conscience' and 'non-discrimination' as legitimate ideation to push the pro-life movement agenda forward. This is akin to Marc Steinberg's assessment of how actors will look for 'gaps, contradictions and silences' in order to 'depict shared understanding of injustice, identity, righteousness for action, and a vision of the preferred future'.[55]

4.3 National guidelines

4.3.1 Draft national guidelines for implementation of termination of pregnancy services in South Africa

Currently, South Africa does not have a formal system for conscientious objection declaration and practice. Recognizing such a gap, the National Department of Health developed draft guidelines for the provision of abortion in 2018.[56] In these guidelines, the term 'conscientious objection' is being regulated as what it actually is: an obstruction to access or an obstruction to care as noted in the Act. This is because the guidelines are not based on the freedom of conscience provision in the Constitution, but rather, on the provisions of the Act which

does not stipulate conscientious objection. Section 10 of the Act notes that it is a crime for anyone to prevent a legal abortion or obstruct access to an abortion facility. The penalty is a fine or imprisonment for up to ten years.

The guidelines obligate a practitioner who refuses to provide abortion services based on personal beliefs to refer the client to a colleague or facility that is able to offer such services. The client's right to information and access to health care services, including abortion, should always be provided for. The guidelines affirm that such refusal should not be to the detriment of the client seeking an abortion.[57]

The guidelines also address the issue of conscientious commitment, that is, a health care provider adhering to their primary health professional ethics: duties to treat and care for patients.[58] The individual conscientious objection of a health care worker cannot violate the rights of the other healthcare workers who are willing to provide abortion services.[59]

4.3.2 Professional ethical guidelines

The right to conscientious objection has been recognized in professional codes of conducts from varied sectors.[60] At the national level, professional ethical guidelines of South Africa's medical, nursing and midwifery societies support and protect their members' exercise of conscience while emphasizing providers' duty to prevent their beliefs from serving as a barrier to their patients access to services and information. The 2013 South Africa Nursing Council's Code of Ethics listed termination of pregnancy and conscientious objection as ethical dilemmas that nurses face but was silent on how they should be addressed. Subsequent revisions provide that a nurse is required to tender in writing their refusal to their employer.[61] The Health Professions Council of South Africa recommends a similar approach in allowing healthcare providers to object to providing termination of pregnancy services on the basis of their religious and cultural beliefs.[62]

Despite these professional ethical guidelines, conscientious objection relating to abortion has not been enshrined into law. The consequences of such a gap serves as an obstacle to the efficacy of a liberal abortion law in practice.[63] As there are no clear laws or guidelines, the environment is conducive to health care providers acting within their 'own' interpretation of the law. Thus, this can lead to the systemic abuse and misinterpretation of what the right entails.[64] It also results to inadequate personnel to perform abortion procedures.[65]

5 Ethical and legal challenges: the need to regulate

Health providers who are unable to exercise their duty of care due to personal conscience still have ethical responsibilities to their patients.[66] Due to the unregulated nature of conscientious objection in South Africa, it makes it difficult to translate the legal right to abortion into effective access to services. In order to regulate conscientious objection to abortion, there are certain conditions that need to be addressed.

(a) *Duty to refer*

The International Federation of Obstetricians and Gynecologists' (FIGO) criteria for conscientious objection includes: giving notice of one's objection based on conscience grounds, referring patients to colleagues and providing emergency care when needed.[67] The *Technical Guidelines of the WHO on Safe Abortion* also state that in order to ensure that the practice of conscientious objection does not delay care within the context of lawful abortion services, healthcare providers must refer women, or where referral is not possible, must provide safe abortion services to which women are legally entitled to.[68]

Indeed, as the United Kingdom's Supreme Court noted in the Doogan case:

> it is a feature of conscience clauses generally within the health care profession that the conscientious objector be under an obligation to refer the case to a professional who does not share that objection. This is a necessary corollary of the professional's duty of care towards the patient.

Furthermore, it can be argued that a healthcare provider who refuses to terminate a pregnancy lawfully and omits to refer a patient to another provider is preventing the lawful termination or obstructing access to a facility for the termination of pregnancy under the CTOP Act. This should not be construed as an infringement of the freedom of conscience provision in the Constitution.

However, given that this has not had the effect of preventing the exercise of conscientious objection to the detriment of women's rights to access legal abortion, laws, policies and codes of ethics must clearly provide that healthcare professionals must refer their patients to other appropriate providers for termination of pregnancy services that the practitioners cannot or will not deliver. Healthcare providers cannot just legally abandon their patients.

(b) *Who can object?*

There is need for clear guidance on who can exercise conscientious objection to abortion services. Dickens and Cook note that the right to conscientious objection protects the personal convictions of personnel who actually perform an abortion procedure rather than those assisting or facilitating the procedure.[69]

Given that the South African courts have not yet had an opportunity to deal with the right to conscientious objection within the context of abortion, it can borrow from the approach of courts from other jurisdictions. For example, the Colombian Court in the case of Case T-388/09 reiterated the principle that the right to conscientious objection can only be exercised by health care providers 'directly involved in performing a procedure necessary to terminate the pregnancy'.[70] In determining whether a judicial officer could invoke the right to conscientious objection to recluse himself from an application for injunction to compel a health facility to provide legal abortion under Colombian law, the Court declared that the right to conscientious objection is only applicable

to personnel directly involved in the procedure for termination of the pregnancy.[71] Thus, the right to conscientious objection is not applicable to a judicial officer hearing a case on abortion, as it undermines the very essence of the legal system of the state. While conceding that judicial officers can hold personal convictions, the Court notes that this does not mean the abdication of their primary duty to apply the Constitution.[72]

This approach was previously laid down in the T-209/08 case dealing with the right to conscientious objection by healthcare professionals. In this case, as a result of rape, a 13-year-old girl became pregnant. She was refused abortion by her healthcare company based on conscientious objection by its physicians. She was then referred to Erasmo Meoz de Cúcuta University Hospital which also invoked conscientious objection to the abortion procedure on behalf of its entire medical staff.

In delimiting the scope of the conscientious objection, the Court held following: 1) women's fundamental rights including timely access to abortion should be guaranteed and respected; 2) conscientious objection is not a right to which institutions or the State are entitled and that only natural persons can exercise that right; 3) the existence of a professional obligation on the part of the healthcare provider who refuses to perform abortion, to immediately refer to another health professional equipped to provide abortion services; and 4) the justification for invoking conscientious objection by a healthcare provider must be made in writing. The Court further held that the state is obligated to guarantee an adequate number of providers who are equipped to provide abortion services. The European Court of Human Rights echoes this in *R.R v Poland*, when it notes that:

> States are obliged to organise the health services system in such a way as to ensure that an effective exercise of freedom of conscience of health professionals in the professional context does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation.[73]

Thus, despite the possibility for individual healthcare providers to refuse to provide abortion services on the grounds of conscience, this does not absolve the state from its obligation to provide services (including information and materials resources) arising from the fulfilment of an abortion right.

The court decisions mentioned above are important juridical resources for interpretation for South Africa in ensuring the efficacy of the CTOP Act to ensure women's right to prompt and effective access to abortion. This also speaks to South Africa's constitutional goal of substantive equality that addresses inequalities in reproductive health.[74]

(c) *Register of conscientious objectors*

It is particularly crucial that a register of abortion services be kept in each facility noting the clinical details of the client, referral process and the name of

the personnel objecting. This will ensure that the state fulfils its obligation of ensuring that there are enough healthcare providers in hospitals and clinics to protect women's right to autonomy. The draft guidelines note that the following standards must be in place:

- Health professionals who are not willing to provide abortion services must inform their Facility Manager in writing when applying for a position in the facility.
- Facility Managers need to confirm whether a staff member is fit for purpose in terms of providing abortion services when appointing staff.
- Each objecting staff member must be dealt with individually. Abortion provision should never be dealt with in a group, or as a group action.
- Refusal only applies to trained health professionals and not to groups or an institution. Likewise, it does not apply to support personnel or complementary services.
- In non-emergency cases, professional health providers who believe that their religious or moral beliefs may affect the treatment or the advice that they provide may refuse to participate in an abortion, but must:
    1. Explain their refusal to the client in a manner that does not stigmatise or judge the client
    2. Explain to the client their right to request a safe abortion
    3. Make the necessary arrangements to enable the client to be seen by a provider who will conduct the abortion
    4. Update the facility register to note the refusal to treat.

Thus, it is critical that there are clear guidelines as to who can object, how they object and what they can object to.

6 Conclusion

In order to ensure women's right to exercise reproductive autonomy and access to timely legal abortion services in South Africa, domestic laws must effectively regulate and oversee the practices of healthcare professionals in relation to their implied right to conscientious objection. As noted above, numerous studies have shown that the failure to effectively regulate and monitor such refusals have served as a barrier to women's ability to obtain safe and legal abortion in South Africa. Such failure contravenes international human rights obligations of the South African government, which require that where states allow healthcare professionals to refuse to provide abortion care on grounds of conscience or religion, they must establish effective legal and oversight framework to ensure that such refusals do not hinder women's access to legal abortion in practice.

Thus, the South African state should design and implement a comprehensive and effective legal and policy framework, as well as oversight mechanisms

to govern the practice of conscientious objection by healthcare providers to ensure that they do not trample on women's access to safe, legal abortion.

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3 Addressing maternal mortality through decriminalizing abortion in Nigeria

Asking the 'woman question'

Ibrahim Obadina

1 Introduction

Nigeria's abortion laws make it one of the most restrictive countries regarding abortion.[1] The geometric rise in maternal mortality rate is because of the criminalization of abortion in Nigeria. This approach to abortion in Nigeria calls for immediate action in a variety of ways to ultimately put an end to this horrible and oppressive practice. Most jurisdictions have liberalized abortion laws and are further making reforms aimed at addressing the existing inadequacies in the laws, in manners that redress the oppression of women. The United States Supreme Court's approach and jurisprudence to the self-determination rights relating to abortion is notable. It has contributed a lot in asking the woman question, handing down cases such as *Roe v Wade*, *Doe v. Bolton*, *Gonzales v Carhart*. While acknowledging their contributions, they are not the focus of this paper. Despite advancements in abortion jurisprudence, statutes in Nigeria affecting abortion are yet to recognize a woman's right to decide whether to carry a pregnancy to term as a matter of her autonomy, equality, or self-determination. To achieve transformative change and to recognize women as autonomous rights-bearers and effectively tackle the menace of maternal mortality resulting from the restriction on abortion in Nigeria, law makers must confront the regulation and politics of abortion from a feminist perspective. This means reflecting the experiences of women and addressing the gendered implications of abortion restrictions or, simply put, to be effective in addressing the scourge of maternal mortality resulting from unsafe abortion, the statutes must reflect the realities of Nigerian women in their provisions and applications by 'asking the woman question', as this research will show.[2]

The restriction has had a negative impact on women in Nigeria and contributes to the alarming increase in the proportion of maternal death in the country due to unsafe abortion. Although there are various causative factors for maternal mortality in Nigeria, unsafe abortion constitutes the highest percentage of all the factors. This paper critically examines the legal framework for abortion in Nigeria, with a view to making suggestion for reforms to reduce the incidence of maternal mortality by suggesting the expansion of the grounds for abortion and decriminalization in line with international standards.

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The paper calls for a rethinking of the lifesaving requirement as the sole basis for abortion under the Criminal and Penal Codes operative in the country, by calling for an amendment of the provision or repeal to incorporate experiences and realities of women. It suggests a rights-based approach and the domestication of human rights instruments that Nigeria is signatory to, i.e. the Protocol to the African Charter on Human and Peoples' Rights and on the Rights of Women in Africa, which entered into force in 2005 (the 'Maputo Protocol'). It examines whether the provisions of the Maputo Protocol ask the woman question. It considers what lessons the African Commission, the monitoring body for the African Charter and its Protocols can learn from interpretations and jurisprudence of similar provisions on reproductive rights from other regional and international human rights bodies, such as CEDAW and the European Union on how to interpret provisions dealing with women's rights.

2 Abortion and maternal death in Nigeria

Any discussion of abortion in Nigeria logically begins with the conception of a person under Nigerian law. Section 307 of the Criminal Code provides that a child becomes a person capable of being killed when it has completely proceeded in a living state from the body of its mother, whether it has breathed or not, and whether it has an independent circulation or not, and whether the navel string is severed or not. Thus, any other termination of the life in a pregnancy short of this is an abortion. The only permissible ground for performing abortion is to save the life of the mother. Consequently, many women resort to unsafe abortion methods. This leads to abortion-related complications and increasing mortality rate in the country. Unsafe abortions remain a major reproductive health concern in Nigeria since most abortions are carried out illegally and are, as a result, performed by unskilled and semi-skilled physicians.[3]

Criminalizing abortion drives women from hospitals where they could get better medical attention, and make them resort to the use of quacks and crude means in a bid to terminate an unwanted pregnancy. Abortions are a major contributor to maternal mortality, accounting for as many as 30–40% of maternal deaths in Nigeria and one in eight maternal deaths in the West African sub-region.[4] The estimated abortion rate was 33 abortions per 1,000 women aged 15 to 49 in 2012.[5] Abortions account for up to 40% of maternal deaths in Nigeria, making it the second leading cause of maternal mortality in the country.[6]

According to a research, an estimated 456,000 unsafe abortions are done in Nigeria every year.[7] A similar study estimates the number of women who engage in unsafe abortions to be at about 20,000 each year.[8] Research has revealed that only 40% of abortions are performed by physicians in regular health facilities, while the remaining percentage are performed by non-physicians.[9] Unwanted pregnancy can and does occur among women from every social, demographic and economic background in Nigeria. Economic, sociocultural and religious factors continue the inequality and lack of respect for the

rights of women are also responsible for the high rate of abortions in Nigeria.[10] Thus, whether an abortion is carried out through qualified medical practitioners or quacks, has implications for the rate of abortions. In the face of high pregnancy rates due to lack of contraceptives, poverty, cultural reasons and family planning, the legal restrictions have no doubt failed to take into consideration the different situations of women.

One of most compelling arguments against restrictive abortion laws is that they are the reason why millions of women have recourse to unsafe abortion and as a consequence lose their lives. Hence, the link between unsafe abortion and restrictive laws is well established.[11] Indeed, it forms the main premise upon which international treaty bodies have recommended the liberalization and decriminalization of abortion laws to reflect the experiences of women. Abortion-related mortality and morbidity are highest in those countries where the law is most restrictive of abortion. It is against this backdrop, that the Maputo Protocol for example, envisages liberalization of restrictive abortion laws across the continent in a manner that guarantees the realization of substantive right to reproductive health of women in Africa. It provides governments with a human rights edifice for taking a lead in reforming laws that impede access to safe abortion.

3 What is the woman question?

Feminist researchers adopt different methods of analysis to address different legal questions to bring the values and experience of women to bare on social and legal problems.[12] Popular perspectives in this regard include rational empiricism, standpoint epistemology, postmodernism and positionality.[13] Bartlett's article titled 'Feminist Legal Methods',[14] discusses such topics as feminist practical reasoning, feminist consciousness raising and asking the woman question.[15] Hence, the approach of this research is to ask the woman question, and determine the implications of asking the question for the provision of abortion law in Nigeria.[16] Drawing on the provsions of the Maputo Protocol, on liberalization of abortion in Africa, this chapter discusses lessons that can be learned from the approach of the Protocol in advancement of the reproductive health and rights of women. .

The research draws experience from feminist as well as legal and judicial jurisprudence from other jurisdictions, where the woman question has been asked. This approach is designed to identify the gender implications of rules and practices which might otherwise appear to be neutral or objective.[17] The method is designed to expose how the substance of law may silently and without justification submerge the perspectives of women, and further entrench the patriarchal tradition.[18] Examining the extant codes through the lenses of the Protocol's interpretive guide and jurisprudence of the African Commission, will, it is argued, promote the legitimacy of liberalizing abortion laws and provide an impetus for the reform of Nigerian abortion law and practice with a focus on the need to advance women's health.

Asking the woman question means 'examining how the law fails to reflect the experiences and values that seem more typical of women than of men'.[19] It is on this sense that women in the regulation of society are discriminated against and oppressed and are disadvantaged and require bespoke approaches to issues concerning them. In cases like abortion, it presumes that the law on abortion has ignored and omitted to reflect the realities and experiences and values of women and has put on masculine lenses to look at issues affecting women[20] to redress existing inequality.[21]

4 Abortion rights and feminist standards

Unsafe abortion has been linked to criminalization of abortion in most countries in Africa, and remains a major public health and human rights challenge especially for women in the African region.[22] It has been argued that the reform of abortion laws in African can go a long way in transforming reproductive rights of women, and has the consequential positive effect of developing the jurisprudence around such rights within domestic legal regimes.[23]

Criminalizing abortion has a social impact which can be damaging to the health of women in the society, though this is contested.[24] It is a much-controversial area of study, especially as the state has power to determine what is criminal, impose different punishments; exceptions include the circumstances surrounding individual case.[25] Thus, it is highly affected by a number of factors such as political will, economic status, cultural factors and most importantly for this purpose, the plural nature of the legal system in the country.[26] Scholars have expressed the opinion that the nature of non-enforcement and implementation of international laws have a lot to contribute to the poor state of reproductive health of women.[27] Others have also expressed that beyond the existence of international human rights framework, there is also the inherent and internal limits that laws have to secure effective transformation of women's rights in such a multi-cultural, multi-ethnic and religious society.[28] While the criminalization of abortion is not an end in itself, it serves as a means to hold states accountable for the implementation of laws affecting women especially international and regional human rights provisions. This to scholars, will transform the abortion laws in these jurisdictions from a crime-punishment model to a reproductive health model.[29]

Four ethical principles have provided the foundation for reproductive and sexual rights for women: bodily integrity, personhood, equality and diversity. They form the basis of what provisions on abortion should reflect for it to reflect women's experiences. By incorporating these in the liberalization process, it will not only recognize the associated human rights in accordance with international human rights instruments, it would have the effect of incorporating the immediate experiences of women. For example, bodily integrity has been construed as an individual and a social right with the implication of entitlement to health, procreation and sexuality. As a ground for abortion, threat to the health of a pregnant woman can be particularly enabling when health is

understood in a holistic sense as envisaged by the WHO, permitting medical abortion when the pregnancy poses threat to *health* and *life of a mother.*

More so, treatment of women, as not merely objects and as a means of achieving social goals such as population control, must be assured through decision making autonomy.[30] The sexual autonomy of women and girls must be given adequate attention. The most prominent basis for the support and criticism of abortion rights is the need to guarantee and protect the right to life, which is the basis of the existence of rights.[31] Some arguments for permitting a right to abortion depend on denying rights to the foetus. Only persons have rights, and foetuses it is argued, are not yet persons.[32] Thomson argue that even if the foetus is a person with a right to life, there are limits to what the state can compel women who carry foetuses in their bodies to do.[33] To ask the woman question in this regard, one may argue that abortion provisions must recognize and give priority to the autonomy of a woman to determine whether she carries a pregnancy or not. This argument is even more compelling especially where the pregnancy poses a threat to her psychological and physical health, life, or because of illicit sexual acts not within her control such as assault or rape. Although some feminists endorse the right to abortion, the issue of abortion cannot easily be reduced to the interests of men versus women.[34] To some, the perspective of thinking of the foetus and the mother as distinct persons emphasizes their intertwined relationship and therefore unfounded.[35] The perspective of abortion as a right, having to do with ownership and control of one's body would open the floodgates for abortion on other seemingly impermissible circumstances or trivial grounds.[36]

To view abortion only in terms of individual choice or even as a clash of rights, neglects a range of other relevant considerations including the fact that women and only women get pregnant and bear children; women earn less than men; they are subjected to sexual violence, and they have less familial or political decision-making power than men. This is what led Cook and Howard to argue that the law should focus on accommodating the differences in biology and experience rather than reinforcing the patriarchal stereotype of the role of women,[37] and that such a law must be sensitive and all-embracing and transformative to value different sexes and their significance.[38] These concepts and rights are the ideals of a liberalized and gender-sensitive and equality-based abortion provision; they are recognized as shaping modern laws affecting reproductive rights of women. Thus, for an abortion law to incorporate these standards is to reflect the sensitivity, reality and experiences of women, and would be seen to have asked the ultimate woman question.

The Human Rights Committee in interpreting Art 3 ICCPR submitts that granting abortion rights for rape victims raises questions on the compliance and implementation of Articles 7 and 24 of the ICCPR. i.e. the right not to be subjected to cruel, inhuman and degrading treatment, and the right of minors to special treatment. Similarly, the CEDAW Committee has interpreted Article 12 of CEDAW on the right to health with discrimination on the basis of gender and biology. In addition, sections 33, 42 and 35 of the Constitution of Nigeria

guarantee the rights to life, non-discrimination and dignity of human persons, and that these rights are inviolable. In a similar vein, the CEDAW Committee in its concluding observation for instance urges Chile to amend abortion laws to permit abortion on the grounds of health, including mental health in compliance with its international human rights obligations. The Committee also urges Zimbabwe to liberalize and decriminalize abortion considering its contribution to maternal mortality, as they violate the right to life of a majority of the victims. Similarly, the treaty monitoring body that supervises government compliance with the ICCPR has also interpreted existing global human rights standards to guarantee a women's right to safe and legal abortion, under certain circumstances as implicating guaranteed rights to equality, non-discrimination, life, liberty, security of the person and the highest attainable standard of health. The CEDAW Committee has also framed the issue of maternal mortality due to unsafe abortion as a violation of women's right to life.

Moreover, Article 2 of the African Charter which is domesticated in Nigeria provides that everyone is equal before the law and that no one should be discriminated against on grounds such as gender, religion, political beliefs or other status. Article 3 similarly guarantees to every individual the right to equality and equal protection of the law. Specifically relating to women, Articles 1 and 2 of the African Women's Protocol prohibit discriminatory practices against women. The African Commission in ruling on the provisions of Articles 2 and 3 in *Legal Resource Foundation v Zambia* relating to non-discrimination and equality rights emphasizes the importance of fair treatment and just treatment within every legal system for all citizens, and the effect of such treatment on the enjoyment of other rights.

Do the abortion provisions in Nigeria ask the woman question? Admittedly, most countries have had to rely on international human rights law to grant these rights without direct local legislation, In Africa, the *African Charter* and the *Maputo Protocol* represent the guiding principle for a liberalized abortion regime. More importantly, the interpretative guide provided by the African Commission in General Comment 2 on the provision on abortion and other rights, offers useful guidance to addressing these concerns, although there is yet to be a direct submission for interpretation on the provisions of Article 14 (2) (c). There are lessons to be drawn from other regional or human rights bodies. For instance, the Commission may draw lessons from CEDAW Committee in the *Alyne da Silva Pimentel v. Brazil* or other related cases, on how to ask the woman question when addressing a communication affecting the sexual and reproductive health and rights of women.[39]

5 Nigerian criminal codes and the woman question

The colonial antecedent of Nigeria created the foundation for the criminalization of abortion. The Offences Against the Person Act, 1861, section 58 remains the foundation of the abortion prohibition in many former British colony jurisdictions like Nigeria. Abortion under the section is prohibited, except when it

is necessary to save the life of the mother as in the case of the southern part of the country. Although most colonial jurisdictions have reformed their abortion laws, abortion-related offences in Nigeria remain of three kinds. They include attempts to procure abortion, killing of an unborn child, and child destruction. The Criminal Code and the Penal Code make it an offence to cause miscarriage and induce self-miscarriage, pursuant to the provisions of section 228 and 229, as a felony with 14 years' imprisonment.

Similar provisions exist in the code applicable in the northern region under sections 232, 233 and 234 of the Penal Code. Section 232 criminalizes causing miscarriage in the absence of good faith, with up to 14 years' imprisonment, or a fine. The offence of killing an unborn child in Nigeria is created under section 328 and 236 of the Criminal and Penal Codes respectively. The Codes provide for the punishment of life imprisonment for any persons who by an act of omission or commission, prevents a child from being born alive by a woman about to be delivered of a child. Allowance is made under sections 297 and 235 of the Codes, respectively, for a situation where the unborn child may be aborted for the preservation of the life of the mother. This is the only statutory expression of the preservation of the life of a mother as a lawful justification for 'abortion' under Nigerian Law.

To attract the application of the codes, the miscarriage should have been caused voluntarily, and should not have been caused in the process of saving the life of the mother. Any other ground attracts a penal sanction. The English abortion precedent-setting case, *R v. Bourne*, construes section 58, the foundation for the sections of the Nigerian Codes under review in giving interpretation to the meaning of the phrase *'for the purpose of saving the life of the mother*'. the court opines:

> …The law does not require the doctor to wait until the unfortunate woman is in peril of immediate death… if the doctor is of opinion, on reasonable grounds and with adequate knowledge, that the probable consequence of the continuance of the pregnancy will be to make the woman a physical or mental wreck, the jury are quite entitled to take the view that the doctor who, under those circumstances and in that honest belief, operates, is operating for the purpose of preserving the life of the mother.

The case expands the lifesaving requirement to include situations where the physical and mental health of the mother is threatened. This is in recognition of the right to dignity and health recognized under English human rights. This has been argued to be the important approach required in dealing with abortion cases in common law and several other jurisdictions post *Bourne*, and premised on this judicial intervention majority of former colonial powers have repealed formerly restrictive positions and liberalized their abortion laws, largely to combat unsafe abortion-related mortality and morbidity.[40] Although the Nigerian Codes provide for exceptions recognized in emergency cases,

they are only applicable in saving the life of the mother as a matter of necessity and ineffective in practice.

The failure of the codes to specify the measures required to preserve the mother's life or what it means to save the woman's life is fundamental and profound for the rights and experiences of women. The Nigerian courts have also failed to thread the path of *Bourne* by recognizing grounds which have the focus of the guaranteed rights of women as evident in the case of *R v. Edgal*, involving a woman seeking abortion on health grounds. The West African Court of Appeal refuses abortion on health grounds and reiterates the life-saving exception as sole grounds. This case represents, to date, the substantive judicial precedent in Nigeria on abortion. This omission or inability to prescribe such tangible criteria leaves so much at the discretion of the physician, and ignores the rights and liberty of a woman to determine whether to abort even when her health and mental being are at risk.[41] It gives wide discretion to a physician to address a pregnant woman's circumstances based on his or her personal interpretation of the situation, or where she has been sexually assaulted, raped, or would suffer psychological harm as a result of a pregnancy. The language of the provisions seems to suggest that it is a question of fact to be determined by the physician, and a subjective interpretation without taking the realities and everyday experiences of women into consideration. It is argued that the Codes in this light failed to ask the woman question, thereby contributing to the incidence of clandestine abortions. It is for this reason that most global public health and human rights experts advocate promoting women's reproductive health.[42] Preventing unsafe abortion related mortality and morbidity includes canvasing for the broadening of the grounds for abortion and decriminalization, with the aim of creating an enabling legal environment recognizing the rights and experiences of women.[43]

To guarantee women's reproductive rights in the context of abortion requires more than merely repealing laws that criminalize abortion.[44] This would entail aspiring towards a comprehensive reproductive health framework.[45] The state should not merely decriminalize abortion but must also recognize reproductive health rights, services and implementation mechanisms in order to cater for the needs of women.[46] Rather than reducing the incidence of unsafe abortions, the restriction has compelled women and girls to resort to clandestine abortion, thereby risking their health and lives.[47] One out of every seven Nigerian woman or girls aged between 15 and 49, have at some point in time attempted to obtain abortion through unsafe means or through unlicensed means, especially through 'unqualified practitioners or qualified ones working under substandard medical conditions'.[48] The implication of the restrictive abortion provisions dictates that most services are unregulated and mostly 'very frequently unsafe'.[49]

6 The Protocol and the woman question

In the last two decades, most countries have witnessed a gradual change towards liberal abortion laws. Admittedly, most countries have had to rely on

international human rights law to grant these rights without direct local legislation. A similar approach of liberalization of substantive abortion law that is not accompanied by concrete implementation also exists at the African regional level. In 2003, liberalization in the region received a significant boost through the African Charter on Human and Peoples' Rights (African Charter), when the African Union adopted the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. Article 14(2) of the Protocol has significantly augmented the trend towards liberalization by recognizing abortion as a human right in given circumstances. However, states like Nigeria are failing to implement a legal and administrative framework aimed at liberalizing effectively abortion laws domestically, in a manner that takes the lived experiences of women into consideration. The African Commission in its General Comment 2 on the provision on abortion and other rights in the Protocol, offers useful guidance to addressing these concerns. Drawing lessons from emerging jurisprudence from the CEDAW Committee, the European Court of Human Rights and United Nations treaty bodies are an important step that can be used to mirror the commissions interpretation and render African governments accountable for failure to implement domestic abortion laws. This inter-jurisprudential approach will enable courts, policy makers and legislatures in African countries to pinpoint needed interventions by way of law reforms to abortion in Africa.

Specifically, the CEDAW Committee and Committee on the Rights of the Child have expressed concerns on the state of abortion in Nigeria and the need to repeal, reform, and modify its restrictive laws. Despite these recommendations and advisory opinions, abortion is still criminalized in the country.

The significance and potential of the Protocol lies in its affirmation of reproductive choice and autonomy as a key human right, and contains an unprecedented and explicit woman's right to abortion when pregnancy results from sexual assault, rape or incest; when continuation of the pregnancy endangers the life or health of the pregnant woman and in cases of grave foetal defects that are incompatible with life. These grounds are the focus of the failure of the criminal codes in Nigeria, and which may now be realized by women through enforcing their human rights under the Protocol alongside the domesticated African Charter. In the light of the high rate of maternal death due to unsafe abortion, the adoption of the Protocol seeks to improve these indicators by putting pressure on governments, including addressing the underlying socio-political and healthcare issues that contribute to the depressing state of women's health across the continent.[50]

Article 14(2)(c) of the Protocol provides that:

> states parties shall take all appropriate measures to: protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where continued pregnancy endangers the mental and physical health of the mother or the life of the mother.

The Protocol broadens the grounds for abortion in Africa towards liberalization of abortion laws. It recognizes the reproductive rights of women in line with the experience of women and the consequence of the restrictive laws.[51] While it is not in doubt that decriminalization is a veritable tool in the woman question quest, this is only a part of the story. A combination of repeal of restrictive abortion laws as well as a comprehensive framework is more effective in addressing maternal mortality. A framework where reproductive rights are recognized considering the experiences of women, production of timely healthcare services and adequate mechanisms for the implementation of the various laws including establishing effective monitoring and remedial process, must be put in place. To complement the Protocol, there is a comprehensive framework for the recognition and enforcement of reproductive rights of women. Obstacles in the way of access to healthcare for women such as the criminalization of abortion have been held to violate the provisions of CEDAW, and the Committee has urged state parties to remove the obstacles and amend such laws. According to Ngwena, unless decriminalization of abortion goes in tandem with state provision of substantive access to abortion services based on need rather than means, the plight of women who need abortion, but have little or no income, is unlikely to change.[52]

It is imperative to examine how the Protocol addresses the woman question differently from the approach by national legislations and in the absence of a direct health right precedent. The African Commission in *Doebbler v Sudan* and *Egyptian Rights Initiative v Egypt*, offers guidance relating to women's rights, but not abortion. These cases have affected the development of the jurisprudence and interpretation of the Protocol provisions for guidance by states. The African Commission issues GC No. 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the Protocol, recognizing the persistent rate of abortion on the continent and the fact that many countries are yet to undertake the necessary legislative reforms towards domesticating the relevant provisions of the Protocol with the objective of reversing the maternal mortality trend. The GC 2 provides interpretive guidance on the overall and specific obligations of States Parties towards promoting the effective domestication and implementation of Article 14 of the Protocol.

The GC is also to guide in drafting and presenting State periodic reports, on the legislative and other measures taken to promote and protect the sexual and reproductive health of women and girls. It thus imposes an obligation on states for effective evaluation of steps taken to guarantee reproductive rights. In an important decision in the *Alyne* case, the CEDAW Committee affirms the violation of Art 2 and 12 of CEDAW when it holds that a state party is directly responsible for the actions of private institutions when it outsources its medical services and that it fails to regulate and monitor such institutions. It also affirms that failure to provide affordable access for all women to adequate abortion care, and effective judicial remedies in line with international standards to address the high rate of maternal mortality, amounts to a violation of the socio-economic and cultural rights. The Committee examines factors such as

poverty and race and intersectional discrimination in arriving at its decision.[53] The ruling offers a sample direction to the interpretation of the provisions of the Protocol by the African Commission in handling communication on abortion considering the rate of maternal mortality and challenges of access to abortion services prevalent in Nigeria.

Similarly, in *L.C v Peru* involving a 13-year-old rape victim who was denied abortion. It establishes obligations on the state to allow abortion when the physical and mental health of women is at stake, especially where the pregnancy results from sexual assault or rape. It calls for decriminalization of abortion on these grounds and affirm states' obligation to provide adequate facilities and effective mechanisms for accountability in protecting women's reproductive rights. It is argued that the provisions of the GC resonate with the standards and ideals of abortion law; section 46 of the GC mandates government to remove laws against abortion, and provides both a legal and social environment conducive for the exercise of women's sexual and reproductive rights.

This guidance in the jurisprudence of the Protocol is aimed at changing the negative experiences women face in the various countries in the application of the substantive, administrative laws, judicial and quasi-judicial bodies. The Protocol imposes on state parties the obligation to protect women's reproductive rights, particularly by authorizing safe abortion on recognized grounds. In addition, the Maputo Plan of Action urges governments to adopt legal policies and frameworks to reduce cases of unsafe abortion, and to develop and implement national action plans to mitigate the prevalence of unintended pregnancies and unsafe abortions. Section 53 of the GC further expresses the obligation imposed on state parties aimed at a comprehensive and reflective of approaches of the woman question, by imposing obligation to ensure availability, accessibility, acceptability and good quality reproductive health care, including family planning, contraception and safe abortion for women. State parties should ensure services are comprehensive, integrated, rights-based, sensitive to the reality of women in all contexts, and free from any coercion, discrimination and violence. This will undoubtedly elevate the abortion provisions beyond a neutral set of regulations, to a more gender and women focused legislation.

It has been argued that the Protocol has contributed significantly to the regime of abortion in Africa. First, is its giving abortion rights an enumerated status at a regional level, furthering the consensus on combating unsafe abortion as a major public peril, promoting the legitimacy of liberalizing abortion laws, and providing an impetus for reform.[54] This has the effect of reforming most abortion laws in Africa from the criminal outlook for a more holistic human rights outlook. The Nigerian restrictive criminal-codes have been criticized, as they fail to recognize other grounds aimed at the autonomy for women. However, the Protocol has also been criticized as being restrictive for failure to concretely recognize other grounds aimed at a deeper autonomy for women, such as abortion by request and socio-economic grounds. The Protocol is only a template, and Art. 31 states that states may recognize other grounds beyond

those recognized by the Protocol. Moreover, it does not apply to states who have already recognized these grounds in their laws, such as South Africa.

In comparison with the Criminal Code, the Penal Code sections are much circumscribed for abortion rights, and gives so much room for discretion to the judges against women, who are the subjects of the provisions. They lack required human rights jurisprudence of the various international instruments, especially the innovative approach that Art. 14(2) (c) of the Maputo protocol offers. Since states have duty to respect, protect and fulfil the equality and dignity of women, legislations limiting rights of women such as in the case of criminalized abortion, are void and a violation of international law. If states interpret the refusal of grounds of abortion due to rape without considering that rape and even assault is a violation of the dignity and security of the woman, such a statute has failed to reflect women's experience.

Unfortunately, there is a lack of regional enforcement mechanisms to ensure compliance and implementation of the Protocol to be supervised by the African Commission. The Protocol may also encounter difficulty in achieving its purpose if left for countries to simply ratify without domestication, or transformation into a domestic law. This has been argued as the major challenge for abortion reform in Nigeria.[55] The pluralistic nature of the legal system has made it difficult for international human rights to be effective.[56] In Nigeria, section 12 of the Constitution provides that such a treaty will have to be enacted into a domestic statute either by way of amendment of provisions, repeal, or adoption as an act of parliament. This will give power to women seeking abortion to rely on such provision in the domestic legal regime, for effective enforcement. While Nigeria has domesticated the African Charter, and ratified the Protocol, it is yet to domesticate the Protocol. The implication is that the lofty goals of the Protocol are far from achievable without domestication.

7 Conclusion

I have argued in this chapter that the restrictive abortion provisions in Nigeria are the reason for the practice of unsafe abortion and a major contributor to the high rate of maternal mortality. The Criminal and Penal Codes only recognize lifesaving as the sole ground for abortion. While this is a colonial heritage, various countries have moved beyond the lifesaving exception to include grounds that reflect the realities of modern times and experiences of women. The research argues that using feminist reasoning, the Codes on abortion fail to ask the woman question.

Against this backdrop, the Maputo Protocol significantly advances human rights protections in Africa to better reflect and incorporate women's experiences. Its significance lies in its affirmation of women's reproductive rights as human rights, and its articulation of women's rights within an African regional context. The legal and moral pressure it exerts over the governments and policymakers responsible for its implementation is commendable. The Protocol

presents a tremendous opportunity for women's rights advocates in Africa, and could herald a new age of sexual and reproductive health for women throughout the continent. The restrictive provisions in the Nigerian codes ought to be reformed, as they are unsustainable and not reflective of the rights of women. They are also contrary to international human rights obligations that Nigeria is signatory to. Most importantly, the restriction is responsible for the high rate of unsafe abortion in the country and the consequential maternal mortality. It is suggested that Nigeria domesticate the Protocol and transform same into local legislation. Judicial and quasi-judicial bodies adopt the interpretive guidelines from the Africa Charter, General Comments 2 and jurisprudence developed by other international bodies, especially CEDAW Committee, EU, and other regional bodies, in implementing abortion provisions. They constitute important sources of norms and standards for national courts. This will significantly improve the experiences of women seeking to assert their autonomy and right to equality.

The recommendations offered by this chapter is that an effective way to redress and control the rate of maternal mortality through abortion is to consider the disadvantageous position of women and give women a voice in the provisions, application, and implementation of laws dealing with reproductive rights of women. Several international bodies have consistently found these restrictive provisions clearly result in a high rate of unsafe abortions, which often result in loss of lives. Finally, to ask the woman question, laws seeking to overcome the restrictive abortion legislations must clearly be seen from a health rights and feminist perspective. Institutional mechanisms leading to the implementation and application of the laws, which are presently absent, are being addressed. These safeguards must ensure that women's rights are given priority with clear remedial guidelines to challenge such institutional process, which must also be less costly, timely and safe, in order(fine) not to defeat its purpose.

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4 Mainstreaming the 'abortion question' into the right to health in Uganda

Robert D Nanima

1 Introduction

Uganda has an estimated 775,000 unintended pregnancies per annum, of which 25% are among adolescents.[1] It is estimated that 297,000 (38.3%) mothers have abortions carried out, usually in dangerous health conditions.[2] These include lack of qualified health practitioners and medication.[3] This still does not engage the reasons that inform the woman's decision to undergo an abortion in dangerous health conditions.[4] This is without regard to the influence of religion and culture concerning abortion.[5] These polarities between the woman and other societal players continue to contribute to the 8% rate of maternal deaths due to unsafe abortion.

According to the World Health Organization (WHO), 47,000 women die from having unsafe abortions carried out.[6] In Uganda, a total of 128,682 women were hospitalized for complications from induced abortions.[7] Disaggregated results show that 93,265 had induced abortions. The methodology of this study shows that the data was obtained from 418 health centres across the country. This data is based on the fact that it is only the women who went for treatment or who had no option but to go to a health centre. The women who procured abortions in other places other than health centres are not reported, and as such the figures would be higher than this. This is fortified by the fact that some women opt for abortions under dangerous conditions due to fear of legal repercussions like imprisonment, societal stereotyping and stigma.[8] As such, first, the research does not question the reasons that lead women to have an abortion. Secondly, it does not contextualize the eminent probability of possible prosecution of the women who have the abortion carried out, or the individuals who procure it. Prosecution of the latter category is based on the use of common purpose through aiding and abetting as principles of criminal liability. What this restrictive regime does to the woman who considers an abortion needs to be evaluated.

In some cultures, the preference for children of a particular sex as a patriarchal element coupled with the scientific prenatal sex identification techniques may inform the reason for an abortion.[9] Other reasons include the existence of non-consensual sex, sexual violence or one's inability to deny a man's sexual

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advances.[10] Non-consensual sex is evident in instances where women or girls are not willing to have their first sexual experience.[11] This is worsened where they are unable to negotiate the use of contraceptives that leads to increased risk of unwanted pregnancies.[12] Further research shows that the prevailing socio-cultural norms and values in Uganda, influenced by religion and the law, are against abortion.[13] On the other hand, men seem to support abortion where it serves their interest.[14] This still posits the control of a girl or woman's sexuality. In effect, the continued protection of the perspectives of the community other than the realities of the girl or woman points to a protection that conflates the meaning of a right to life of the foetus and the mother. There is a need to balance reasons for state action that protects the rights of women along with the default emphasis on the protection of unborn human life as a constitutional value.[15]

The foregoing statistics call for introspection into the position of international, regional and national law on abortion. The chapter evaluates the position of international law on abortion followed by an evaluation of regional initiatives under the African human rights system. This is followed by an examination of Uganda's reservation to the Maputo Protocol. This chapter draws on Uganda's restrictive legislative position to inform the subsequent analysis. Conclusions and recommendations follow.

2 International law on abortion

The right to safe, legal and effective abortion is provided for in international law in the context of other rights. Concerning the right to life, Article 6 of the International Covenant on Civil and Political Rights (ICCPR) states in part that every human being has the inherent right to life. In its General Comment, the Human Rights Committee argues that deprivation of life involves an intentional or otherwise foreseeable and preventable life-terminating harm or injury, caused by an act or omission. The failure by any state to take on deliberate pro-active steps to ensure that abortion does not lead to maternal death is a violation of the right to life. This right is buttressed by the provision of the right to the highest attainable standard of health in the International Covenant on Economic, Social and Cultural Rights (ICESCR). The women's right to health extends to their sexual and reproductive health.[16] States have an obligation to respect, protect and fulfil rights related to women's sexual and reproductive health. This obligation extends to the use of necessary steps to reduce the stillbirth and infant mortality rate and to provide for the healthy development of the child. In its General Comment 14 on the Right to Health, the Committee on Economic, Social and Cultural Rights (CESCR) underscores the need for state parties to implement measures to

> [I]mprove child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information.

Barriers that would otherwise affect the women's enjoyment of the highest level of care need to be removed to ensure that the right to health is enjoyed without any form of discrimination. The CECSR has recommended to State Parties to ensure that these barriers are removed. A complete discussion of the international law on abortion is beyond the scope of this chapter. What can be shown in the interim is that despite the lack of a direct provision that speaks to the right to abortion, an engagement of various rights indicates that the right is recognized in international law.

In the regional human rights system, the African normative framework presents the first human rights instrument that expressly articulates a woman's right to an abortion in specified circumstances. The African Charter on Human and Peoples' Rights (ACHPR) provides for the right to the highest attainable standard of health. It establishes the African Commission on Human and People's Rights (African Commission) to promote and protect the rights of the people. In Africa pursuant to the need to engage women's rights, the African Commission adopted the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol). Under the Maputo Protocol, the relevant article provides:

> States Parties shall take all appropriate measures to … protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.

According to the drafting history of this article, the intent was to cover all aspects that affect the reproductive rights of women that needed the engagement by state parties. It was after a subsequent meeting of experts that the draft was amended to state as follows: to 'protect the reproductive rights of women particularly by authorizing medical abortion in cases of sexual assault, rape and incest'.[17] At a subsequent preparatory meeting in Addis in January 2003, both national and regional women rights organizations proposed that the grounds of danger to life, physical or mental health of the mother had to be included as abortion grounds.[18] This led to the final wording in Article 14(2) (c). The article in this review was not imposed upon the state parties. Conversely, its development was through engaged dialogue with stakeholders such as civil society organizations, experts and state parties.

According to the African Commission's General Comment 2 on the Maputo Protocol, three points underscore the application of Article 14(2) (c). First, the conduct of unsafe abortions in Africa contributes to preventable maternal mortality and disabilities. This is due to restrictive legal regimes that make it hard for women to seek a safe abortion. Secondly, discrimination is embodied in the state's parties' use of impediments to the health services reserved for women and the use of the conscientious objections by health personnel. The African Commission reiterates the non-application of the conscientious

objection where a woman's health is compromized, and one requires emergency care or treatment. Other discriminatory practices include bureaucratic challenges in administrative laws, policies, procedures, practices and socio-cultural attitudes that violate the woman's right to life, non-discrimination and health through the deprivation of decision-making power on her sexual and reproductive rights. This discrimination extends to the subjection of women to criminal proceedings, prosecution or disciplinary action for benefiting from health services like abortion and post-abortion care. Thirdly, the categories of women who should benefit from abortion and post-abortion care ought to include those who conceive due to sexual assault, rape and incest. It highlights the possible trauma that a woman may suffer where she is forced to keep the pregnancy to its full term. As such, the Maputo Protocol promotes women's control of their sexual and reproductive health and rights. However, Uganda entered a reservation on the application of Article 14.[19] As will be shown, the recommendations on Uganda's reservations to these articles impede the full enjoyment of women's health and reproductive rights concerning medical abortion.

The African Union has policies like the Maputo Plan of Action for the Operationalization of the Continental Policy Framework for Sexual and Reproductive Health. Adopted in 2006, this Plan of Action requires states to adopt administrative and legal frameworks aimed at reducing unsafe abortions, including providing comprehensive safe abortion services under the law and educating communities on the services provided under the laws.

As a socio-economic right, it is expected that states progressively realize this right through the creation of a conducive environment for the enjoyment of good health including the ability to control one's body in the sexual and reproductive form. Any barriers that affect the enjoyment of this right like lack of access to health services and education in the sexual and reproductive rights are a violation of the right to health. As such the application of restrictive abortion laws and their undue regard to the consequences of unsafe abortion on women's health have to be placed into perspective. A practitioner who is not willing to carry out an abortion should refer the woman to another practitioner who may be consulted. This approach envisages abortion as a measure that offers a woman the ability to make a decision that in the long run accords her the attainment of a high standard of health. This autonomy enables her to make informed decisions about her sexual and reproductive rights.

Another principle that underscores the right to health is the requirement for progressive realization by states.[20] The state has to take steps to ensure the maximum utilization of its available resources, to progressively achieve the full realization of the rights recognized in the International Covenant on Economic, Social and Cultural Rights.[21] The state uses the principles of availability, accessibility, acceptability and quality. The failure to progressively realize this duty within a state's financial resources eludes the incremental enjoyment of economic, social and cultural rights.[22] Where resources are insufficient, states should show the steps taken to ensure an improvement in the enjoyment of

these rights.[23] Two points are evident. First, in international law, the right to abortion can be engaged through the enjoyment of other rights. Secondly, as a point of departure, Africa's Maputo Protocol expressly articulates a woman's right to an abortion in specified circumstances. Thirdly, the right to health can be progressively realized. The author now considers Uganda's reservation to the Maputo Protocol.

3 An examination of Uganda's reservation to the Maputo Protocol

Uganda entered a reservation to Article 14 (2) (c), to the effect that the article would be interpreted subject to domestic legislation on abortion. Although it has been suggested that this reservation is limited to the application of Article 14 of the Maputo Protocol without rendering abortion illegal,[24] this position is not reflected in the wording of the reservation.

It is argued instead that Uganda seeks to maintain the domestic regulation of abortion to override the notion that a woman's right to abort forms part of the sexual and reproductive rights. This presents a dangerous predicament; first, the reservation defeats the purpose of the Maputo Protocol. Secondly, it does not consider the polarities that misinform the abortion question in the Ugandan society.[25] The cumulative effect of this reservation is a restriction on the ability of the Protocol to address the question of abortion. This reservation should be subject to the Limburg Principles, which require that state parties begin the immediate implementation of the obligations under the ICESCR.[26] The Limburg Principles state that:

> Some obligations under the Covenant require immediate implementation in full by all States parties, such as the prohibition of discrimination in article 2(2) of the Covenant.

This provision applies to Uganda by virtue of its stand on the position of international law. Although the applicability of international law is not clearly indicated in the Constitution, this is solved by the requirement that its application in Ugandan Courts is conditioned on the ratification of a treaty under the Ratification of Treaties Act and then domesticated by an Act of the Ugandan parliament. The continued application of the reservation is a violation of the requirement for the immediate implementation of the non-violation of the right against discrimination. An evaluation of the right to health in the context of abortion needs to be placed into perspective.

4 An evaluation of the right to health in Uganda

4.1 The position of the right under the Constitution

The Constitution of the Republic of Uganda does not provide for the right to health. However, various principles and provisions on how the woman may

enjoy this right are evident. According to the national objectives and principles of state policy,

> [t]he State shall endeavour to fulfil the fundamental rights of all Ugandans to social justice and economic development and shall, in particular, ensure that … all Ugandans enjoy rights and opportunities and access to … health services…

Policies developed by the government should be used to improve the welfare of all persons including the woman to have and enjoy health services. The goal of the health policy is to protect and promote the health of individuals and the community.[27] The drafting of any policy on health starts from the recognition of the foundation under the National Objectives. All policies on health require that

> [t]he State shall provide the facilities and opportunities necessary to enhance the welfare of women to enable them to realise their full potential and advancement.

In addition, the state is mandated to protect women and their rights, taking into account their unique status and natural maternal functions in society. These policy directives should guide the state in enhancing the welfare of women, to the position of achieving their potential with due regard to their maternal function.

The Constitution recognizes equality between women and men, which underscores freedom from discrimination, for affirmative action in favour of women and for outlawing practices that undermine the welfare, dignity and interests of women. Provisions that undermine the welfare and dignity of women affect her attempt to secure a livelihood. In *Salvatori Abuki v the Attorney General,* the court held that the right to life encompasses the enjoyment of other rights which lead to the ability to have a livelihood. These provisions have to be reconciled and used as a guide in 'mainstreaming' the abortion question.

Also, Uganda is a signatory to the International Covenant on Economic, Social and Cultural Rights, the African Charter on Human and Peoples, Rights, and the Convention on the Elimination of All Forms of Discrimination against Women, as well as being a member of the United Nation's World Health Organization. All these bodies interpret the right to health as the right to the highest attainable standard of health. In this regard, the state has a duty to ensure the progressive realization of this right by respecting, protecting, fulfilling and promoting it.[28] As such, Uganda's status concerning these various human rights instruments enables it to apply them. In addition, the Supreme Court ruled that International Customary Law is applicable in Uganda.

The judgements from the courts speak to the enjoyment of the right to health. For instance in *The Centre For Health, Human Rights & Development &*

2 Others v The Executive Director, Mulago Referral Hospital & Another, the Court acknowledged various duties of the state with regard to the provision of the right to health. It referred to General Comment 14 and stated,

> The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive health, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection, which provides equality of opportunity for people to enjoy the highest attainable level of health.

This position reads the existence of the right to health into Uganda's Constitution, lays out the nature of the right, recognizes Uganda obligations under international law about the right to health, and requires that whoever seeks to enjoy that right has to do so in a manner that envisages his or her freedom in making such decisions.

Based on the foregoing discussion, it is clear that the lack of the right to health in the Constitution is not a justifiable reason to the provision of an enabling environment for its subsequent enjoyment by the woman. Various hypotheticals question the context of abortion: is the government doing enough to enhance the plight of the woman on issues relating to her maternal health? Do the policies progressively enhance the woman's enjoyment of the right to health? A look at the subsidiary legislation and national policies may give some guidance.

4.2 Subsidiary legislation and national policies

The Penal Code Act (PCA) has various provisions that speak to the position of abortion in Uganda. It provides,

> [a]ny person who, with intent to procure the miscarriage of a woman ... unlawfully administers to her or causes her to take any poison or other noxious thing ... or uses any other means, commits a felony and is liable to imprisonment for fourteen years.[29]

This section of the Act makes several dangerous assumptions about abortion. First, it does not qualify the type of person referred to. In so doing, it fails to recognize persons with professional qualifications and experience, such as doctors and other medical officers. It conflates professionals with all other persons. Secondly, based on this conflation, it implies that such persons, regardless of their professional qualifications or experience, have the intention of procuring an abortion – an act which is portrayed in a false negative light. The intention, indeed, may be to save the mother's life or to uphold the rights of the mother, among other things, an intention which is then put into practice by procuring

an abortion. Thirdly, the section assumes that abortion is a mode of family planning that is outlawed by the section. It is argued that abortion should not be seen as a form of family planning but as a mode of promoting the sexual health and reproductive rights of the woman. Therefore, this provision is based on assumptions that do not take into account the various circumstances that may inform a Ugandan woman's decision to procure an abortion.[30]

A similar section provides:

> Any person who unlawfully supplies to or procures for any person anything, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman, whether she is or is not with child, commits a felony and is liable to imprisonment for three years.[31]

Section 141 adds to the previous section by criminalizing the actions of the person referred to therein. To reiterate, the two sections fail to capture the reasons that may lead a woman to procure an abortion. The cumulative effect of these two provisions is to discriminate against the woman on account of her sex and her need to decide when to have a child. This discrimination is further evident in the failure of the penal laws to appreciate the sexual and reproductive health and rights of a woman, because of the community misconceptions about abortion.

Furthermore, the PCA provides that

> [a]ny woman who, being with child, with intent to procure her own miscarriage, unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means, or permits any such things or means to be administered to or used on her, commits a felony and is liable to imprisonment for seven years.[32]

This provision criminalizes a woman's attempt to procure an abortion on herself. While this is a good provision insofar as it criminalizes abortion where a woman performs it herself, it fails to engage with the circumstances of the woman who has done so: there is a need to focus on the 'why' question.

The final provision in the Penal Code that deals with abortion states as follows:

> A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his or her benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time, and to all the circumstances of the case.[33]

One may raise the defence that he or she acted in good faith and with reasonable care in performing the operation to save a mother's life. However, this a defence can only be raised after one has been arrested and has been prosecuted.

The persons who have acted in good faith and with reasonable care are still subjected to the same process as those who have not exercised good faith. This defence may not necessarily lead to an acquittal but rather may be used to mitigate the sentence in terms of the length of imprisonment or the amount of the fine payable. The application of the penal provisions results in criminal justice procedures that undermine the welfare and dignity of women. Consequently, the provisions fail to reflect the constitutional values that are ascribed to a woman.

Apart from the legal framework, the policy framework needs to be addressed as well. The National Gender Policy (NGP) recognizes gender as a useful concept in understanding the social roles and relations of women and men of all ages and how these impact on development.[34] With regard to sexual and reproductive health and rights, the NGP, at its core, has a specific strategy to develop and implement sexual and reproductive health rights programmes.[35] It follows that reduction of the high teenage pregnancy rate, which addresses the discriminatory tendencies that the penal laws present, is part of this agenda. On a positive note, the NGP recognizes the high incidence of teenage pregnancies and the risks that arise concerning the health of the mother and child.[36] Since Uganda is a signatory to the International Conference on Development and Population (ICDP), the policy reiterates the government's commitment to the promotion of sexual and reproductive health rights by putting gender relations at the centre of health and population interventions.[37] The position consequently raises questions about Uganda's reservation about the implementation of the Maputo Protocol.[38] Furthermore, it raises questions on the ability of the Penal Code Act to promote the sexual and reproductive health and rights of women given the restrictive regime coming to the fore. While the NGP recognizes the woman and the peculiar realities she faces, the penal laws criminalize abortion. The policy and the laws present a parallel engagement in dealing with abortion in Uganda.

In addition, the Uganda National Policy Guidelines and Service Standards for Sexual and Reproductive Health Rights (GSS) were adopted to address all aspects of SRR.[39] This was a broad-based approach that moved beyond a narrow engagement with family planning and maternal health.[40] The GSS recognize that the prevention and management of unsafe abortion is a component of sexual and reproductive health.[41] While this is a welcome development, it should be recalled that the Penal Code Act does not provide for safe abortion. It criminalizes the acts of the person and the woman without clarifying what constitutes safe or unsafe abortions and generalizes all acts of abortion as illegal.

The GSS provides for comprehensive abortion care services for a woman or a couple seeking advice or services for termination of a pregnancy on grounds like life-threatening maternal illness, severe foetal abnormalities, cervical cancer or HIV, or rape, incest and defilement.[42] This is a radical departure from the general provisions of the PCA, insofar as they acknowledge the various situations that may require a woman to terminate a pregnancy. In addition, the GSS is silent on the use of abortion as a mode of family planning. As with

the NGP, the GSS embrace the constitutional values of non-discrimination, affirmative action and equality.

However, the implementation of these values is curtailed by the general criminal provisions of the PCA. The simultaneous application of the legal and policy regimes presents a parallel application of the policy and the restrictive regime. This position does little to harmonize the contradictory position of the abortion question. This position is similar to that in other policy documents, such as the National Policy on Post Abortion Care (NPPAC) and the Africa Plan of Action for Abortion (APAA).[43] These contribute to the lack of medical infrastructure to conduct safe abortions.

4.3 The marginalization of women in Uganda

The Ugandan woman forms the backbone of Uganda's economy. She has been able to engage in activities that have the potential to create lucrative livelihoods and lift thousands of Ugandans out of poverty, especially with the adoption of modern techniques and better quality inputs.[44] While women control only 27% of plots and 20% of all cultivated land, 73% of the plots and 80% of cultivated land are either controlled by men or managed jointly with women.[45] The bigger picture indicates that 77% of women are involved in agriculture, compared to 62% of men. While women's engagement in economic activities would mitigate poverty, it is hindered by discrimination in various aspects of their lives. A notable concern is discrimination in the realization of their socio-economic right to reproductive health.[46]

As earlier indicated, Uganda has an estimated 775,000 unintended pregnancies per annum, of which 25% are among adolescents.[47] A total of 297,000 (38.3%) result in abortions.[48] The continued recourse to abortion under dangerous conditions due to the restrictive regime negatively affects women's economic productivity.[49]

Uganda has reported great strides towards the realization of Sustainable Development Goal 5 on Gender Equality. At the presentation of its Report on the Sustainable Development Goals (SDG) of gender equality, it reported progress in the reduction of the rate of discrimination and marginalization by 4%.[50] Uganda reported progress in the mainstreaming of gender and rights in policies, plans and programs in all sectors.[51] It also reported strides in the formulation of gender-sensitive regulatory frameworks, promotion of women's economic empowerment initiatives and protection of the rights of vulnerable groups.[52] The report made no mention of the rights of the reservation to the Maputo Protocol as a step towards gender equality. This marked a missed opportunity that Uganda would have used to withdraw its reservation to the Maputo Protocol.

The marginalization extends to the failure to correct the disconnect between the Ugandan woman's hard work and the failure to recognize her right to sexual and reproductive health in totality.[53] While she contributes to the economy, she is hampered by the lack of adequate protection under the

law concerning abortion.[54] Her inability to make decisions about her sexual and reproductive health and rights hinders her enjoyment of the highest attainable standard of health.[55] This marginalization violates the right to equality and freedom from discrimination as provided for in Uganda's Constitution and its international law obligations.

5 Conclusion

While abortion can be read into international law as a result of evolving jurisprudence, the Maputo Protocol expressly articulates a woman's right to an abortion in specified circumstances. Both regional and international law point uphold progressive realization of the right to health. The lack of an express provision to the right to health in the Constitution does not oust Uganda's obligation to the ratified human rights instruments. The existence of a reservation to the provision of abortion in the Maputo Protocol makes it an uphill task to contextualize any progressive realization of the right to abortion. This is exacerbated by the restrictive laws on abortion in the country. While the policies seem to progressively enhance the woman's enjoyment of the right to health, the law provides otherwise. As such, there is a parallel regime, where the executive policies seem to contradict the legislation. Until the policies and legislation speak to each other to the benefit of the woman, the parallel engagement is far from over.

The research has identified a silence that does not interrogate the position of the woman. This is contrary to the various voices in the legislation, in the community, from religious and cultural circles that all point to the shunning of abortion. A model that engages all the competing voices needs to be adopted. Durojaye and Oluduro use an interesting principle to evaluate the African Commission's jurisprudence on the rights of women.[56] They argue that the African Commission's development of jurisprudence on the rights of women requires that it not only ask the 'woman question' but the question that affects the 'African woman'.[57] When one asks the right question, the African woman has to be placed at the centre of any decision in the light of her realities. A hybrid approach needs to be added to this model. The realities of the Ugandan woman should inform the conversation, other than the assumptions that are held by society. An evaluation of the various polarities needs to be done. It is clear that there are competing polarities. On one hand, the society controls the sexuality of the woman, through various restrictive laws, cultural, religious and economic undertones. On the other hand, there is a woman whose realities inform her decision to have an abortion. The competition arises in the need for each party or entity to control the decision of the woman without having an informed evaluation of her realities. The control of a woman's reality at the expense of misunderstood notions needs to be stopped. There is a need to recognize that there is no need for competition but conversations that look at the various polarities and harmonize perspectives of the various voices. An empirical study on the position of women from a psychological and psychosocial

position should be deliberately done. This should inculcate a similar study on other societal aspects like culture and religion. Following the hybrid approach, such findings should then be evaluated to make informed decisions.

The restrictive regimes on abortion have to be lifted, as they are doing more harm in terms of unsafe abortion. Research in Africa points to a link between the criminalization of abortion and unsafe abortion as a major public health and human rights challenge.[58] As required by the Maputo Protocol, abortions should be allowed in instances of 'sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus'. In the short run, education in sexual and reproductive rights has to remove discrimination and gender stereotypes against women. Central to this will be the correction of the misconception that the government seeks to use abortion as a family planning tool. This will be key to ensuring that societal, socio-cultural, religious stereotypes that inhibit discrimination are greatly reduced. These recommendations will go a long way to show that hybrid interventions that place the Ugandan woman at the centre of the abortion question are inevitable.

Notes

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3 As above.
4 As above.
5 As above.
6 World Health Organization (WHO) *Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008* (2011) 1.
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16 Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, Report A/61/338GA adopted at the 61st session of the General Assembly dated 13 September 2006.
17 Report of the Meeting of Experts on the Draft Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, Expt/Prot.Women/Rpt(1) (12–16 November 2001 in Addis Ababa, Ethiopia). See also Nabaneh (2012) 11.
18 Meeting by the Africa Regional Office and the Law Project of Equality Now on 4–5 January 2003 in Addis Ababa (6 January 2003) indicated that the 2001 draft Protocol fell below existing international standards, and needed to be amended as such. This may lead one to question the regional and international standards and who sets them for application. This is, however, beyond the scope of this paper.
19 This is discussed under sec 3 of the chapter below.
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21 L Forman et al 'Conceptualising minimum core obligations under the right to health: How should we define and implement the 'morality of the depths' (2016) 20(4) *International Journal of Human Rights* 531.
22 As above 532.
23 As above 532.
24 C Ngwena 'Reforming African abortion laws and practice: The place of transparency' in R Cook et al (eds) *Abortion law in transnational perspective: Cases and controversies* (2014) 166.
25 C Oguttu et al 'Time to act—comprehensive abortion care in east Africa' (2016) 4(9) *The Lancet Global Health* 1. See also Center for Reproductive Rights Briefing paper: A technical guide to understanding the legal and policy framework on termination of pregnancy in Uganda (2012) generally. JD Mujuzi 'The protocol to the African charter on human and peoples' rights on the rights of women in Africa: South Africa's reservations and interpretative declarations' (2008) 12(2) *Law, Democracy and Development* 41–61 generally.
26 Oguttu (n 26) generally.
27 H Fineberg et al *Society's choices: Social and ethical decision making in biomedicine* (1995) https://bit.ly/3aytI7L (accessed 21 April 2020).
28 Forman (n 22) 536.
29 The Penal Code Act Cap 120 Laws of Uganda, section 141.
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31 The Penal Code Act (n 30), sec 143.
32 As above sec 142.
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42 As above para 2.2.

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5 Barriers to access to contraceptives for adolescent girls in rural Zimbabwe as a human rights challenge

Michelle Rufaro Maziwisa

1 Introduction

Approximately 214 million women in developing countries between ages 15 and 49 have an unmet need for contraception.[1] In Zimbabwe, 12% of unmarried adolescent girls have an unmet need for contraception. Contraceptive use among adolescents is 46%, compared to the national average of 67%.[2] The World Health Organization (WHO) reports that 810 women die daily (295,650 per year) due to preventable pregnancy-related and child birth related causes, and this risk is worse for girls aged 10–14.[3] Persons aged 15–24 constitute 20% of Zimbabwe's population. Moreover, 42% of women of reproductive age and 34% of maternal deaths in Zimbabwe are within this age-group, while HIV prevalence in ante-natal young women is 27%.[4] However, young people are reluctant to obtain sexual and reproductive health (SRH) services due to systemic and legal barriers. If these barriers are not addressed, many rural adolescent girls will forfeit economic advancement and risk early pregnancies and child marriages, maternal mortality and morbidity, and sexually transmitted infections (STIs), including human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS).

This chapter examines the regulatory framework for sexual and reproductive health and rights (SRHR) in Zimbabwe, specifically access to contraception for adolescent girls in rural areas. It argues that the legislative framework is inadequate as it excludes rural adolescent girls from accessing information, education and services related to contraception. The chapter (1) has provided an introduction, and will define SRHR. Thereafter, the chapter will (2) identify barriers, (3) provide an analysis of the regulatory framework, followed by (4) an analysis of the implementation of this framework in Zimbabwe and (5) a conclusion and recommendations. The paper recommends reform of the Children's Act and Public Health Act to advance rural adolescent girls' access to contraception and family planning information, education and services.

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Understanding sexual and reproductive health

The WHO meeting on education and treatment in sexuality in 1974 was the first to address sexual health,[5] followed by the International Conference on Population and Development (ICPD)'s 1994 Programme of Action (POA). The ICPD defines reproductive health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes'.

'Reproductive health' is linked to sexual health, and includes the enhancement of life and personal relations, and 'a satisfying and safe sex life', whereas 'sexual health' is 'a state of physical, emotional and social well-being in relation to sexuality'.[6] It is the absence of disease, and also the possibility of safe, pleasurable and respectful sexual relationships. SRHR means *inter alia* that people can have a satisfying and safe sex life, and be able to reproduce and to decide if, when and how often.[7]

2 Barriers to adolescent girls' access to contraception and family planning in Zimbabwe

Adolescent girls in rural Zimbabwe face a multitude of barriers to accessing SRHR because of social, traditional and legislative constructs that perceive adolescents as asexual and adolescents' sexuality as taboo. With the erosion of traditional family structures that provided information on sexuality, adolescents are left to rely on local clinics and social media. However, they often have to walk long distances to reach the nearest clinic to access SRHR services, and access to digital devices and data is significantly limited in rural areas.

The negative attitude of health workers is a major barrier to SRHR. A study in Masvingo found that adolescents do not attend clinics for SRH services because they do not want their parents to find out that they are sexually active and they are afraid of how nurses will treat them. Nurses reportedly yell at adolescents when they seek contraception, refuse to provide contraception services, and mock adolescents if they contract STIs or fall pregnant.

Consultations are conducted with open doors, such that other patients can hear and see the consultation, and condoms are placed in the lobby, making it uncomfortable for adolescents to collect free contraceptives in clinics, or obtain SRH information or services because of the heightened risk that someone will see them and inform their parents.

There is a shortage of qualified doctors, specialists and nurses in rural areas. In Matebeleland North, nurses conceded that they are trained in primary health care, but only have basic training in family planning methods during their pre-service training, and they sometimes do not know how to administer family planning methods such as 'Jadelle' insertion and removal.[8] The lack of knowledge by health workers is passed on to the rural women they serve, who are given inadequate or incomplete information. Healthcare workers do not explain the full range of available family planning methods and their side effects.[9]

Although Zimbabwe outlawed exclusion from school due to pregnancy, social and cultural stigma force adolescent girls to rather walk 30 km to a clinic in another village, than attend their own clinic, to avoid nurses or other patients gossiping about their condition or telling their parents. Nonetheless, nurses in those distant villages inform the headmaster or headmistress, identifying the student and her medical condition and/or treatment, compromising patient confidentiality. As clinics open during school hours, adolescents have to request permission to attend the clinic. Permission is granted, provide the student presents her medical card, which shows the medical condition or reason for visiting the clinic, further making it undesirable for adolescents to seek SRH information and services.

Moreover, alarming 40% of health expenditure in Africa is out of pocket which often results in the very poor being unable to access health care services, especially in a struggling economy like Zimbabwe. User fees are restrictive for rural adolescent girls, who are usually unemployed. Currently, this is exacerbated by declining economic conditions and the Covid-19 pandemic which has forced government to reprioritise its limited resources to fight the pandemic.

Finally, the process is time-consuming and may dissuade rural adolescent girls from obtaining SRH services because they are responsible for most household chores. The UN reports that women spend up to four times as much time as men in providing unpaid care work.

Having identified barriers to SRHR, the following section explores the regulation of adolescent girls' SRHR in legislative and policy frameworks.

3 Access to family planning and contraception as a human rights issue

Since time immemorial, women's autonomy over their bodies has been contested. Numerous cultures and religions deny women the freedom to choose whether, how and what to do with their bodies. Traditional morality feared giving women freedom to have sexual relations with no consequences of pregnancy or illness, and this paternalistic morality now forms part of legal systems through laws that seek to control women's behaviour.[10]

3.1 International norms and standards

Since ICPD, various rights-based instruments have developed the concept of SRHR. First, according to Articles 2 and 12 in the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), states must eliminate discrimination against women in all its forms to enable women to exercise the full range of human rights. However discrimination is deeply rooted in patriarchal systems and traditional practices that undermine women's sexual autonomy.[11] Continuous education after pregnancy is one way to achieve this, as stipulated in General Comment 15 of the Committee of the Rights of the Child (CRC), because dropping out of school can worsen the cycle of poverty.

Secondly, the right to contraception is intricately linked to the right to life. States should provide adequate health care to prevent maternal mortality and morbidity, and reduce unwanted pregnancies and unsafe abortions.[12] Access to 'safe, legal and effective' abortion should be provided if continued pregnancy would be harmful or cause substantial pain and suffering such as rape or unviable pregnancies. Further, states should not criminalize abortion as this increases reliance on illegal abortions harmful to adolescent girls.

Thirdly, Cook argues that the right to liberty and security of the person (Article 9 (1) ICCPR) is violated when fertility control is denied by the state'.[13] Criminalizing abortions encourages adolescent girls to seek unsafe abortions in the event of unwanted pregnancies or contraceptive failure.[14] States should protect children from 'all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse'. Article 9 (1) ICCPR read with Article 19 UNCRC, shows that lack of access to contraception-related information, education and services and denial of abortion violate adolescent girls' rights to liberty and security of the person.[15]

Fourthly, Durojaye argues that a strong correlation exists between adolescent girls' literacy and SRHR.[16] Literacy facilitates access to SRHR information and can help to reduce early pregnancies, STIs, HIV and early marriage, especially in rural areas where adolescent-friendly services are not easily accessible. Adolescent girls require information about contraceptive methods and side effects to make informed decisions. States should provide or facilitate knowledge on the correct use and effects of contraceptive methods to enable adolescent girls to protect themselves as they start exploring their sexuality, and help adolescent girls develop healthy, safe and respectful sexual behaviour. In South Africa, for example, the incidence of HIV infection in young women between the ages of 15 and 24 is four times higher than that of men in the same age group, which brings to question whether adolescent girls know, understand and use contraception.[17]

Linked to information, is the right to education. Education about contraceptives and family planning through properly trained persons, enables girls to exercise bodily autonomy, and understand the impact of their choices. Failure to access SRHR education increases the risk of early pregnancies and resultant complications such as foetal loss, infant death, induced abortion and other health risks such as vesicovaginal fistulas, and injuries to the bladder, urethra and bowel causing incontinence, excretion of faeces through the vagina and infertility.[18]

Fifthly, Zimbabwe committed to protect the right to the 'highest attainable standard of physical and mental health', and to enjoy the benefits of scientific progress, which includes emergency contraception and abortion medication. This is important because carrying unwanted pregnancies can affect adolescent girls' mental and social well-being.[19] General Comment 24 of the CEDAW Committee requires states to take appropriate legislative and other measures within their maximum available resources to realize women's right to health.

Finally, states must take all appropriate measures to abolish harmful traditional practices and prioritize the best interests of the child. States must develop procedures and criteria to guide health workers' in the provision of medical

treatment to children, including HIV/AIDS. States must improve SRHR accessibility, including physical accessibility, important in rural areas.

In relation to soft law, the United Nations Sustainable Development Goals (SDGs) aspire towards healthy lives, well-being and universal access to SRH services by 2030 and to reduce maternal mortality. Maternal mortality of adolescent girls should be prioritized, as they constitute 34% of maternal deaths in Zimbabwe. African Union Agenda 2063 envisages the use of Africa's resources to promote 'sound health and well-being'. The SADC Strategy also encourages interventions to reduce barriers to SRHR and ensure financial commitment by the state.

3.2 Regional norms and standards

Regionally, Article 14 Maputo Protocol protects the rights of adolescent girls to family planning education, control their fertility, decide whether to have children, the number and spacing of children, and to choose any method of contraception. Article 14 requires states to protect adolescent girls and ensure that they can protect themselves from sexually transmitted infections (STIs) such as HIV/AIDS, and be informed about their own or a partner's health status, particularly if infected with STIs. This enables adolescent girls to make informed decisions about their health and can reduce the risk of STIs. Article 14 (f) read with Article 1(k) of the Maputo Protocol requires states to take measures to provide preventive health care, including family planning education for adolescent girls.[20]

Article 14 (2) requires states to 'take appropriate measures to provide adequate, affordable and accessible health services', especially SRHR education in rural areas, and to authorize medical abortion in cases of sexual assault, rape, incest and where the continued pregnancy endangers the mental and physical health or life of the mother or foetus. The *Mapingure* case below illustrates that this provision is not fully realized in Zimbabwe.

Article 14 of the African Children's Charter guarantees the right to 'the best attainable state of physical, mental and spiritual health' and requires states to develop a national health plan with comprehensive SRHR services and guidelines.

States should protect children from cultural practices that affect children's health or are discriminatory, and should allocate adequate financial resources for the provision of comprehensive family planning, contraception and safe abortion care. Article 20 (2) (a) African Children's Charter requires states to assist parents and care givers with material assistance and support programmes for children's health.

Article 16 and 26 SADC Protocol requires states to reduce maternal mortality, enact laws and policies and provide services that enhance gender-sensitive, safe, appropriate, effective, acceptable and affordable quality health care.

3.3 Domestic laws and policies for access to contraception in Zimbabwe

The section starts with constitutional provisions, and then statutory and policy provisions.

3.3.1 Constitution

Section 81 of the Constitution defines children as boys and girls under 18 years, in line with the Maputo Protocol, and entrenches their right to equality, including the rights to be heard, to education and healthcare. The High Court is the upper guardian of children and the best interests of the child are recognized as paramount. Section 52 of the Constitution protects the right to personal security, which includes the right to bodily and psychological integrity, and freedom from all forms of violence and freedom to make reproductive choices.

Section 62 (1) guarantees the right to access to information from anyone (including the state) for the exercise or protection of a right. SRHR information affects the right to equality between men and women, and between unmarried and married women. CEDAW Committee General Recommendation 21 requires states to provide women with information about contraceptive methods to enable them to make informed decisions. However, section 62(3) of the Constitution claws-back on section 62(1) by stipulating limitations regarding defence, public security or professional confidentiality.

Further, the Constitution provides for progressive realization of health rights, including SRHR. Section 76 of the Constitution provides that '*[e]very citizen and permanent resident* (emphasis mine) of Zimbabwe has the right to have access to basic health-care services, including reproductive health-care services' and that '[n]o person may be refused emergency medical treatment'. Unlike Article 24 (3) UNCRC which requires the state to take 'all effective and appropriate measures', section 76 of the Constitution vaguely requires 'reasonable legislative and other measures, within the limits of the resources available to it, to achieve the progressive realisation of the rights set out in this section'.

Finally, cultural practices that violate women's rights are void to the extent of the infringement. However, section 60(3) of the Constitution allows parents and guardians to determine morality and religion for their children, making adolescent girls' SRHR dependent on their parents' religious and moral convictions. Kangaude and Skelton explain that unlike colonial Western notions of adulthood based on the ownership of a minor girl by her ward, the traditional African conception of adulthood is determined by the individuals' physical ability to undertake adult roles such as child-bearing for girls, and the ability to take care of a family, for boys, accompanied by rites of passage.[21] However, as Tamale and Batisai, respectively, rightly note, girls have a heavier burden of chastity due to a conflation of colonially derived laws, patriarchal customary practices and religious morality.[22]

3.3.2 Legislation

The Public Health Act (PHA) requires the Minister to implement and monitor Zimbabwe's international commitments and to prioritize and allocate resources for health services. It further requires health practitioners to observe patient confidentiality. Section 44 is interestingly phrased in constitutional language,

supposedly guaranteeing 'the right' to participate in decisions affecting one's health and treatment, but immediately qualifying this by stipulating that persons who lack capacity to consent must 'if possible' be consulted by persons having capacity to consent on their behalf.

The Children's Act aims to regulate the protection, welfare and supervision of children, yet it is silent on adolescents' SRH, except regarding abuse, neglect and adoption, and it does not distinguish between children and adolescents. Further, adolescent girls are prohibited from making decisions about their SRHR (including contraception) unless they have parental consent.

Moreover, abortion is prohibited, except in strict listed circumstances, where there is risk to the mother or child's life or physical health, risk of physical or mental defect of the child upon birth, and unlawful intercourse (rape or incest). While this aligns with Article 14 (2) (c), the reality shows some major legal gaps. In the *Mapingure* case for example, a woman was forced to carry a pregnancy resulting from rape to full term, and effectively denied access to justice. Zimbabwe thus in practice falls short of General Comment 2 of the African Commission requirement that adolescent girls must not incur legal or criminal sanctions for receiving abortion or post-abortion services.

3.3.3 Domestic policies

Zimbabwe's National Family Planning policy acknowledges the importance of SRH information and services for adolescent girls, noting the high incidence of early and more frequent pregnancies than in the past, and importantly, that rural teens are 'more than twice as likely' as urban teens to fall pregnant. More than one in every five girls aged between 15 and 19 is pregnant. With increased fertility rate within the 15–19 age group, from 99 births per 1000 women between 2005 and 2006, to 110 births per 1000 women in 2015, contraceptive use among unmarried adolescents has remained low, while contraceptive use for married adolescents in both urban and rural areas has increased.

In line with Article 14 (f) Maputo Protocol, the National Health Strategy aims to strengthen adolescent SRH by improving youth-friendly services, implementing comprehensive sexuality education and advocacy for legislation against child marriage. This is supported by the National Adolescent Sexual and Reproductive Health Strategy (ASRH Strategy), which envisages a package of SRH services for adolescents within health facilities, and education and counselling on pregnancy prevention in schools.

In addition, ZNFPC launched the one-stop SRHR youth-centres which has improved access to SRHR for rural adolescent girls, for example, the Magunje Youth Centre in Mashonaland West (Magunje Growth Point caters for schools in rural areas).[23] The youth centre has a health advisor, qualified youth friendly nurse counsellor and peer educators. The premises have a library, sporting facilities, a television room, SRHR medical supplies and counselling facilities for adolescents. However, these youth facilities are only in a few rural areas as they require financial and other resources in order to function.

The following section analyzes the implementation of the SRHR legislative and policy framework in Zimbabwe.

4 The implementation of the SRHR legislative and policy framework in Zimbabwe

Although Zimbabwe has committed itself to SRHR obligations, there are legal gaps and implementation challenges.

4.1 The conception of childhood and adulthood

The first challenge is that legislation perceives adolescents as asexual and does not distinguish between children and adolescents. As early as 1987, feminist theorizing has been adult-centric, denying children autonomy and agency over their own bodies, and based not on children's interests, but on adult's perceptions of children's interests.[24] Kangaude and Skelton argue that the Western perception of childhood as 'asexual, irrational, and unstable' and being in a state of progression, until children reach adulthood, was imported into Africa through colonial laws.[25] The fact that the Children's Act is silent about adolescent's SRHR and that both the Children's Act and PHA require parental consent for the provision of health services to children under 18 is indicative of this and is a major legal gap as almost 20% of girls between 10 and 19 have experienced pregnancy, and thus have a higher risk of HIV-infection.

For a long time, consensual sexual intercourse between adolescents was regarded as a crime in Zimbabwe. *State v B. Masuku* provided clarity on the contrasting positions in the South African *Teddy Bear* case, and the Kenyan CKW case. In the *Teddy Bear* case, the South African Constitutional Court found sections 15 and 16 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act unconstitutional because it criminalized normative sexual intercourse between consenting minors and was harmful to the minors it sought to protect, and was therefore not in their best interests. In *CKW*, the Kenyan High Court took an opposite, and indeed regressive, approach by convicting a 16-year-old boy for consensual intercourse with a 16-year-old girl. The Zimbabwean *Masuku* case shared the reasoning of the South African Constitutional Court. Judge Tsanga noted that:

> Ignoring the reality of consensual sex among teenagers and adopting an overly formalistic approach to the crime can result not only in an unnecessarily punitive sentence, but also a criminal record and stigmatisation as a sex offender.

A similar position was taken by an earlier court in *State v. CF (A Juvenile)*, in which Judge Kudya noted that consensual sex between minors is not a criminal offence, yet the High Court was receiving many reviews from the Magistrates'

Court, where Magistrates had convicted minor boys for sexual conduct with minor girls within the age of consent.

4.2 Equality

Section 60(3) of the Constitution could have protected children's SRHR; however, the drafters undermined its potential by inserting a superior right to parents' and guardians' religious and moral choices. Preventing adolescent girls from accessing contraception and family planning information and services based on their age, gender or marital status undermines their right to equality and jeopardizes their capacity to enjoy other rights, including continued education.[26] Despite Articles 2 and 12 CEDAW, Zimbabwe has delayed to rectify the discrimination between married and unmarried adolescents' in relation to access to contraception and family planning information and services, and has failed to make legislative reforms and allocate resources. This position is worsened by the attitudes of health workers that undermine the attainment of SRH for adolescent girls in rural areas in Zimbabwe.

4.3 Right to life

The CEDAW Committee commends Zimbabwe's progress towards SDG 3.1 and 3.7 to reduce the global maternal mortality ratio and ensure universal access to SRH services. However, it has called on Zimbabwe to improve access to affordable healthcare especially in rural areas and to intensify the HIV/AIDS strategic plan and Adolescent SRH strategy (ASRH). The Committee also encourages Zimbabwe to improve adolescent girls' access to SRHR information, education and services by strengthening awareness on SRHR including contraceptive use, mandatory age-appropriate education on responsible sexual behaviour, access to confidential SRHR services, including safe abortion and post-abortion services, and to decriminalize abortion. Forty per cent of girls under 18 are sexually active and 51% buy contraceptives from private pharmacies, which are not prevalent in rural areas.[27] Whereas the 2018 Zimbabwe Report to CEDAW acknowledges a legal gap in adolescent SRHR, this alone is not enough, the Children's Act and Public Health Act must be amended to give effect to these human rights commitments, and resources should be allocated for adolescent girls' SRHR, including contraception and family planning. Denying adolescent girls access to contraceptives based on their age violates their right to life as protected in Article 6 (1) ICCPR.

4.4 Liberty and security of the person

Parents, doctors, nurses, partners and even the government can make decisions about rural adolescent girls' sexuality, but the girls themselves cannot, which undermines their rights to liberty and security of the person.[28] While

section 76 of the Constitution and section 33 PHA stipulate that no person may be refused emergency medical treatment, rural adolescent girls still struggle to access emergency post-coital contraception. Further, section 64 of the Criminal Law (Reform and Codification Act) allows children between the ages of 12 and 16 to consent to sexual intercourse, but section 35 PHA prohibits them from consenting to SRH services which means they cannot buy contraceptives and cannot obtain SRHR-related medical treatment without parental consent. Allowing consensual sex, while denying sexual protection, subordinates adolescent girls in intimate relationships and makes them more vulnerable to early pregnancy and STIs, including HIV.[29] Moreover, limited access to female condoms disempowers adolescent girls from negotiating safe sex, preventing early pregnancy and STIs.[30]

Even in countries like South Africa which provide free condoms in public toilets, male condoms are more available than female condoms, which further disempowers adolescent girls from exercising agency over their own bodies.[31] Despite efforts made by the Joint United Nations Programme on HIV/AIDS in developing the FC2-latex female condom to replace the FC1-polyurethane female condom, the FC2 is still beyond reach of many urban and rural adolescents in Zimbabwe due to its cost, distance and the prohibition of selling contraceptives to children under 16.[32]

4.5 Information

Section 62(1) of the Constitution provides the right to information but, in practice, adolescent girls' access to information is limited on grounds, such as age, marital status, gender and the morality of the attendant health worker, yet, the unconstitutionality of this practice is still to be challenged. Despite Zimbabwe's commitments in Articles 10 (h) and 16 (1) (e) of CEDAW to recognize women's and by extension, adolescent girls' right to SRH information, health workers often refuse to give SRH information, or give incomplete or inaccurate information as noted in Matebeleland.[33] Further, Durojaye notes that often adolescent girls are ignorant about contraceptives, are not allowed by their parents to use them or otherwise cannot afford to pay for them, and in my view this is more so in rural settings.[34] Limiting adolescent girls' access to information on SRH undermines their basic human rights. Without information, adolescent girls are left to make life-changing and in some instances life-taking decisions in the blind.

The 2018 State Report to CEDAW shows that Zimbabwe has made significant efforts to remove barriers to accessing SRHR information for women in rural areas by radio, television, newspaper and/or magazine, mobile phone, and pamphlet and/or poster mediums. The state report further suggests that 'women in rural areas are more likely than those in urban areas to be exposed to family planning messages' (62.6% in rural areas and 34.2% in urban areas). However, hearing about family planning is a long way from accessing these services, especially for adolescent girls in rural areas, and girls in rural areas, especially those

without access to media, and who are orphaned or poor are more likely to have early pregnancies due to the absence of adequate social safety nets.

Whereas the African Commission observes that Zimbabwe protects the rights of young people to knowledge and life skills to prevent HIV infection, the reality is different as sexuality is not taught in schools, is denied by health workers, and is usually not taught in the home, and contraception is denied without parental consent. The Concluding Observations of the African Commission note importantly that Zimbabwe lacks resources to support its SRHR efforts, and has collaborated with development partners, but in the current coronavirus pandemic, donors are likely to pull out as resources become re-prioritized.

4.6 Education on SRHR

In light of CEDAW's recommendation to Zimbabwe to promote SRHR education for adolescents, the government expanded the Zimbabwe National HIV and AIDS Strategic Plan for 2015–2020 (ZNASP III) and the National Gender and HIV Implementation Plan (2017–2020) to every person. ZNASP III identifies negotiation of safe sex, limited access to HIV services, early marriages, transactional sex and the inconsistent and incorrect use of condoms as challenges for adolescent girls. The government also introduced the ASRH Strategy II (2016–2020), and a 'Start Free, Stay Free, AIDS Free' campaign. The second pillar of the campaign is to be able to protect oneself to stay free from HIV infection and live without fear of sexual violence, abuse or exploitation. It is therefore difficult to understand why government has failed to translate these policies into justiciable rights and binding law, despite its policies clearly showing that there is a need and a legal gap.

Unfortunately, in an increasingly urbanized and modern world, the traditional social fabric which acted as a safety net for girls no longer exists for the most part. For example, traditionally, paternal aunts, '*tete*' and maternal uncles, '*sekuru*' played an important role of providing basic sexual education by availing themselves to assist adolescents with questions about sexuality. Like other African countries, many adolescents are unable to ask their parents for guidance on sexual matters, as it is perceived as offensive and culturally inappropriate.[35] Together with the hostility of health workers towards adolescent girls, there is an enormous void when it comes to adolescent girls' access to SRHR information and education.

4.7 Health

In addition to Article 24 (2) UNCRC and in line with Article 14 (f) Maputo Protocol, which requires states to develop preventive health care including family planning education and services, the Concluding Observations of the CRC to Zimbabwe have urged the government to introduce mandatory age-appropriate HIV/AIDS and SRH education. This was also recommended by the CEDAW Committee's 2020 Concluding Observations to Zimbabwe. It

is concerning that the African Commission's last Concluding Observations to Zimbabwe (2007) do not mention adolescents, or SRHR at all. The closest comment is the recommendation for Zimbabwe to review the application of statutory and customary laws to ensure that there are adequate safeguards to protect the human rights of women and girls.

Section 70 Criminal Law (Codification and Reform) Act, prohibits sexual intercourse with a person under 18, and under strict circumstances provides reprieve for sexual intercourse with a person over 16 years. This provision has become an additional barrier to health workers who would otherwise be inclined to provide contraceptive services to adolescents for fear that they may become complicit to the criminal act of rape.[36] Section 5 TPA also makes it harder for doctors to help adolescents for fear of prosecution. While section 39 PHA requires confidentiality, it is evident from studies in Masvingo that health workers violate adolescents' right to confidentiality of their SRH information.

Feltoe argues that sections 33 and 35 PHA, which require parental consent for medical treatment, puts doctors in a difficult position especially in emergencies where parental consent cannot be obtained. General Comment 4 CRC reinforces the principles in General Comment 3 CRC on the state's duty to protect the rights of adolescents to medical treatment without parental consent and to ensure privacy of their information.[37] He notes that should a medical doctor act without this consent, he or she could rely on the defence of necessity, but in my view, it is difficult to imagine a doctor opting to risk breaking the law in order to help an adolescent, who is seen as a 'child' who has 'misbehaved'.[38] Feltoe notes that in reality health workers are not likely to provide contraception in the absence of parental consent. At the same time, adolescent girls may fear telling their parents that they are sexually active, and may resort to unprotected sex, risking STIs and pregnancy, and eventually resorting to unlawful 'back street' abortions.[39] The fact that global HIV-related deaths among adolescents between 10 and 19 years of age significantly increased from 21,000 in 2000 to 60,000 in 2014, but has dropped among other age groups, illustrates that adolescents are falling through the cracks.[40]

Other jurisdictions have dealt with this dilemma decisively. For example, in the English case of *Gillick v West Norfolk and Wisbech Area Health Authority*, the Department of Health issued a circular that allowed doctors to provide SRH services to minors without parental consent in limited circumstances. Mrs Gillick sought to have the circular declared unlawful. However, the House of Lords found it lawful, concluding that a medical doctor can provide contraception to a minor below the age of 16, provided the minor is sufficiently mature to understand the implications, and specifically that the doctor is satisfied that:

- The girl who was under 16 would understand the medical advice;
- The doctor cannot persuade her to inform her parents or to allow him to inform the parents that she is seeking contraceptive advice;

- The girl is very likely to have sexual intercourse with or without contraceptive treatment;
- Unless the girl receives contraceptive advice or treatment her physical or mental health or both were likely to suffer;
- Her best interests required the doctor to give her contraceptive advice or treatment or both without parental consent.[41]

As Zimbabwe's legal system is founded in English and Roman-Dutch law, it is likely that the *Gillick* case may be relied on in Zimbabwean courts should the matter arise. A definitive legal position would clarify the uncertainty of whether a nurse or doctor who provides contraception to an adolescent is guilty of contravening section 70 of the Criminal Law (Codification and Reform) Act.

This courts' approach to apply the maturity test is a step forward in promoting access to SRH information and services by adolescent girls, although even this is not sufficient. A more desirable approach is perhaps that taken by South Africa, which gives adolescent girls autonomy over their sexuality and reproductive choices. Section 134 of the South African Children's Act protects the confidentiality of minors, and prohibits the refusal to sell condoms or give condoms (when provided free of charge) to children over 12 years old. For other contraceptives, children over 12 must be given proper medical advice and medical examination to determine whether there are any medical reasons to deny the specific method of contraception.

Obtaining parental consent is problematic for some adolescents due to their parents' religious convictions. For example, the CRC noted that members of apostolic churches in Zimbabwe bar their children from seeking medical attention, causing high maternal mortality among adolescents. The CRC also raised concerns about the high rate of sexual violence, early pregnancy, child marriages and resultant school dropout, restrictive abortion law and parental consent as posing major challenges for adolescent girls. The CRC has urged Zimbabwe to take immediate measures to stop sexual violence, reduce maternal mortality resulting from teen abortions by ensuring children's access to safe abortion and post-abortion care, provide SRHR education as part of the mandatory school curriculum and more importantly to ensure alignment of the Constitution and legislation.

Finally, although sections 29 and 76 of the Constitution protect the right to health including SRHR and require the state to take 'all practical measures' to provide basic accessible and adequate health services', it is my argument that the government has not taken 'all practical measures' as it has not amended legislation to reflect this constitutionally entrenched right.

5 Conclusion and recommendations

While Zimbabwe has done well to introduce SRH programmes through national strategies and especially through the ZNFPC, more must be done

towards protecting, promoting and fulfilling adolescent girls' right to access SRH information, education and services, particularly contraception and family planning, especially in rural areas. Moreover, as national policies such as the National Health Strategy and the NFP expire in December 2020, the state must evaluate the gains and losses under the current national strategies in order to develop more beneficial strategies for the future, taking into account the recommendations of the African Commission, CRC and CEDAW Committees.

The biggest drawback of the constitutional protections of the rights of adolescents are first that adolescents are recognized only as children and as asexual and secondly, the SRHR-related protections have claw-back provisions. For example, section 52(1) of the Constitution, which protects every person's right to security, including the right to make decisions about reproduction, is immediately cancelled by s52(3) which subjects this provision to other provisions in the constitution.

The fact that the PHA and Children's Act are blind to the sexuality of adolescent girls shows huge dissonance between the political rhetoric in the policies around SRHR such as the HIV and ASHR strategies on one hand, and the enforceable legislation, such as the PHA and Children's Act on the other hand. It also shows that current legislation must be updated to comply with the 2013 Constitution.

The state must allocate adequate monetary and non-monetary resources to improve rural adolescent girls' access to SRHR, including information, education and services as required in Article 14 (2) of the Maputo Protocol and Article 21 CEDAW General Recommendation 21.

The government must stop giving lip-service to the needs of adolescent girls and start re-writing the law. Guidance can be taken from the *Gillick* case and from the South African Children's Act to guard rural adolescent girls' autonomy and bodily integrity, and to protect their SRHR. Finally, government must introduce age-appropriate sexuality education.

Notes

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6 It takes two to tango!: The relevance and dilemma of involving men in the realization of sexual and reproductive health and rights in Africa

Sibusiso Mkwananzi

1 Introduction

Over the years, efforts have been made to ensure the inclusion of men in policies and programmes towards the realization of sexual and reproductive health and rights in Africa. While the road has been strewn with thorns, modest progress has been made. Experience has shown that the enjoyment by women and girls of their sexual and reproductive health and rights as enshrined in international, regional and national documents may not be possible unless men are viewed as partners in this effort. Often men are regarded as the culprits with regard to the violations of the sexual and reproductive health and rights of women and girls in the region. It is often argued that due to power imbalance and the patriarchal nature of most African societies, men have remained the privileged sex that continue to benefit from this lopsided structure. However, men can equally become important allies in transforming behaviours and advocating for change in societal practices that can advance the sexual and reproductive health and rights of women.

Against this background, this chapter examines the factors that continue to predispose women and girls to sexual and reproductive ill-health in Africa. Using South Africa as a case study, it discusses some of the benefits of involving men in policies and programmes towards the realization of the SRHR of women. In addition, the chapter identifies some of the challenges that may arise in attempting to involve men in programmes to realize SRHR of women. The chapter makes some useful suggestions on the way forward.

2 Normative framework on sexual and reproductive health and rights

Sexual and reproductive health and rights are not new sets of rights; rather they are found in existing international and regional human rights instruments.

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For instance, Article 12 of the International Covenant on Economic, Social and Cultural Rights (CESCR) states that all individuals have 'the right to the enjoyment of the highest attainable standard of physical and mental health'. Sexual and reproductive health and rights refer to optimal wellbeing and independence of your body's reproductive system as well as timing, ability, conditions and decision to reproduce.[1] Specifically, the Committee on Economic, Social and Cultural Rights (CESCR) has developed General Comment 22 on sexual and reproductive health and rights (SRHR) as part of Article 12 and recognizing these as fundamental human rights. Although these rights should have been enjoyed by women as well as men, historically this was not the case, as sexual and reproductive health focused on population control, and thus was linked largely to the policing of women's bodies.[2]

In response, several international norms and standards were developed to ensure women had rights to equality, bodily autonomy, decision making regarding SRHR matters and safety with respect to gender-based violence.[3] These progressive international norms included Articles 16 and 10 of the Convention on the Elimination of All forms of Discrimination against Women (CEDAW) that ensures women have equal rights to deciding 'freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights' and the right to education should encompass 'access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning', respectively. Additionally, general recommendation 24 of CEDAW states that nations emphasize the 'prevention of unwanted pregnancy through family planning and sex education', general comment 14 of the CESCR highlights the inclusion of safe pregnancy and childbirth in ensuring a right to health and the Beijing Platform for Action of 1995 concluded that 'the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence'.[4] To this end, a stark priority was placed on the specific rights pertaining to women as a marginalized group in most societies, with women disproportionately becoming the focus as well as bearing the responsibility of SRHR in homes and society.[5] As a result, men seem to have been unintentionally and systematically excluded from this process.

The 1994 Cairo ICPD Conference and Sustainable Development Goal 15 highlight the importance of including men in improving sexual and reproductive health and right (SRHR) globally and this has led to this need being widely accepted by advocates, educators and policy makers.[6,7] Interventions involving men and boys as crucial partners in improving SRHR across society effectively have accordingly increased globally over the past decade.[8] However, rates of male partner involvement as well as health-seeking behaviour of men and boys remain low worldwide.[9] For example, in Southern Africa few men accompany their partners to access sexual and reproductive health services, and HIV testing rates in this group is lower than 50%.[10] South African rates of male

partner involvement and health-seeking behaviour among men and boys remain some of the lowest in the country.[11] Snow et al (2010)[12] showed that in rural South African settings, women went for HIV testing at three times higher levels compared to their male counterparts. Additionally, the study by Mohlala et al. (2011)[13] demonstrated that these challenges occurred regardless of the rural-urban divide, as even in South Africa's urban Cape Town, none of the participant men accompanied their partners to clinics for antenatal services before the intervention. However, this rose to one in three men after the intervention implementation.

South Africa has an estimated population of 57.7 million people, with 49% of this composing of males.[14] Although the country fares better developmentally than its counterparts within the Southern African region, some social and reproductive health challenges still remain nationally.[15] The unemployment rate has been found to range from 20% to 30% depending on geographic location.[16,17] Additionally, although the country's fertility levels have steadily decreased to a total fertility rate (TFR) of 2.4 children per woman currently, this varies greatly by race, and adolescent fertility remains rather high at 50 births per 1000 of 15–19-year-old women.[18,19,20,21]

South Africa has the highest levels of HIV globally with 13 in every 100 individuals (7.52 million) living with HIV.[22] Correspondingly, there are 1.4 million AIDS orphans nationally, 7% of who live in child-headed households, and only one in three children live in households with an employed adult.[23] Many children in South Africa live without their biological father – a direct continued effect of apartheid. Levels of absent yet living fathers rose to 48% in 2009.[24] Research has shown that South Africa has one of the highest levels of gender-based violence in the world.[25] Jewkes et al[26] found that one in five young women had encountered more than one incident of physical or sexual intimate partner violence.

In 1994 the reproductive health task force first discovered in their assessment of national sexual and reproductive health (SRH) services that such services do not include men.[27] Subsequently, the South African government and non-governmental organizations have created numerous policies and programmes to ensure the inclusion of men and boys in SRH services. For instance with specific reference to HIV services the South African National Strategic Plan on HIV, STIs and TB (NSP), National Action Framework (NAF) for 'No Child Born with HIV by 2015 & Improving the Health and Wellbeing of Mothers, Partners and Babies in South Africa' and 2010 South African national PMTCT guidelines all directly or indirectly refer to the inclusion of women's partners. Nevertheless, much still needs to be done nationally, as South African studies have shown that women are still more likely than men to attend clinics and initiate treatment after being diagnosed with HIV.[28,29] Therefore, it is important to explore the challenges that surround this important move.

This chapter aimed to describe:

1. What previous studies have found are the benefits and difficulties of involving men in SRHR work

2. The challenges that underlie men being 'left behind' in conversations and advancement of SRHR
3. Ways in which men could be involved in SRHR work

3 Effects of involving men in SRHR

The first question becomes why does the inclusion of men in sexual and reproductive health remain important? For the purpose of this chapter, involving men in SRHR is limited to the individual level. Also, the chapter only provides examples and implementation of involving men in SRH work that encompasses prevention of sexually transmitted infections (STIs) including HIV, prevention of maternal mortality, anti-gender based violence (GBV) initiatives as well as contraceptive use. Previous studies from developing countries have shown large bodies of empirical evidence to suggest that involving men (i.e. individual partners) in SRHR work has advantages as well as disadvantages for the men in question, their partners, the couple as a unit and even subsequent offspring as will be discussed further below.

3.1 The advantages of involving men

Benefits for men incorporated in South African and Ugandan programmes aimed at engaging them on sexual and reproductive health matters include less risky sexual decisions that encompass increased condom use, delayed sexual debut as well as a decreasing likelihood of multiple concurrent sexual partners.[30,31,32] Additionally, Reddy et al (2014)[33] established that involving men in reproductive health decisions led to the prevention of STI & HIV/AIDS and improved reproductive health of men in such programmes in South Africa.

Nevertheless, the effects of including men go beyond the individual male included, having advantages for their partner as well. Such partner gains encompass increased support of their partner's needs and higher levels of escorting of partners to clinic to access SRH services including termination of pregnancy management as evidenced in Uganda and Asia.[34,35] Overall increased levels of maternal health have also been shown to occur through men's participation in Malawi resulting in increased uptake of antenatal and postnatal care, birth preparedness, lower maternal workload while expecting and decreased maternal stress.[36] Another dimension to partner benefits are the added advantages that come with changed attitudes amongst men that promote gender equality and decrease tolerance to gender based violence that can lead to increased enthusiasm and conscientiousness towards conducting domestic chores as shown in the East African study.[37] Similarly, in Iran most studies testing the influence of men's awareness and involvements have shown a positive effect on women's SRH.[38] Another evaluation of initiatives that included men in Sierra Leone, Cote d'Ivoire, Liberia and the Democratic Republic of Congo (DRC) found reduced levels of gender based violence (both sexual and physical forms) as well as improved views on men's use of violence.[39] Although such an advantage is immediately experienced by one's partner, greater society could also

subsequently benefit from these changed attitudes. Therefore, it becomes particularly important in the context of South Africa where 20%–40% of women (depending on locality) have experienced some form of violence in their lifetime.[40]

Gains for the couple have also been suggested as Zamawe et al. (2015)[41] showed that engagement of men was associated with increased use of family planning and contraceptives in Malawi. Similarly, a higher likelihood of open discussion with partners about reproductive planning and decision making were said to occur in Uganda after engaging men on SRHR matters.[42]

Benefits for the children born include higher levels of child health with reduced likelihood of preterm births, low birth weight, foetal growth restriction and infant mortality.[43] This may be linked to the ability of male engagement to increase access and uptake of new-born and child health services as shown in rural India.[44] Additionally, Reddy et al (2016)[45] in Asia showed that men who were involved in reproductive health decisions have a stronger bond with their offspring. This of course has been determined to have future benefits for the child regarding self-esteem, confidence and the ability to achieve better life outcomes in general.[46,47] Thus, what can be deduced from the discussion here is that involving men in SRH issues can boost family bond and congeniality thereby advancing the realization of women's rights as well as enhancing their reproductive autonomy and bodily integrity.

Despite the benefits of involving men in SRHR matters, it is important to ensure that this does not undermine women's rights to choice and autonomy. In essence, while it is desirable for men to be involved in decision-making relating to SRH, women should still be accorded the autonomy to decide whether to involve their partners on this issue. Thus, questions may be asked: what should happen when women do not want their male partners involved? Where should the line be drawn to ensure that the rights and responsibilities of both parties engaged in sexual relations are honoured? Some of these issues are discussed in the next section.

3.2 The difficulties of involving Men

Despite the advantages of involving men in SRH matters as discussed above, there are some challenges associated with this. As scholars and programme implementers, it is evident that involving men in SRHR is important, yet this continues to be conducted in exceptional cases. Beyond the dilemma occurring among scholars and programmers, previous work in different settings has also highlighted some difficulties to involving men in SRHR. These include:

First and foremost traditional gender norms exist at the societal level.[48] These reveal themselves through men not being interested in their own SRH or that of their partners as the subject is generally regarded as a 'woman's issue'.[49] Research in South Africa has reported that even when men want to be involved they may be scrutinized and giggled at by other female clients, reprimanded and chased out by health workers on site, as well as made to

feel uncomfortable by male-unfriendly clinic environments.[50] The restrained contraceptive, health service delivery and reproductive health awareness campaign options specifically designed for men in Uganda further exacerbate these problematic societal norms.[51] Therefore, addressing this challenge will require community-wide education as well as more resources for the shifting of social and institutional gender norms.[52] The examples from above highlight the need for institutional buy-in for the accommodation of men in SRH issues in order to decrease stigma. Additionally, clinic and hospital staff members exhibiting discriminatory practices and prejudices against male partners may invariably be infringing their rights to dignity, equality and freedom.

Over and above societal norms are masculine-related convictions, beliefs and attitudes that prevent HIV testing, treatment and care among men, hinder the involvement of men in SRH services as well as promote negative views about family planning.[53] Many of these views stem from cultural and traditional patriarchal paradigms that disallow men to show signs of weakness, uncertainty, loss of confidence and vulnerability.[54] This can even lead to an inability among some men to share their emotions in all-male environments making the creation of safe male dialogue platforms difficult.[55,56] To address these gender biases, it is necessary to reform school curriculum on SRHR so that rights and responsibilities are assigned to both girls and boys at an early age.

Over and above this, the reforming of societal and individual masculine-related norms will require the focus of women in national policies and health systems across Africa to change. Mullick et al. (2005)[57] suggest that successful male involvement will occur as health infrastructure addresses questions of accommodating employed men, the unmet need of male contraceptive methods, men-friendly SRH services as well as designing comprehensive health packages that couples and families can attend simultaneously. Lack of access to SRHR services for men results in a systematic violation of the right to SRHR that is in breach of a state obligation under international law. Therefore, it is important that an enabling policy environment be created to encourage and support the presence and participation of men in SRH. This would also need to include a possible change in the language of SRH messaging in order to make it less centred on women. All individuals are accorded the right to information, including information for correct decision making as regards SRH.

4 Challenges that underlie not involving men in SRHR work

The second question that arises is that in spite of the above advantages, why does a reluctance of including men in SRHR work still exist? The general notion seems to be that SRHR scholars and programme implementers want to include men, but do not want to end up regretting this stance. Numerous elements of this notion could answer the question stated for this section, and the next section unpacks a few of these as well as attempts to give solutions as a means of progressing forward.

The concern that comes to mind initially is the fear that involving men may change largely female-led and pro-partner SRHR current work into male-led, pro-man SRHR campaigns. This would lead to SRHR work losing its drive to promote women's health and rights and the objectives for having started such programmes that involve men will no longer be achieved. For example a ten-year study evaluating programmes that engaged men in groups in Sierra Leone, Cote d'Ivoire, DRC and Tanzania, showed a consistent straying from violence against women and girls to discussions on the struggles that men face. Facilitators also found it difficult to sway the focus back to its primary aim.[58]

Slightly related to the point above is the notion that if SRHR work is to include male leaders and train them up to be advocates in this field, what if they are then found to be in violation of the very principles that they were advocating for? This concern is rather valid as seen in the recent case of a prominent advocate of women's rights who was accused of sexual harassment, sexism, transphobia and homophobia.[59] Similarly, this challenge occurred when transformative gender programmes that aimed to involve men in West, East and Central Africa led to male domination of mixed-group discussions, silencing of women as well as facilitators struggling to address verbal and mental resistance from male participants. In response to these first fears, possibly the onus is on us as female advocates of SRHR to ensure not only that we lead programmes that involve men, but that we monitor and stay attached to such programmes for as long as possible so as they adhere to the original ethos of the programme's spirit of being pro-partner if male advocates have been capacitated to lead such sessions. Additionally, we can never be completely sure of people's character, be they male or female, and hence this is a risk we are going to have to take as we embark upon this journey. Knowing the risk in advance though may assist us to ensure that we catch any worrying signs earlier on, and it is comforting to know that such cases are rather the exception than the rule in the field of SRHR advocacy work.

The hashtag movements of #metoo and #churchtoo, where over the past year there has been a rising level of women, men and boys coming forward and speaking against widespread outcry against sexual harassment and violence in the film industry as well as the church, has revealed how widespread the abuse of power is. The alleged perpetrators in the above scenarios occupying these positions of power have largely been men. However, maybe such programmes could be opportunities to change the mind-set of powerful men to see the importance of SRHR personally for themselves and to become actively engaged in the well-being of their partners and their reproductive health. This could possibly lead to a drop in gender-based violence and increase gender understanding. Additionally, as structural drivers have been repeatedly identified as the factors that hinder gender equality and SRHR health, men in positions of power could use the resources and influence available to them to ensure effective redress. An example of this having worked well is the training and education of traditional chiefs and municipal leaders in Zambia in child marriage, that has led to the criminalization of it and more cases of child

marriage being addressed at local traditional courts with subsequent reporting to and arrest by police.[60,61] Hence, it becomes no surprise that child marriage is on the decline even in rural areas in Zambia.[62,63]

Also, some male scholars and programme implementers may ask: to what extent would men be involved, as many feminist researchers have shown tendencies of no longer wanting to engage with men in an attempt to deconstruct patriarchal systems and ideologies? The approach of including men is in fact a feminist stance due to it advocating for gender equality education and awareness among men. Additionally, it is important to note that feminism has never been against men, but rather has advocated against the unfair treatment of women regardless of race, culture, age, etc.[64] Additionally, the approach of educating on gender equality is not about emasculating men but rather discouraging hegemonic and aggressive masculinities to decrease violence perpetration as well as risky sexual behaviours. However, caution should be taken in order not to overemphasize this element in the pursuit of progressive and transformative masculinities. How do men and boys enter this SRHR debate? Is it our desire to label them as the problems or as part of the solution? As scholars and programme implementers, we will have to decide carefully how to frame men in the SRHR conversation in order to keep them as willing allies. It is imperative that we do not alienate men, particularly in African contexts through problematizing manhood and all aspects of masculinity.

The same goes for problematizing culture too harshly. SIHA (2016)[65] speak of 'In many African societies, challenging masculinities and negative male norms can meet with resistance and taboo'. The secret statuses accorded to these rituals also 'mystify' masculinity and may contribute to the normalization of men's violent behaviour towards women. Furthermore, there are incredibly misogynistic ideologies attached to the defence of certain traditional rites (of passage) and rituals practiced by and on men. It is important not to throw out the baby with the bathwater in such cases as are mentioned here. Rituals associated with the rites of passage into adulthood are performed for men and women in African cultures.[66,67] Additionally, the rituals themselves do not make men violent, but rather it is the teachings and messages that accompany the rituals which may promote misogyny, the performance of hegemonic masculinities and subordination of women. Therefore, eliminating traditions completely is a rather colonial approach and should not be advocated, rather we need to remember that culture is forever evolving and therefore allows leeway to be adapted to be less harmful when the appropriate steps are taken.

Finally, the question can be asked at what cost do we have to include men and is this the smartest approach to use? It is important to involve men without excluding other activities. In other words, this should be added as one of the strategies that we pursue to ensure SRHR for women without abandoning those already present. Particularly, the idea of replacing women-geared programmes with men-geared programmes is dangerous. Indeed it is the other side of the relationship; however, the approach may assist researchers to reach more relationships as well. be they same-sex or heterosexual relationships. Additionally,

a feedback mechanism where good and bad components of programmes are reported back to the implementers will be useful to determine where modification of programmes is necessary. Consequently, despite the above numerous challenges being valid and making it understandable why female scholars and programme implementers may deliberately choose to exclude men in their work, a strong case can still be made for including men in SRHR.

5 The way forward

5.1 Ways in which men can be involved in SRHR work

The last question then becomes in what ways could men be involved in SRHR work? There are three areas to consider as proposed by the male involvement model of Greene et al. (2006).[68]

Men as clients: this component argues the need to increase the number of men accessing SRH services. Ensuring the presence of sexual and reproductive health infrastructure that targets men, including policies, services and opening hours is vital. Such services should incorporate: SRH knowledge, family planning, HIV and other STI testing, VMMC, urologist referral for complicated cases as well as prostate check-ups.

Men as partners: this component argues the need to educate and increase awareness among men to ensure optimal SRHR for their partners. Although women remain the custodians of decision-making regarding their bodies since they enjoy autonomy, men can be empowered to take up supportive role. This involves advocacy and education via workshops, posters and community dialogues to change gender inequitable attitudes and perceptions among men; this would eliminate the tolerance of violence against women and teach men the SRH rights that women have (external and internal to relationship). This aspect aims to increase: communication about sexual decision-making and choosing family planning options, supporting women's initiation of contraception, escorting their partners to access SRHR services and antenatal care as well as postnatal care. In as much as men are partners in this process, the ultimate and final decision lies with the woman in accordance with the rights of women to equality, dignity, and respect for private life, without discrimination by the OHCHR.[69]

Men as advocates of change: this element argues the need to educate and increase awareness among men that supports men to mobilize other men's involvement in sexual and reproductive health.

6 Conclusion

The opportunity to include men in sexual and reproductive health and rights advancement of women remains full of positive rewards. This article has attempted to show the benefits and challenges, reasons for reluctance as well as possible ways that the move could be implemented on the ground. Risks may

still occur as shown in the paper. However, the benefits seem to far outweigh these and hence programmes should be modified for contextual factors as they are implemented in various African settings. Zusak (2018)[70] states that 'Like everything else worth fighting for in our lives, the idea of raising good men feels to me like something that never ends. It will to and fro between triumphs and failures…' This is the attitude that we need to have as we continue to include men in SRH services. It is important to acknowledge and accept that things will not happen rapidly, as attitudes and behaviour change are slow processes regardless of gender.[71] Nevertheless as the title of this chapter rightly states, it does take two to tango. Heterosexual relationships do not involve women alone. Consequently, it is when we include men consistently in SRH service conversations and work that there will be strides in changing mind-sets and behaviour to achieve optimal sexual and reproductive health and rights for women and men in sub-Saharan Africa.

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7 Positive approaches to childhood sexuality and transforming gender norms in Malawi

Godfrey Dalitso Kangaude

1 Introduction

Adolescence is a critical stage of human development. The decisions made, and behaviours formed at this stage, have a lasting impact on the life trajectory of an individual.[1] Gender norms shape the experience of biological changes associated with puberty such as the development of secondary sexual characteristics and the social changes associated with new roles ascribed at the emergence of adolescence. These gender norms shape social behaviours of adolescents including how they form social relationships and engage in sexual practices, and later reproductive practices. The Global Early Adolescent Survey (GEAS), also implemented in Malawi, showed that gender norms begin to exert a strong influence on very young adolescents (VYAs) from the age of 10.[2] Behaviours and practices appear during adolescence that differentially shape the developmental trajectories of boys and girls. Girls experience mortality and morbidity related to reproductive health such as complications of early pregnancies and unsafe abortions. Boys, on the other hand, experience a different set of challenges such as road injuries and interpersonal violence.[3] However, girls are more likely than boys to experience harmful practices such as child marriage, human trafficking, and all forms of gender-based violence including physical, sexual and emotional violence. Gender inequitable norms underlie this disproportionate distribution of sexual and reproductive health burdens between boys and girls.

Most societies including in Malawi perceive children and VYAs as asexual or assume that sex and sexuality do not matter to children.[4] When adolescents begin to express sexual and romantic interests, parents react with anxiety and fail to communicate openly with their child about sex and sexuality, or are mostly worried about the negative consequences of sexual activity for girls.[5] Because gender and sexuality are inextricably linked, failure to positively and openly communicate with adolescents about sexuality also implies that gender inequitable norms that shape early relationships in adolescence are not addressed.[6] For instance, the GEAS revealed that romantic relationships between VYAs in Malawi are common, but there is already a high prevalence of intimate partner violence (IPV).[7]

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Inequitable gender norms consolidate when adolescents start to experience sexual feelings and engage in sexual relationships.[8] Evidence suggests that early adolescence is an opportune time to encourage positive sexual practices and gender-equitable norms, and this has immediate benefits but also over the life course.[9] An important prerequisite, therefore, is to recognize children and adolescents as evolving sexual beings. A positive approach toward childhood sexuality is critical to addressing gender inequality which would also contribute to improved sexual health and wellbeing beyond adolescence.

The global agendas to address gender inequality and promote human and child rights motivate this chapter. The following highlight from paragraph 7.34 of the Program of Action (PoA) of the 1994 International Conference on Population and Development (ICPD) is especially salient:

> Human sexuality and gender relations are closely interrelated and together affect the ability of men and women to achieve and maintain sexual health and manage their reproductive lives. Equal relationships between men and women in matters of sexual relations and reproduction, including full respect for the physical integrity of the human body, require mutual respect and willingness to accept responsibility for the consequences of sexual behaviour. Responsible sexual behaviour, sensitivity and equity in gender relations, particularly when instilled *during the formative years* (emphasis supplied), enhance and promote respectful and harmonious partnerships between men and women.

This exhortation of the ICPD PoA is read with aspirations articulated in Sustainable Development Goal 5 of United Nation's (UN) Agenda 2030 which calls on states to achieve gender equality and to empower women and girls. It is also read with Goal 17 of African Union's (AU) Agenda 2063 to achieve gender equality in all spheres of life. The African Committee of Experts on the Rights and Welfare of the Child (ACERWC) published Africa's Agenda for Children 2040, describing ten aspirations based on recognition of the role of children in shaping Africa's development, and therefore, the importance of protecting and realizing the rights of children.

Malawi has ratified human rights treaties including the United Nation's Convention on the Rights of the Child (UNCRC), the African Charter on the Rights and Welfare of the Child (ACRWC), the Convention on the Elimination of All Forms of Violence Against Women (CEDAW), and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol). Malawi has also taken steps to address gender inequality by enacting laws such as the Gender Equality Act (GEA).

Based on the evidence from the GEAS of the influence of gender norms on VYAs, Promundo and the College of Medicine (Malawi) developed a curriculum aimed at transforming gender inequitable norms for VYAs including in interpersonal relationships.[10] In a similar vein, this chapter draws upon evidence and insights from the life course perspective of individual development, and is inspired by Malawi's obligations and commitments under international

law and regional and global agreements, to discuss positive approaches to childhood sexuality to address gender inequitable norms for children and VYAs.

2 Understanding the sexual and gendered world of the child and adolescent

2.1 Gender, sexuality and the life course

A life course perspective conceptualizes individual life courses as composed of multiple and simultaneously occurring interdependent trajectories through various dimensions of life such as sexuality, family and work.[11] A trajectory is a pathway through one's life extending from birth to death, and is made up of a sequence of life events and transitions. An event is a relatively abrupt change or occurrence, for instance, first sexual intercourse, while a transition is a gradual change from one social role to another, for example, from childhood to adolescence.[12] The life course has contributed to understanding sexuality development in the transition from childhood to adolescence.

First, early sexual experiences influence sexual attitudes and behaviour at a later stage in life, for example, it has been shown that coercive experiences at sexual debut are associated with sexual risks in the life course.[13] The period of adolescence can cushion against or exacerbate childhood experiences, allowing for accumulation of prior advantage or disadvantage, thereby launching the adolescent into a sexual health trajectory that is on one hand unique for the individual, and on the other hand shares common characteristics with the trajectories of peers.[14]

Second, an individual's sexual biography is shaped by social, cultural and historical forces. For instance, to appreciate the social attitudes toward sexuality of adolescent girls in Malawi, one should understand the complex interaction of colonial laws, religious beliefs and social norms.[15]

A third insight is that life is not determined entirely by external forces. Individuals do exercise agency to determine their trajectory, because 'young people select into personal experiences, interpersonal relationships, and social settings in ways that reflect their past and contribute to their futures'.[16] Individuals may be influenced by external forces, but they are also self-determining and responsible for shaping their sexual and gendered behaviours.

Finally, gender and sexuality are mutually constitutive in the life course. As Carpenter and Delamater has stated: 'Throughout the life course, transitions in an individual's sexual and sexual identity trajectories will affect his gender trajectory, even as the gender-related transitions that he experiences help to construct his sexual and sexual identity trajectories'.[17] A good example is that boys learn to associate masculinity with sexual prowess so that sexual aggression is perceived as a mark of manhood.[18]

2.2 The invisible process of learning sexuality

Most adults believe that sexuality (and gender) does not concern children until they are older.[19] Most parents have difficulty in communicating expressly with

children and adolescents about sex and sexuality.[20] However, as shall be further explored later in the chapter, communication about sex and sexuality between parents and children also takes place invisibly. In fact, people invest in or legitimize particular power relations without being conscious of or being aware of their actions.[21] As Pierre Bourdieu has put it, '[i]t is because subjects do not, strictly speaking, know what they are doing that what they do has more meaning than they know'.[22] Parents and adults, both intentionally and unawares, instil in children norms and values that influence early sexual behaviours and practices, and relationships of power.

This part of the chapter draws mostly from Simon and Gagnon's *Sexual conduct: The social sources of human sexuality* in which they explain how this social learning takes place leading to the emergence of sexual identity at adolescence.[23] The authors make an important point that adolescence is linked to the preceding stage of infancy because 'we do not become sexual all at once at puberty; there is a significant level of continuity with the past'.[24] Experiences occur in infancy, even before the acquisition of language, that influence sexuality development later in the life course. These experiences are not necessarily sexual in character because they will influence other aspects of the infant's development in addition to sexual development.[25]

According to Simon and Gagnon, there are two important experiences in the years running up to puberty that influence development of sexual identity:

> The first of these is the pattern of naming the child's behaviors in general and the specific adult reaction to behaviors that are conceived to be sexual. The second is the continued building of conventional gender identities based on preverbal social decision about the gender of the child.[26]

In these experiences, parents and caregivers play a significant role in the child's learning process. Parents tend to be reactive when dealing with the behaviour of a child interpreted by the parents as sexual. Parents react to cues such as use of words or actions of the child which they read or define as sexual. Parents employ several strategies as a response to what they perceive is sexual behaviour. They may 'describe the behavior as sexual and say that it is wrong, may mislabel the behavior, describing it as something it may not be, or may nonlabel the behavior by ignoring or providing a judgment without a specific label'.[27] So, for instance, a parent may tell their daughter to 'sit properly' or reprimand her for showing interest in a boy, but would rarely explain to the child the meaning of the parental concerns. When parents take such action that is motivated by their belief about sexuality, they rarely describe it in sexual terms but rather in moral terms using expressions or commands such as 'dirty', 'bad', 'stop', 'good girls don't…', and in so doing endowing the behaviour with moral significance that indirectly shapes its sexual meaning.[28] It is also in the difference in how parents react to boys and girls that the child learns what is appropriate feminine and masculine (sexual) behaviour.[29]

In most cases, the child does not understand or fully understand the meaning of the actions or reactions of adults, because adults perceive the sexual behaviour of the child in adult terms. The child is therefore exposed to 'judgments and responses that follow from the application of a sexual vocabulary that they do not know'.[30] Simon and Gagnon also describe the reverse situation, whereby the child is exposed to sexual vocabulary but without at first associating it with sexuality, for instance, a child might first learn to use the word 'fuck' but only later on learn its sexual meaning. In the process of becoming sexual, therefore, the child on the one hand learns from experiences that are judged in certain ways, but also learns words before experiences to which they refer. This creates a dilemma because '[t]he possession of words, experiences, and judgments, all unassembled, leaves the young child without a vocabulary with which to describe his emerging physical or psychic experiences'.[31] Typically, therefore, information on sexuality during childhood is provided by adults through judging perceived sexual behaviour but without naming it, so that children understand things largely in terms of what they ought not to do. Children adapt by piecing together fragments from these parental moral injunctions and actions which then become the basis for early learning experiences of children which shape children's attitudes and values toward sexuality.[32]

Therefore, parents communicate to children about sexuality and gender in two modes: expressly where the messages about sexuality are explicit, and invisibly through the parents' action or nonaction, and reaction or nonreaction to what they perceive is sexual behaviour of the child. Failure of parents to talk about sexuality to the adolescent is itself communication about sexuality. In most cases, because of underlying beliefs and norms, parents communicate sexuality as negative, especially to girls, so that the child learns to associate sexuality with shame, guilt and secrecy.[33]

2.3 An example of sexual conduct of adolescents shaped by gender norms

Gender inequitable norms learned in the family find expression in school cultures. This section briefly discusses gender discrimination using a study conducted by Muhanguzi in Uganda, in which she interviewed girls and boys about sexual behaviours and practices. The study results revealed that gender norms influence societal expectations creating a double standard for girls. Boys expected that a 'good' girl would show modesty when a boy proposed to her. A girl should not say 'yes' too quickly or enthusiastically because the boys would consider her a slut.[34] In other words, the girl should suppress her sexual desire. However, boys also expected girls to acquiesce to love or sex proposals from boys. Boys would respond with violence and abuse to those girls that resisted their advances. This created a double standard because of the expectation that a girl should simultaneously reject and accept the invitations of the boy.[35] The double standard diminishes the power of girls to exercise choice about sexuality and to negotiate safe sex. It also justifies violence from boys when girls try to assert themselves.[36]

Girls learn sexual passivity early in life.[37] The norm has wide implication, for instance, an evaluation of the Youth Friendly Health Services in Malawi showed that 'many girls who would have requested condoms failed to do so for fear of being labelled sex workers'.[38] Another study in Malawi also showed that parents are biased towards the education of girls because of the belief that girls are sexually weak and would end up being impregnated by boys.[39]

Malawi has put in place various laws and policies to address gender inequality including the GEA. However, to tackle gender inequalities children learn in the parent/child relationship and to positively influence the sexual relationships of adolescents requires that adults first recognize and accept the evolving sexual agency of children and adolescents.

3 Transforming childhood sexuality and gender norms through the legal framework

3.1 The Gender Equality Act and Section 19 rights

Malawi's enactment of the GEA in 2013 is an important expression of its commitment to its obligations to address the negative impact of gender norms. The GEA aims to advance gender equality by prohibiting harmful practices, sex discrimination and sexual harassment, promoting gender non-discriminatory access to employment, education and training, and recognizing sexual and reproductive health rights. In this chapter, the discussion focuses on applying the concept of sexual and reproductive health rights to advance positive approaches to childhood and adolescent sexuality. To achieve this, it is necessary to understand the genesis of Section 19 of the GEA.

Section 19 (1) of the GEA provides that

> Every person has a right to adequate sexual and reproductive health which *includes* (emphasis supplied) the right to
>
> (a) access to sexual and reproductive health services;
> (b) access to family planning services;
> (c) to be protected from sexually transmitted infection;
> (d) self-protection from sexually transmitted infection;
> (e) choose the number of children and when to bear those children;
> (f) control fertility; and
> (g) choose an appropriate method of contraception.

However, the use of the term 'includes' suggests that the list is not exhaustive. But then, what is the expansive list? Further, what influenced the choice of the list? The answer to the first question is in the report on the development of the GEA by the Malawi Law Commission (MLC), the body responsible for developing the GEA. Drawing on various authoritative instruments, the MLC recognized that sexual and reproductive health 'requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of

having pleasurable and safe sexual experiences, free of coercion, discrimination and violence'. Further, '[f]or sexual and reproductive health to be attained and maintained, the *sexual rights of all persons* (emphasis supplied) must be respected, protected and fulfilled'. The MLC defined sexual rights as:

> [A] subset of human rights that are already recognized in national laws, international human rights law and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to
>
> (a) the highest attainable standard of sexual health, including access to sexual and reproductive health care services;
> (b) seek, receive and impart information related to sexuality;
> (c) sexuality education;
> (d) respect for bodily integrity;
> (e) choose their sexual partner;
> (f) decide to be sexually active or not;
> (g) have consensual sexual relations;
> (h) enter into consensual marriage;
> (i) decide whether or not and when, to have children; and
> (j) pursue a satisfying, safe and pleasurable sexual life.

Interestingly, when articulating the list of rights in Section 19 of the draft bill it proposed, the MLC did not use the list under the sexual rights concept it discussed in its report. Rather, it appears to have followed the list under the concept of sexual *and reproductive health* rights as stipulated in the ICPD PoA which emphasizes reproductive health rights. The challenge is that reproduction, and even 'health', are not the main concern for children and VYAs. Early experiences of sexuality are mostly to do with non-reproductive aspects, such as curiosity about their bodies, forming romantic partnerships and non-penetrative sexual conduct. The list of sexual rights that the MLC did not explicitly include in Section 19 such as the right to sexuality education, the right to choose a sexual partner and the right to decide to be sexually active or not, are precisely the ones that are critically important for children and VYAs.[40]

The MLC did not list these sexual rights, most likely to avoid controversy. Conservative and influential groups such as the Holy See adopt the position that sexual rights should not extend to children and unmarried adolescents.[41] Indeed, Malawi and other African countries, have previously rejected the notion of the right to sexuality education when it was proposed by the former UN Special Rapporteur on Education.[42]

Nevertheless, Section 19 of the GEA is progressive for recognizing sexual and reproductive rights. This author argues that Section 19 rights should be interpreted to include the unlisted sexual rights on the basis that this is what the MLC, in proposing the bill that became enacted as the GEA, had intended in conceiving the provision, and this intention was assumed by parliament when it

passed the bill into law. The evidence is in the *travaux préparatoires* that include MLC's report of the development of the GEA. Further, Section 19 deliberately uses the term 'include' to mean that the express list is not exhaustive. This author argues, therefore, that a court interpreting Section 19 could be persuaded to determine that sexual rights are applicable in Malawi and are recognized for every person including children.

Despite Section 19 being progressive, the invisibility of the unlisted rights makes it difficult for them to be accessed and applied. The route to confirm their application would be through the interpretation of a tribunal such as the national courts or treaty monitoring bodies. This chapter will explore what some of the UN and AU treaty monitoring bodies have said regarding childhood sexuality and gender to argue that state and intergovernmental institutions should adopt positive approaches to addressing childhood sexuality and gender.

3.2 Positive discourses on childhood and adolescent sexuality in treaty monitoring bodies

The author reviewed general comments and recommendations issued by UN and AU treaty monitoring bodies, and especially looked for positive language about childhood sexuality, that is, language that recognizes the child as having sexual agency.

Human rights instruments including the UNCRC and ACRWC do not expressly mention sexuality. However, the UN and AU Committees have interpreted and analyzed various provisions relating to childhood sexuality. The dominant discourses about sexuality construct children as powerless and victims.[43] Undeniably, children and adolescents are more vulnerable to sexual harms than adults. However, to address these harms and the underlying norms that fuel these, children should be recognized as sexual beings with an evolving capacity for ethical sexual exploration, negotiation and pleasure.[44]

The UN and AU treaty documents reflect the dominant constructions of child as lacking sexual agency. Few texts use language that acknowledges sexual agency of children and adolescents. Those texts that recognize sexual agency still draw on discourses of victimhood and vulnerability to sexual abuse, violence and HIV/AIDS. Table 7.1 presents some texts from the Committee on the Rights of the Child (CRoC), the African Commission on Human and Peoples' Rights (ACHPR) and the ACERWC that are positive about childhood and adolescent sexuality.

As the table shows, the CRoC has used language that recognizes sexual agency of children such as: 'First sexual intercourse'; 'sexual activity of girls'; sexual behaviours of children that do not conform to societal expectations; deal positively and responsibly with their sexuality; and 'express their sexuality'. The CRoC also requests states to not criminalize adolescents for consensual and non-exploitative sexual conduct.

The AU treaty monitoring bodies have also used some progressive language. The Joint General Comment of the ACHPR and the ACERWC on

Table 7.1 Text from treaty monitoring bodies that constructs childhood and adolescent sexual agency positively

Document	*Text referring to childhood sexuality*	*Location in document*	*Applicable sexual rights*	*Implications for policy and practice in Malawi*
The Committee on the Rights of the Child				
General Comment No 3: HIV/AIDS and the rights of the child.	Adolescents are vulnerable to HIV/AIDS because they may have no proper information and guidance at their first sexual experience. Gender-based discrimination combined with taboos and negative or judgemental attitudes to sexual activity of girls, contribute to limiting access to HIV/AIDS preventive measures and services for girls. States have the obligation to pay careful attention to sexuality as well as behaviours of children even if they do not conform to societal expectations. States should ensure that have relevant, appropriate and timely information, appropriate to their age to enable children to deal positively and responsibly with their sexuality to protect themselves from HIV/AIDS. States should ensure that children are able to acquire knowledge and skills to protect themselves and others as they begin to express their sexuality.	Para. 2 Para. 8 Para. 11 Para. 16 Para. 16	The right to information; The right to sexuality education; The right to access health care; The right to choose their sexual partner; The right to decide to become sexually active or not; The right to equality and non-discrimination; The right to life, survival and development; The right to be heard and participation; The right to have consensual sexual relations; The right to pursue a satisfying, safe and pleasurable sexual life	Sexuality education should start early before children begin to engage in sexual behaviours. In fact, sexuality education should begin in pre-school. The government should work with policy actors to change judgemental attitudes towards the sexuality of girls. The government should work with policy actors to respond positively to children's expression of sexuality and to understand developmentally normal behaviour even if it may not conform to social expectations. Social expectations sometimes reflect gender inequitable norms such as views that girls are sexually passive than boys. Policy actors should dialogue with adolescents about sexuality and not just impose their views based on social and cultural expectations. The government should conduct research with children as partners in the research, to understand how gender inequitable norms influence adult views about childhood sex and sexuality. Policy actors should consider the thoughts and views of adolescents about sex, sexuality, and love, and take seriously their romantic interests and sexual pursuits. The government should decriminalize adolescent consensual sexual behaviours but maintain protections of adolescents from relationships that are potentially exploitative.
General Comment No 20: On the implementation of the rights of the child during adolescence.	States, in dialogue with adolescents themselves, should promote environments that acknowledge the intrinsic value of adolescence and introduce measures to help them to thrive, explore their emerging identities, beliefs, sexualities and opportunities, balance risk and safety, build capacity for making free, informed and positive decisions and life choices, and successfully navigate the transition into adulthood. In accordance with article 12 of the Convention, States parties should introduce measures to guarantee adolescents the right to express views on all matters of concern to them, in accordance with their age and maturity, and ensure they are given due weight, for example, in decisions relating to their education, health, sexuality, family life and judicial and administrative proceedings. States parties should take into account the need to balance protection and evolving capacities, and define an acceptable minimum age when determining the legal age for sexual consent. States should avoid criminalizing adolescents of similar ages for factually consensual and non-exploitative sexual activity	Para. 16 Para. 23 Para. 40		

The African Commission on Human and People' Rights and the African Committee of Experts on the Rights and Welfare of the Child				
Joint General Comment of the African Commission on Human and Peoples' Rights and the African Committee of Experts on The Rights and Welfare of the Child on Ending Child Marriage 2017.	To encourage the uptake of sexual and reproductive health services, States Parties should develop and implement comprehensive sexuality education and information programmes. School curriculums should include age-appropriate information about sex, sexuality, sexual and reproductive health rights and sexually transmitted infections, including HIV and AIDS. Comprehensive sexuality education should also include age-appropriate information about what constitutes consent to sex, as distinct from consent to marriage, and information about gender, sexuality and social norms and stereotypes that perpetuate gender inequality and its manifestations, including child marriage.	Para. 36 Para. 36	The right to sexuality education; The right to access sexual health services; The right to choose their sexual partner; The right to decide to become sexually active or not; The right to have consensual sexual relations.	The government should ensure that sexuality education addresses gender norms that perpetuate stereotypes about sexuality such as sexual double standards for girls. The government should adopt the concept of sexual rights in its laws and policies that recognise that children and adolescents have sexual aspirations beyond being protected from early marriage

Child Marriage (JGC on Child Marriage) encourages states to implement comprehensive sexuality education (CSE) that includes sexuality and sexual and reproductive health rights. It recommends that CSE should include consent to sex and provide information about gender and sexuality and address the stereotypes that perpetuate gender inequalities. More of this language that constructs children and adolescents as having sexual agency should appear in such authoritative and interpretive documents, to guide states to create legal and policy environments in which children learn about sexuality as a positive aspect of their human development.

4 The importance of decriminalizing adolescent sexual conduct

In Malawi, sex between consenting adolescents is criminalized under Section 138 of the Penal Code. Criminalizing adolescent consensual sexual conduct is an extreme form of denying that children and adolescents are sexual beings. Laws criminalizing child consensual sexual conduct are a form of violence. Social expectations supported by gender inequitable norms tend to influence the design and implementation of these laws. Criminalising adolescent consensual sex has a negative impact on the sexual rights of adolescents. Such criminal laws also serve to maintain attitudes toward adolescents that are rooted in gender inequitable norms. A case in point is *Martin Charo v Republic* decided by the High Court of Kenya, which is described below.

Kenya, like most countries in sub-Saharan Africa including Malawi, adopted colonial sexual consent laws that restricted sexual conduct with children and adolescents of below a certain age. These so-called 'age of consent' laws were premised on gender stereotypes that regarded girls as sexually passive and in need of protection from men and boys whose active sexuality posed a threat to the virginity of girls.[45] Even after Kenya transformed its sexual offences law to align it with the rights of the child and gender equality, gender inequitable norms still influence how legal institutions and actors perceive and respond to adolescent sexuality.

In *Charo*, the appellant, a 23-year-old male, had sexual intercourse with a girl of 14. A magistrate's court convicted him of the offence of defilement under section 8(1)(3) of the Sexual Offences Act 3 of 2006 (Sexual Offences Act) of Kenya and sentenced to imprisonment for 20 years. On appeal, the High Court quashed his conviction and sentence. The court's decision hinged on the interpretation and application of sections 8(5) and 8(6) of the Sexual Offences Act. Under section 8(5) of the Sexual Offences Act, it is a defence if an accused person proves that the complainant deceived him or her into believing that he or she was over the age of 18, and if the accused person reasonably believed that the person was above the age of 18. According to section 8(6), the court should in determining the accused person's belief envisaged under section 8(5), consider all circumstances including the steps the accused person took to learn the age. The defence argued that by voluntarily leaving her home

and going to the home of the appellant for the purposes of having sexual intercourse with the appellant, the complainant behaved, deceptively, like an adult. The court allowed the defence to stand and quashed the conviction.

What is interesting for this chapter is the judge's belief about the sexual conduct of girls. The judge restated the aim of the defilement provisions in these terms: 'It is the law that a child below the age of 18 years cannot consent to sex'. He went on to express the opinion that: 'However, where the same child under 18 years who is protected by the law opts to go into men's houses for sex … why should the court conclude that such a person was defiled'. The judge believed that the 14-year-old girl behaved like an adult. In the view of the judge, 'although PW1 was a young lady aged 14 years; she was behaving like a full grown up woman who was already engaging and enjoying sex with men'. Further, the judge thought that: 'Children are not meant to enjoy sex', and that 'where the child behaves like an adult and willingly sneaks into men's houses for purposes of having sex, the court ought to treat such a child as a grown-up who knows what she is doing'. In the judge's reasoning, the sexual behaviour of the girl was against social norms about how a girl is supposed to behave sexually. The wording of the law provided the opportunity for the judge to interpret the legal provisions to ascribe meanings that reflected societal gender norms and expectations about a girl's sexual behaviour.

Sexual offences laws that criminalize adolescent consensual sexual conduct are often vehicles for communicating negative and gendered messages about sexuality to children. It is difficult to imagine circumstances in which such laws would be compatible with the rights of the child. For instance, Section 138 of Malawi's Penal Code constructs the girl, but not the boy, as the object of protection from harmful sexual intercourse. This provision is more aligned to gender stereotypical and inequitable norms than it is to the GEA and constitutional values.

5 Conclusion

Though Malawi has a robust legal framework to address gender inequality, the social environment does not support children to develop positive sexual behaviours and practices. However, Section 19 of the Gender Equality holds promise because, as has been argued in this chapter, it ought to be interpreted to promote sexual rights of children and adolescents, including the right to sexuality education, the right to decide to be sexuality active or not and the right to choose a sexual partner.

To support creating a positive environment for sexuality development of children, this author recommends that Malawi should include a section on sexuality in the National Policy on Early Childhood Development (ECD) to guide ECD practitioners to implement laws and policies in a manner that recognizes the sexual agency of children. For instance, respect of the right of the child to be heard means that ECD practitioners are obligated to take seriously children's views about sex, sexuality, love and romance, because

these are important for children, and they form the basis for sexual conduct that has a lasting impact on their sexual development and sexual health trajectories.

Another recommendation is that CSE should start early in pre-school. The design of CSE should be to address not only what adults believe children should learn, but to also enable children to critically engage with what they already learn, and to address gender discriminatory values about sexuality prevalent in society. It is, therefore, crucially important to build the capacity of educators to effectively engage with children and adolescents on sexuality and gender.

There has been little guidance from treaty monitoring bodies especially the ACERWC on how to implement the ACRWC to promote sexual rights of children, beyond protecting them from harms of sexual conduct and early marriage. The JGC on Child Marriage is, however, progressive because it has called on African states to provide CSE that includes consent to sex and information about sexuality. An important entry point for the ACERWC to further promote child rights relating to sexuality would be to encourage states to review age of consent laws that punish children and adolescents for engaging in normative consensual sexual conduct. Such laws have a negative impact on childhood sexuality development and gender equality in Africa, for the reasons discussed in this chapter. It would be of tremendous significance and impact if the ACERWC could analyze age of consent laws and guide states to align their laws and policies with the rights of the child and the advancement of gender equality in accordance with Africa's Agenda for Children 2040.

Notes

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20 P Mudhovozi et al 'Adolescent sexuality and culture: South African mothers` perspective' (2012) 16 *African Sociological Review/Revue Africaine de Sociologie* 121. However, in some cultures, sexuality is talked about in other spaces such as initiation rites.
21 N Fairclough *Language and power* (2001) 33.
22 P Bourdieu *Outline of a theory of practice* (1977) 79.
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24 Simon & Gagnon (n 24) 21.
25 As above.
26 As above
27 Simon & Gagnon (n 24) 24.
28 Simon & Gagnon (n 24) 27.
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33 Limaye et al (n 6) 123.
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35 Muhanguzi (n 35) 718.
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8 Addressing female genital cutting/mutilation (FGC/M) in The Gambia

Beyond Criminalization

Ebenezer Durojaye and Satang Nabaneh

1 Introduction

Female genital cutting (FGC) or sometimes referred to as female genital mutilation (FGM) or circumcision is a cultural practice in some parts of Africa that has become a subject of concern for many years. The term FGC and FGM are sometimes used interchangeably. Although human rights organizations and activists tend to prefer the use of FGM, it is often believed that this is stigmatizing and judgemental of the culture of the people. Thus, the use of FGC is believed to be non-judgemental. An estimated 200 million girls and women alive today have experienced FGC/M in 30 countries in Africa, the Middle East and Asia where this practice is concentrated.[1] About 3 million girls are said to be at risk of FGC/M annually. Indeed, it has been noted that the practice and social acceptance of FGC/M persist in many countries.[2]

The WHO (2016) estimates that 100–140 million girls and women worldwide are currently living with the consequences of the FGC/M.[3] It is mostly carried out on young girls at some point between infancy and the age of 15 years. In Africa, an estimated 92 million girls from ten years of age and above have undergone FGC/M.[4] While recent evidence would seem to indicate that this practice is declining in some countries, however, this is not the same in other countries as the practice would seem to remain prevalent.[5]

According to the 2013 Demographic and Health Survey (DHS), FGM is a universal practice in The Gambia, with 75% of girls and women between 15 and 49 undergoing the practice, and 76.3% for those between 15 and 19.[6] The practice is mainly performed by traditional practitioners. In 2015, the Gambian government took a giant step forward in addressing the menace of FGC/M in the country.

The purpose of this chapter is to examine the various approaches that have been adopted to address FGC/M in some African countries. In particular, the chapter discusses the pros and cons of criminalization approach to FGC/M. It then focuses on the amendment to the 2010 Women's Act in The Gambia which prohibits FGC/M. The paper evaluates the utility of the approach adopted by the Gambian government vis-a-vis its obligation under the Protocol to the African Charter on the Rights of Women (African Women's Protocol/

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Maputo Protocol). The paper concludes by noting that while prohibition of FGC/M through sanction is important, such an approach will fail to achieve its desired aim of reducing incidence of this practice unless other complementary measures are adopted by states.

2 FGC/M in The Gambia

FGC/M refers to 'all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons'.[7] FGC/M is classified into four major types. These are:

- Type 1: Often referred to as clitoridectomy, this is the partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals), and in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).
- Type 2: Often referred to as excision, this is the partial or total removal of the clitoris and the labia minora (the inner folds of the vulva), with or without excision of the labia majora (the outer folds of skin of the vulva).
- Type 3: Often referred to as infibulation, this is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoris (clitoridectomy).
- Type 4: This includes all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

In The Gambia, FGC/M is carried out throughout childhood, with 55% of women reporting that they were circumcised before the age of five. Another 28% of women were circumcised between the ages of 5 and 9, and 7% were circumcised between the ages of 10 and 14. Around 85% of women circumcised indicated that what they went through involved cutting and removal of flesh.[8] According to the 2018 Multiple Indicator Cluster Survey (MICs), 75.7% of women aged 15–49 years and 50.6% for those aged 0–14 years had undergone FGM.[9] FGM is often performed by traditional practitioners commonly called circumcisers in The Gambia. The procedure is performed without anaesthesia and using knives or razor blades.

Kaplan et al., conducted a clinical study on the health consequences of FGM in The Gambia from 2008 to 2009.[10] The study indicated that type 1 is most common in The Gambia accounting for the highest cases of FGC/M, followed by types 2 and 3, while type 4 is not evident. The study found that a substantial number of cases were observed with health complications arising directly from the practice of FGC/M. Complications, whether immediate or late, were present in 23.7% of the patients with type 1(137/ 577), 55.0% of patients with type 2 (126/229) and 55.4% of patients with type 3 (36/65). The most common immediate complication, for all types, was infection.

Nevertheless, knowledge about the extent of health consequences of FGC/M in The Gambia remains scarce.

FGC/M is a deeply rooted and widely supported practice that is sustained through many cultural justifications that reinforce its continuation in The Gambia. Common reasons for performing FGC/M include female purity/virginity, family honour, maintenance of cleanliness and health and assurance of women's marriageability. Some also associate it with religious beliefs.[11]

3 FGC/M as a human rights violation

Given the nature of FGC/M, there is a consensus that this practice tends to undermine the human rights of girls as guaranteed under international human rights law. This practice is a threat to the enjoyment of various rights of the girl-child, including the rights to life, health equality and non-discrimination, liberty, freedom from inhumane degrading treatment, dignity and autonomy.[12] These rights are guaranteed in international and regional human right instruments such as the International Covenant on Economic, Social and Cultural Rights (ICESCR), International Covenant on Civil and Political Rights (ICCPR), Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child (CRC). Different UN treaty monitoring bodies have expressed concerns about FGM and its implications for the rights of women and girls. For instance, the CEDAW Committee in General Recommendation 24 has condemned this practice as gross violation of women's rights to health, non-discrimination and life. It urges states to adopt decisive measures including imposition of sanctions on the perpetrators of this act. In its General Recommendation 30, the Committee notes that states are obligated to eliminate all forms of harmful practices that undermine the rights and dignity of women as well as perpetuate the low status of women in society. Also, the Human Rights Committee has stated that FGM is in breach of Article 7 of the ICCPR and constitutes torture or other cruel, inhuman or degrading treatment or punishment and has also raised concerns regarding its persistence.

The Committee on the Rights of the Child in its concluding observations recommended to The Gambia to adopt legal provisions fully criminalizing the practice of female genital mutilation. It also requires the state to provide physical and psychological recovery programmes for victims of FGM and establish reporting and complaints mechanisms accessible to girls who have been victims, or fear becoming victims of the practice. In addition, The Gambia should take measures to help practitioners of female genital mutilation finding alternative sources of income.

At the regional level, provisions of the African Charter on Human and Peoples' Rights (African Charter) and the Protocol to the African Charter on the Rights of Women in Africa (African Women's Protocol) are important in addressing human rights violations occasioned by FGC/M. Indeed, Article 5 of the African Women's Protocol specifically enjoins states to prohibit 'all forms of female genital mutilation, scarification and para-medicalization of female

genital mutilation and all other practices in order to eradicate them'. The African Women's Protocol is particularly concerned that, despite the ratification of the African Charter and other international human rights instruments by the majority of African states, and their solemn commitment to eliminate all forms of discrimination and harmful practices against women, discrimination against women persists in Africa. The African Women's Protocol, therefore, aims at holistically addressing this situation. The Protocol, highlighting the implications of such practices on women's health, provides that any practice that hinders or endangers the normal growth and affects the physical and psychological development of women and girls should be condemned and eliminated. This is because such practices may hinder women from enjoying fully their fundamental rights and prevent the promotion, protection and realization of women's rights. Failure on the part of African governments to address such harmful practices will result in violation of women's inherent human rights, such as the rights to non-discrimination, equality and human dignity. As a result, the African Women's Protocol enjoins states parties to prohibit and condemn all forms of harmful practices which negatively affect the human rights of women and which are contrary to recognized international standards.[13] For example, it specifically urges state parties to take all necessary measures to eliminate FGC/M including:

> … prohibition, through legislative measures backed by sanctions, of all forms of female genital mutilation, scarification, medicalisation and paramedicalisation of female genital mutilation and all other practices in order to eradicate them; … protection of women who are at risk of being subjected to harmful practices or all other forms of violence, abuse and intolerance.

These provisions of the Women's Protocol distinctively address the elimination of FGC/M which is prevalent in many African countries. This makes the Protocol unique in the eradication of FGC/M in Africa, unlike other existing international human rights instruments such as the CEDAW ratified by many African countries. Whereas the CEDAW generally condemns cultural practices against women in order to protect their human rights, it lacks a specific provision relating to FGC/M.

It should be noted that Article 5 of the Protocol must be read together with Article 2 which relates to elimination of all discriminatory practices against women. Moreover, the Protocol in Article 3 on violence against women enjoins African governments to ensure that victims of all violence (including those perpetuated as a result of cultural practices) are rehabilitated. This is very important in that it will ensure that the dignity and well-being of women and girls that have undertone harmful practices are safeguarded. A combined reading of these provisions would seem to show that the Protocol has adopted a three-prong approach to eradicating cultural practices such as FGC/M.

First, the Protocol proposes the use of sanctions to curb the spread of this practice. Second, the Protocol recommends education and awareness campaign that will address behavioural change in societies. Third, the Protocol adopts a humanistic approach of rehabilitating victims of all forms of violence. This approach of the Protocol is not only pragmatic but also commendable.

It should be noted that applying criminal law to public health issues has remained very contentious and experience has shown that this may, in the long run, become ineffective.[14] Indeed, such an approach may become counterproductive in the end. Therefore, the holistic approach of the Protocol will go a long way in ensuring the eradication of this practice in many African countries. This issue is explored further below. It should be noted that The Gambia has ratified virtually all these international and regional human rights instruments. The implication under international law is that the Gambian government is obligated to comply with the provisions of these internments.[15]

In addition, to the binding instruments, there are consensus statements and declarations relevant to this discussion. For instance, the international community during the 1995 Beijing Declaration and Platform for Action, affirmed that if women and girls were to be free from violence and coercion, cultural and patriarchal practices will need to be addressed.

The Special Rapporteur on violence against women stated that:[16]

> those cultural practices that involve 'severe pain and suffering' for the woman or the girl child, those that do not respect the physical integrity of the female body, must receive maximum international scrutiny and agitation. It is imperative that practices such as female genital mutilation, […] or any other form of cultural practice that brutalizes the female body receive international attention, and international leverage should be used to ensure that these practices are curtailed and eliminated as quickly as possible.

On 20 December 2012, the United Nations General Assembly adopted a historic and unanimous resolution calling on the international community to eliminate FGC/M. The then UN Secretary-General, Ban Ki Moon, commenting on the historic resolution, urged countries 'to condemn all harmful practices that affect women and girls, in particular female genital mutilation, and to take all necessary measures, including enforcing legislation, awareness-raising and allocating sufficient resources to protect women and girls from this form of violence'.[17]

Also in 2013, the 57th UN Commission on the Status of Women agreed on a number of resolutions including a reference to the need for states to develop policies and programmes to eliminate FGC/M as well as other forms of violence against women.[18] Similarly, on 25 September 2015, the global community agreed to a new set of development goals – the Sustainable Development Goals (SDGs) – which includes a target under Goal 5 to

eliminate all harmful practices, such as child, early and forced marriage and FGC/M, by the year 2030.

From the foregoing, most of the human rights instruments recommend the use of sanction as a means of addressing FGC/M. This is further explored in the next section of this paper.

4 Criminalization and FGC/M

Over the years, different approaches have been adopted to address this serious challenge to human rights and freedom of the girl-child in the region. In their seminal article, Johansen et al., have discussed some of the approaches adopted by African countries to address FGC/M in the region. Some of these include health, criminalization and alternative/mock ceremony. These approaches have their pros and cons. In this chapter, focus will only be on use of criminalization to address FGC/M. As noted above, most of the human rights bodies and instruments seem to recommend the use of sanctions to address FGC/M.

4.1 Criminalization

In many African countries, the use of sanctions to address FGC/M is by far the commonest response adopted by governments. Criminalization often involves the imposition of jail sentence or fines. The essence of enacting prohibitory laws in most countries is not just to punish the culprits, but also to serve as an act of correction or maintaining moral justice in society.

One of the most popular justifications for the use of criminal sanction is the deterrence theory. The major philosophical basis for deterrence is to discourage individuals from committing a crime. The origin of this theory has been traced to the works of classical philosophers such as Thomas Hobbes, Cesare Beccaria and Jeremy Betham. In his seminal work the *Levithans*, Hobbes argues that human beings are inherently good or bad.[19] He further asserts that human beings tend to pursue their self-interests such as material gain, personal safety and social reputation, and make enemies without caring if they harm others in the process. This sometimes may be in conflict with the needs of the society they belong. Thus, the need for what he calls 'social contract' where people agree to submit to the state, which is expected to enforce the contract. According to Hobbes, even where the state strives to enforce the contract, crimes are inevitable, therefore, it is necessary that the state imposes punishment for crime higher than the benefits an individual may derive from it. This will serve to deter future commission of a crime and thus maintain the sanctity of the social contract.

In addition, Beccaria in his highly influential work, *On crimes and punishments* first published in 1764, has argued that human beings by nature are rationally centred and will not likely commit crimes if the costs of committing such crimes out-weight the benefits they will derive from engaging in undesirable acts.[20] While he notes that the purpose of punishment should be to prevent crimes, he submits that punishments will become unjust and severe if they

exceed what is necessary to achieve deterrence.[21] In other words, punishment should serve to deter others from committing crimes and to prevent the criminal from repeating his/her crime. He holds the view that excessive imposition of punishments will aggravate rather than prevent crimes in society. Following after Becaaria, Betham in his classical work *An Introduction to the Principles of Morals and Legislation*, has noted that human beings are generally under the control of two sovereign masters – pain and pleasure.[22] He argues that morality in every society tends to promote 'the greatest happiness of the greatest number'. Consequently, he reasons that the major duty of the state is to promote the happiness of the society by punishing and rewarding. Like Beccaria, Betham cautions against arbitrary imposition of punishments but maintains that punishments should only be used to avert greater evil or control the action of the offender.

In summary, the argument of these classical philosophers is that the more serious a punishment, the more likely a rational individual will desist from commission of a crime. Thus, to prevent crimes in society, punishment must be imposed to ensure that citizens obey the law. In essence, if individuals know that they will be punished for the crimes they commit, they will likely think twice before attempting to commit a crime. This reasoning has influenced modern-day criminal justice systems in many societies. Thus, the idea that sanctions discourage commission of crimes has led to the imposition of the death penalty and other severe punishments for offenders. This thinking has influenced moves towards criminalization of FGC/M in many countries in the region. However, this reasoning has been criticized as misleading and unfounded. For instance, one of the justifications for the continued retention of the death penalty is that it serves as a deterrent for commission of serious crimes. However, a publication by the United Nations has noted that 'research has failed to provide scientific proof that executions have a greater deterrent effect than life imprisonment. Such proof is unlikely to be forthcoming. The evidence gives no positive support to the deterrent hypothesis'.[23] On the contrary, countries that have abolished the death sentence tend to witness fewer serious crimes.[24] The publication further identifies other disadvantages of the death penalty as being too expensive and sometimes used to target certain groups in society.

4.2 Limitation of criminal law in addressing FGC/M

Indeed, commentators have noted that if truly sanctions serve as deterrence to commission of crimes, the world would have been peaceful today. However, on the contrary, the world has almost been turned to a jungle where the fittest tend to survive. Despite the imposition of the death sentence and other severe punishments for offenders, the crime rates in the world have not reduced. As discussed below, similar situation plays out with regard to the criminalization of FGC/M.

Egypt is one of the African countries where the prevalent rate of FGC/M is very high. It is believed that about 91% of women are mutilated.[25] It practices

all the forms of FGC/M, subjecting women and girls to perpetual torture and health crisis. To curb this act of torture, a presidential decree was enacted in 1958. It made the practice punishable by a fine and imprisonment. Also, a resolution was signed by Egypt's Minister of Health in 1959 to medicalize the practice. This is based on the belief that carrying out this practice in a hospital under more sanitary conditions would eventually reduce some of the detrimental, physical and psychological risks associated with FGC/M.[26]

Similarly, in Burkina Faso the high rates of death and health effects suffered by victims of FGC/M have led to the enactment of a specific legislation prohibiting the practice. Article 380 of the Penal Code specifically punishes any person who violates or attempts to violate the physical integrity of the female genital organ. This may either be by total ablation, excision, infibulation, desensitization or by any other means. It may result in a punishment of a fine or imprisonment, depending on its gravity. Other countries such as Ghana, Senegal and Ivory Coast have laws punishing the practice.[27]

Most of these laws have not been effective in curbing the practice of FGC/M in affected countries. This might be due to the fact the communities where this practice is prevalent, have not been sensitized or provided with needed information on what these laws entail before enacting them. They have not been sensitized on the health hazards that the practice was causing to women and girls. It might also be that the language of these laws was not well understood, especially as the wording of these laws may seem alien. Moreover, the fact that members of the affected communities were not always carried along before these laws were enacted has made it difficult for members of the communities where it is practised to understand or respect the laws. They have considered these laws as foreign and an affront to their culture.[28] Therefore, this general lack of acceptance of the laws caused the practice to persist, especially in hiding. In his seminal work, *Why People Obey the Law*, Tyler has noted that legitimacy and trust are crucial factors that determine whether a group of people will obey the law.[29] He argues further that obedience to the law is easier where the people are carried among in its conceptualization and adoption rather that when laws are imposed on the people. According to him, people obey the law not for the fear of punishment but for legitimacy sake. He reasons that law makers and those responsible for implementing the law will do much better if they ensure that the legal system is worthy of respect rather than creating fear in the people. In sum, Tyler would seem to suggest that people are more likely to obey the law if they have confidence in the system. Conversely, people will disobey the law for lack of respect no matter how severe the punishment for such disobedience. He further reasons:

> To be authoritative, legal rules and decisions must affect the actions of those toward whom they are directed. A judge's ruling means little if the parties to the dispute feel they can ignore it. Similarly, passing a law prohibiting some behavior is not useful if it does not affect how often the behavior occurs.[30]

He concludes by noting that the 'regulation of behaviour through social control is inefficient and may not be effective enough to allow a complex democratic society to survive'.[31] This could be true for many of the anti-FGC/FGM laws in many parts of the region.

Harmful cultural practices such as FGC/M are sensitive cultural issues falling within the spheres of women and the family in that, if women are against the practice, they may be ostracized by the family. This is due to the cultural belief that a woman's denial or rejection of the practice amounts to a cultural taboo. Thus, the total elimination of such a practice can only be effectively based on the full commitment and political will of the government. In addition to enactment of laws, they have to put programmes, structures and resources in place to intensify sensitization against the practice especially as most perpetrators do not respect the laws nor understand the human rights implications of the practice.[32]

5 An analysis of The Gambian law on FGC/M vis-a-vis obligations under international law

As noted earlier, The Gambia is a party to a number of international and regional human rights instruments that protect the rights of women in the context of cultural practices. In addition, the 1997 Constitution of The Gambia contains a catalogue of rights and freedoms under Chapter IV relevant to protecting the rights of women and girls in relation to harmful cultural practices. The rights and freedoms provided in the Constitution include the right to life and personal liberty, torture and inhuman treatment, the rights to privacy, property and fair trial, freedom of speech, conscience, assembly, association and movement, the right to political participation, and freedom from discrimination. The Constitution does not provide a specific provision against FGC/M. Given the various physical and psychological implications of FGC/M, it could arguably be considered a violation under these provisions.

It is arguable that FGC/M can be considered a violation of sections 210 and 212 of the Criminal Code of Chapter XXII (Offences Endangering life and health). Section 210 states that any person above 16, with responsibility for a child under the age of 14, found to have treated or exposed a child to unnecessary suffering or injury commits a misdemeanour. However, this provision is inconsistent with the definition of a child and it victimizes children. No case on FGC/M has ever been made on this provision.

The Children's Act was enacted in 2005. The Act was promulgated to ensure the effective enjoyment and enforcement of the CRC and the African Children's Charter through the incorporation of their provisions into national law. The Act clearly provides various rights that children should enjoy as well as their responsibilities, reflecting the aspirations of the African Children's Charter. Section 19 of the Children's Act 2005 states that:

> no child shall be subjected to any social and cultural practices that affect the welfare, dignity, normal growth and development of the child and in

> particular, those customs and practices that are- a) prejudicial to the health of the child, b) discriminatory to the child on the grounds of sex or other status.

Section 19 of the Act does not specifically mention FGC/M as a form of harmful traditional practice. This was a compromise as the 2003 Children's Bill under Article 25 provided for the prohibition of harmful traditional practices. It stated that a person who subjects or causes a female child to be subjected to a harmful traditional practice commits an offence and liable on conviction to a fine of five thousand Dalasis. The definition of harmful traditional practice expressly includes FGC/M and its different forms. However, this was modified before the bill was passed.

The Women's Act was signed into law by the president Yahya Jammeh on 28 May 2010. It is intended to provide for the protection of women's rights in addition to the rights guaranteed under Chapter IV of the Constitution. A key deficiency of the Women's Act is the absence of an equivalent provision of Article 5 of the Protocol, dealing with 'Elimination of Harmful Traditional Practices'.

Efforts have been made to address FGC/M since the mid-1980s when the first campaign group with a specific focus on harmful traditional practices (HTPs) including FGC/M, was established. Various groups work actively to mobilize public opinion against FGC/M and also to persuade circumcizers to engage in other alternative employment. These groups have also demanded that the Gambian Government adopt a law that criminalizes FGC/M which led to a draft FGC/M Bill which was never tabled before the National Assembly.[33] However, on 24 November 2015, President Jammeh declared a ban on FGC/M stating that it was a cultural and not a religious practice. He stated that for 21 years, he conducted research on the Qur'an and consulted religious leaders whether female circumcision is mentioned in the Qur'an but he did not find it there. [34]

6 The Women's Amendment Act 2015

The presidential pronouncement against FGC/M was swiftly followed by the passing of the Women's (Amendment) Bill 2015 by the National Assembly on 2 December 2015 to prohibit female circumcision. The amendment addresses one of the key deficiencies of the Women's Act 2010 which was the absence of a provision eliminating harmful traditional practices. The Amendment Act added sections 32A and 32B in the Women's Act.

The reasons for the amendment were premised on The Gambia's international and regional human rights obligations such as Article 5 of the African Women's Protocol. Thus, it was geared towards ensuring the compliance of The Gambia with its international obligation 'to prohibit female circumcision due to the proven harmful nature of the practice'. However, as will be discussed below, the drafters of the law did not wholly incorporate the provisions of the African Women's Protocol.

Section 32A makes it an offence for any person to engage in female circumcision. and whoever contravenes it is liable on conviction to an imprisonment for a term of three years or a fine of fifty thousand Dalasis (approximately $1250) or both. The Act also stipulates a life sentence in prison when the circumcision results in death.

The Act also addresses those who commission the procedure in section 32B (1). It states that 'a person who requests, incites or promotes female circumcision by providing tools or by any other means commits an offence and is liable on conviction to imprisonment for a term of three years or a fine of fifty thousand Dalasis or both'. In addition, a fine of ten thousand Dalasis (approximately $250) as provided in section 32B (2) of the Act is levied against anyone knowing about the practice and failing to report. In addition, although there have been concerns about the ban leading to medicalization of FGC/M, however, there has been no evidence of such happening in The Gambia. Countries such as Senegal which amended its Penal Code to prohibit FGC/M in 1999, calls for imprisonment from six months to five years, the maximum punishment which applies when FGC/M has been practised or facilitated by a member of the medical or paramedical profession.[35]

Generally, people would rarely come forward to report gender-based violence cases unless there is a scandal such as the death of a child. Recently, two suspects were indicted and remanded in custody for allegedly practising FGC/M. Two people were charged with conspiracy to commit felony, prohibition of female circumcision and accomplices to female circumcision. Sunkaru Darboe (grandfather) was accused on several counts of taking, inciting and promoting female circumcision which led to the child's death. Saffiatou Darboe was charged with having knowledge about the circumcision taking place but failing to inform authorities concerned about it. The facts of the case are that on 27 February 2016 in Sakandi Village in Kiang West, the two accused persons conspired and took one Aminata Drammeh, a five-month-old baby to the circumciser for the purposes of conducting FGC/M which later resulted in her death. The accused persons denied the charges and applied for bail to which the state objected stating that another accused person was still at large, and it would not help the investigation if the accused persons were granted bail. The case was then adjourned for ruling on bail while the accused were remanded in prison. The case is still pending and no one has been convicted yet.[36]

There is no gainsaying that indeed the abolition of FGC/M in the Gambia is a welcoming legal and policy achievement, but the case involving the Sankandi girl was the first litmus test to determine the intentions and capacity of the state to enforce the law and fulfil its international obligations. A comprehensive and coordinated approach is crucial to accelerating the abandonment of FGC/M. A comprehensive national movement that involves all public and private stakeholders, including government institutions, community and religious leaders, educational institutions, the media, NGOs, civil society, girls and boys, and women and men can eliminate this harmful practice.

The Gambia is known to enact laws that address specific issues such as the 2013 Domestic Violence Act and the Sexual Offences Act. It is thus surprising that an anti-FGM law was not enacted but rather was subsumed in the Women's Act 2010. However, one reason for this may be the fact that cultural practices such as FGC/M tend to evoke emotions and sentiments, thus the need to avoid singling them out for prohibition through specific laws and potential backlash. This approach is not peculiar to The Gambia, as Nigeria recently prohibits FGC/M through the enactment of the Violence against the Persons Act of 2015.

Generally, the enforcement of the Women's Act is weak. To ensure sections 32A and 32B do not become 'paper promises', it will be necessary to put in place detailed plan for implementation and monitoring as well as establishment of enforcement mechanisms such as an Anti-FGM Prosecution Unit and the Anti-FGM Board. The existence of such 'tools' may bring about accountability in terms of reporting, investigating and prosecuting FGM cases.

The challenges faced with the recent passing of legislation discouraging harmful traditional practices include lack of well-equipped local police stations with the required legislation for charging of offences and a better understanding of the law. In addition, various communities believe that some of these laws especially the laws criminalizing FGC/M and child marriage was imposed on the citizenry by the former regime and thus believe that with the new change of government, the laws no longer exist. This has therefore led to low rate of report of cases of FGC/M and child marriage.

Nevertheless, the Act constitutes a major step forward in terms of promoting and protecting the rights of women to bodily integrity and dignity. Like most other laws in other African countries prohibiting FGC/M, the Gambian Women's Act fails to incorporate the need for education and awareness programmes as an essential part of addressing this cultural practice. As noted earlier, the African Women's Protocol enjoins African governments to embark on educations and awareness programmes to supplement the efforts in combating harmful cultural practices including FGC/M. This is a missed opportunity on the part of the drafters of Women's Act. Nabaneh and Muula have argued that the use of criminal sanction to address FGC/M is not sufficient and must be complemented with other strategies including mobilization and awareness campaign programmes.[37]

Although female circumcision is now banned in the country, there is need for continuous intensive education of practicing communities. This would seem to be consistent with the approach adopted by the African Women's Protocol. A long-standing and cherished traditional practice may not easily go away with the enactment of a law. It could, on the contrary, drive the practice underground and make it more harmful and dangerous for the children. For instance, Egypt is among those countries where efforts are underway towards the reduction and eventual eradication of FGC/M. The country has employed strategies such as a strong media campaign, a *fatwa* against FGC/M by the grand mufti of Egypt and the amendment of the decrees. Nevertheless, many people

still consider FGC/M part of their culture or religion and identity. Appiah has argued that deep-rooted cultural practices such as FGC/M would need to be made less 'honourific' before it can be totally eradicated among the people.[38] He notes further that deep-rooted cultural practices cannot be easily eradicated through mere appeals to reason, morality, law or persuasion. Appiah's argument would seem to sum up the point that the mere imposition of criminal sanction on FGC/M will not necessarily lead to the eradication of the practice. This would seem to reinforce the argument by Tyler that criminal sanction alone will not deter people from disobeying the law unless there is general acceptance and legitimacy of the process leading to its enactment.[39]

It is therefore vital that in The Gambia, there is continuous engagement and dialogue with the practicing communities, including circumcisers, religious leaders and traditional gate keepers, popularization of the law to every nook and cranny of the country, enhancing coordination among relevant sectors and empowerment of children and young people are necessary conditions to bring about lasting change.

The CEDAW Committee in its General Recommendation 31 has emphasized the need for states to embark on awareness and education programmes with a view to eradicating harmful practices that may impair women and girls from enjoying their fundamental rights and freedoms. One of the advantages of education and awareness programmes is that it may lead to behavioural change in the communities where FGC/M is practiced. This will be consistent with the aim of the African Women's Protocol in preventing violence against women and girls.

The Human Rights Committee in 2018 recommended that The Gambia strengthen the Women's (Amendment) Act of 2015, which criminalizes FGC/M, and enhance public awareness, particularly among traditional and religious leaders, of the lifelong negative consequences of such practices. In addition, more than 15 recommendations from the recently concluded Universal Periodic Review were on FGC/M focusing on the need for government to raise awareness and enforce the legislation, as well as strengthen and accelerate mechanisms aimed at eradicating the practice.[40]

Another important omission in the Women's Act is the fact that it fails to address the situation of victims of FGC/M. Unlike the African Women's Protocol, which urges states to ensure that victims of violence are rehabilitated, the Women's Act seems ominously silent on this. While it is important to go after those that perpetrate this act, it is equally important to provide for the needs of those that have undergone the practice and suffered some health consequences. This is consistent with a human rights-based approach, which is often centred on respect for human dignity. It is believed this will go a long way in further cementing the fundamental rights of women and girls who are victims of this harmful cultural practice. A substantive approach to equality requires that the historical disadvantaged position of women is taken into consideration in responding to gender inequality. Given that FGC/M is a manifestation of the patriarchal tradition of many African societies, prohibition of the

practice alone will not suffice to assuage the injustice it portends for women. A more pragmatic and holistic approach is needed which reflects the lived experiences of women and girls that have undergone this practice.

There is no doubt that the abolition of FGC/M in the Gambia is a welcome legal and policy development. A comprehensive and coordinated approach is crucial to accelerating the abandonment of FGC/M. Such a movement must include all public and private stakeholders, including government institutions, community and religious leaders, educational institutions, the media, NGOs, civil society, girls and boys, and women and men. Examples from some countries in the region have shown that a combination of different strategies is imperative to addressing the challenge posed by FGC/M. In Egypt for instance, the Positive Deviance Approach, which include, one-on-one education talk, community awareness campaigns, involvement of local communities on discussions relating to FGC/M, collaboration between NGOs working on FGC/M and community members and training and empowerment of people to realize the negative effects of FGC/M, has recorded modest success.[41] This project has elicited open discussions among community members on the cultural relevance of FGC/M and whether it should still be retained. Moreover, a considerable reduction in the number of girls circumcised was observed during the execution of the project.[42]

7 Conclusion

This chapter has discussed some of the approaches to addressing FGC/M in African countries. Also, it has argued that FGC/M violates international norms espoused by international human rights instruments most of which The Gambia is a party. It has been contended that this practice is discriminatory and undermines the rights to sexual autonomy of women since it seeks to control women's sexuality. It examines the provisions of the Women's Amendment Act of 2015 of The Gambia which prohibits FGC/M in the country. It is argued that the Act misses a great opportunity to incorporate some of the important provisions of the African Women's Protocol.

It should be noted that a legal prohibition is not necessarily a guarantee that girls and women would be protected against FGC/M. The law would need to be effectively enforced and implemented. This requires political will from the state. One can draw lesson from Burkina Faso's experience, which is being recognized as one of the few countries where the government has been able to effectively implement laws on FGC/M. Other strategies such as awareness creation, capacity building of law enforcers, participation of children and young people, livelihood skills for ex-circumcizers, dialogue with religious and traditional leaders, engagement with men and boys should be enhanced to complement the legal reform. Time will therefore tell how far well the government mean in what can only be described yet as a legal and policy success against FGC/M. This is in line with the UN General

Assembly Declaration 2012, which enjoins states to adopt a holistic approach to addressing FGC/M.

Notes

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9 In search of a middle ground

Addressing cultural and religious influences on the criminalization of homosexuality in Nigeria

Adetoun T Adebanjo

1 Introduction

Nigeria is a largely homophobic nation. Cultural and religious beliefs have a major role to play in this stance. The disposition to same-sex relationships is rooted in the belief that same-sex relationships are alien to African culture, and to Christianity and Islam, the two major religions practised in Nigeria.

Prior to the introduction of the Same Sex Marriage (Prohibition) Act 2013, the Criminal Code Act (applicable in the South),[1] the Penal Code Act (applicable in the North) and Shariah Law (applicable in 12 Northern states) had already criminalized homosexuality.[2]

Homosexuality is a felony under section 214 of the Criminal Code and is punishable by up to 14 years imprisonment. The Penal Code has adopted an even stricter stance. In terms of section 284, an offender is liable to a fine and imprisonment of up to 14 years, while section 405(2)(e) defines a vagabond to include 'any male person who dresses or is attired in the fashion of a woman in a public place or who practices sodomy as a means of livelihood', and an offender could be liable to two years imprisonment and a fine.

Shari'a Law is also notorious for prohibiting same-sex relationships.[3] The provisions vary from state to state. Punishments range from receiving hundred lashes of the cane to being stoned to death. For instance, in Kano and Zamfara,[4] unmarried offenders receive hundred lashes of the cane and one-year jail terms, while for married offenders, the law prescribes stoning to death. In Bauchi state, the law prescribes the death sentence 'or any other means decided by the state'.[5] In Kebbi State, all offenders are to be stoned to death.[6]

The combination of all these laws was already lethal for gay people in Nigeria. The 2013 Act was therefore unnecessary. It merely goes further to specifically ban same-sex marriages, and impose liabilities on anyone seen as aiding and abetting these unions. However, since no court in Nigeria would have solemnized a marriage involving gay people, the Act is practically redundant.

This chapter will argue that Nigeria's anti-gay laws violate several fundamental human rights principles and must therefore be addressed. The chapter will suggest amendments to Nigeria's Constitution to better protect sexual minorities. Drawing on specific examples of victimization experienced by gay people in Nigeria, the chapter will show the urgency in addressing the current

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situation. It will draw on the inspirational story of an Australian Catholic priest who championed the fight to end the violence against gay people in Australia, to show that religious or cultural beliefs should not preclude tolerance and respect for sexual minorities.

2 Cultural and religious influences on same-sex relationships in Nigeria

In Nigerian culture, religion and morality are often so intertwined that separating them can prove difficult. For example, the two major religions i.e. Christianity and Islam have expectations of high morality and modesty on their followers. Homosexuality is believed to be against African culture and morality.[7] In a 2013 survey by the Pew Research Centre, ninety-eight percent of Nigerians were polled to be against homosexuality as they believed it was incompatible with cultural and moral values.[8] Mujuzi believes this mindset stems in part from the belief that everyone was born straight, and that homosexuality is a practice to which people are lured.[9]

The above survey report notes the existence of a strong relationship between a country's religiosity and opinions about homosexuality, with usually far less acceptance being recorded in countries where religion was central to people's lives, and conversely more widespread acceptance of homosexuality in countries where religion was less central to people's lives.[10] Hence, religious bodies are vocal in the attack on homosexuality in Nigeria.[11] Former President Olusegun Obasanjo had said of homosexuality during his presidency 'Such a tendency is clearly un-Biblical, unnatural and definitely un-African' and was therefore 'totally unacceptable'.[12] Statements like these have the effect of endorsing criminalization and abuse.

Understanding sexuality as an innate thing in the individual will aid a better understanding of homosexuality and encourage tolerance for gay people. In the words of Adebanjo, taking time to understand gay people will sow the seeds necessary for change.[13] It is therefore important to correct the above mindset. In a society such as Nigeria where the law, religion, culture and morality are so deeply intertwined, it may be necessary to pull at the layers of each of these components, to unravel the way society's mind works. Baxter postulates that in determining how the law affects morality, it is expedient to ask if we have a moral obligation to follow the law, and conversely that in determining how morality affects the law, the question then becomes how relevant morality is in fixing the law.[14]

Nigerian culture is such that seeks a spiritual angle to explain any sexual orientation which does not conform to the norm. Some ethnicities have been known to perform 'cleansing rituals' on homosexuals, while religious houses also perform exorcisms to rid people of 'the gay spirit'.[15]

Nigeria is not alone in its criminalization of same-sex relationships. Many African countries have held on to the belief that homosexuality is incompatible with African culture and morality. Uganda introduced the Uganda

Anti-Homosexuality Act in 2014,[16] but it was declared invalid by the Constitutional Court of Uganda in August of the same year, on the basis that the required quorum was not formed before the law was passed.[17] Other African countries which criminalized same-sex relationships include Malawi[18] and Kenya[19] to mention just a few. South Africa therefore stands out for decriminalizing same-sex relationships on a continent where same-sex relationships are being demonized and vilified.[20]

3 The Same Sex Marriage (Prohibition) Act 2013

The Same Sex Marriage (Prohibition) Act 2013 is a harsh law which stifles the rights of Nigeria's gay community. The UN High Commissioner for Human Rights rightly sums up the Act in the following words:[21]

> Rarely have I seen a piece of legislation that in so few paragraphs directly violates so many basic, universal human rights. Rights to privacy and non-discrimination, rights to freedom of expression, association and assembly, rights to freedom from arbitrary arrest and detention: this law undermines all of them. In addition, the law risks reinforcing existing prejudices towards members of the LGBT community, and may provoke an upsurge in violence and discrimination.

Comprising eight sections, the Act goes for the jugular. To clear any ambiguity, the Act defines marriage and sets out parties to a valid marriage in Nigeria thus '"marriage" means a legal union entered into between persons of opposite sex in accordance with the Marriage Act, Islamic Law or Customary Law'.[22] As pointed out by Barnard and De Vos, refusal to let go of this ingrained idea could be borne out of the thought that to change the definition of marriage will be unnatural or even impossible.[23]

Section 1 prohibits marriages or civil unions between persons of the same sex in Nigeria irrespective of the jurisdiction they were contracted in. Under the section, such unions were not entitled to benefits accruing to valid marriages.[24] The impact of this section is that valid same-sex marriages/unions of foreign nationals were invalid in Nigeria. Likewise, same-sex marriages of Nigerians conducted in foreign jurisdictions which recognize same-sex unions would not be recognized in Nigeria. This provision creates problems for gay foreigners living in Nigeria who have contracted valid unions elsewhere. Section 5(1) prescribes a term of 14 years imprisonment for offenders.

Section 2 prohibits places of worship from solemnizing same-sex unions. No certificate issued in respect of a same-sex marriage/union will be valid in Nigeria.[25] Section 3 goes ahead to emphasize that only a marriage contracted between a man and a woman shall be valid in Nigeria.

The Act arbitrarily bans the registration of gay clubs and associations,[26] and attaches a ten-year jail term for those found to be operating or participating in such.[27] It also seeks to punish persons who administer or witness the solemnization of same-sex unions, and prescribes a ten-year jail-term for offenders. This

effectively means loved ones of the couple could be penalized just for showing support.

Public shows of affection between same-sex couples are prohibited, and offenders are liable to ten years imprisonment.[28] The use of the words 'directly or indirectly' under section 5(2) makes the interpretation of what constitutes 'public show' subjective and therefore difficult. For instance, two long-lost friends who are genuinely happy to see each other and expressing that happiness can be misconstrued to be 'directly or indirectly' making a public show of a homosexual relationship.

While the Same Sex Marriage (Prohibition) Act has been mostly welcomed in Nigeria, it has been greeted with disdain in the international community, with several countries calling for its withdrawal or review.[29] Noting the negative impact of the passage of the Act, Dorothy Aken'Ova, executive director of the International Centre for Reproductive Health and Sexual Rights observed that the Act had reawakened interest in communities to rid the country of gay people and gay tendencies, and had driven many gay people 'into the closet'.[30] Arrests of suspected gay people multiplied, with rights activists having to go underground and several gay people seeking asylum in foreign countries.[31]

Juxtaposed with the South African regime, inadequacies in the Nigerian system become glaring. Not only has South Africa decriminalized homosexuality, it has actively tried to protect the rights of its gay population. In addition to expressly legislating to protect their fundamental rights, the introduction of the Civil Union Act is another step towards this aim. It must be pointed out however that even though the South African Civil Union Act confers full marriage rights on qualifying same-sex couples, it has been criticized for a number of reasons, a major one being that it is perceived to have unnecessarily complicated South Africa's family law system by favouring heterosexual couples to marry under both the Marriage Act and the Civil Union Act, but presenting same-sex couples with only the option of a civil union under the Civil Union Act.[32]

Nigeria needs to urgently review its anti-gay law and decriminalize same-sex relationships. This would be a good place to start showing tolerance and acceptance of its gay population and to recognize their struggles.

4 The non-conformity of Nigeria's anti-gay stance with Human Rights principles.

The protection of the right of sexual minorities has been of paramount interest for international and regional bodies in recent times. The rationale for this has been eloquently set out by the UN thus:

> The case for extending the same rights to Lesbian, Gay, Bisexual and transgender (LGBT) persons as those enjoyed by everyone else is neither radical nor complicated. It rests on two fundamental principles that underpin international human rights law: equality and non-discrimination[33]

The UN Human Rights Council adopted resolution 17/19,[34] which was the first of its kind from the UN on issues pertaining to human rights, sexual orientation and gender identity. It mandated the UN High Commissioner for Human Rights to commission a study documenting discriminatory law and practices and acts of violence against people based on sexual orientation and gender identity, and how international human rights law could aid in putting an end to violence and other HR violations in this regard. In September 2016, the Human Rights Council adopted resolution 32/2, which also sought, among other things, to protect sexual minorities from violence and discrimination, and to appoint an independent expert on Sexual Orientation and Gender Identity. This shows a commitment at the international level to enforce the protection of the rights of sexual minorities. Also, General Comments such as General Comment No 22 of 2016 which will be discussed in further detail below support this assertion. Attempts at regional level will also be examined further into the chapter.

As a State Party to numerous international human rights instruments, Nigeria has an obligation to comply and ensure compliance with the provisions of these instruments. The 2013 Act violates regional and international principles of fundamental human rights. these include the right to privacy, dignity, health, equality and non-discrimination, and the right to found a family.

4.1 The right to privacy and family life

Section 37 of the Nigerian Constitution guarantees the right to privacy and family life to all citizens.[35] It provides 'The privacy of citizens, their homes, correspondence, telephone conversations and telegraphic communications is hereby guaranteed and protected'.

This right is guaranteed to every individual, and everyone should be able to enjoy it, irrespective of their sexual orientation. The Universal Declaration on Human Rights (Universal Declaration)[36] and the International Covenant on Civil and Political Rights (ICCPR) also guarantee this right.[37] Hence, the constant harassment of gay people and the compulsion to 'out' them is an invasion of this right.

The right to privacy has been argued successfully in cases such as *Toonen v Australia*,[38] and *Norris v Ireland*.[39] In the *Toonen* case, Nicholas Toonen was a homosexual living in Tasmania, Australia who challenged the criminalization of homosexuality in Tasmania.[40] Toonen sent a communication to the Human Rights Committee of the ICCPR arguing that section 122(a) and (c) and section 123 of the Criminal Code of Tasmania which criminalized sexual contact between men violated his rights to privacy (Article 17 of the ICCPR) and non-discrimination (Article 26).[41] He lost his job during the pendency of the case.

Tasmania alleged that issues of morality should be regarded as being domestic decisions for individual governments, and that the provisions in question could help prevent the spread of HIV/AIDS.[42] On the first issue, the

Committee noted that there was danger in allowing such an argument to stand, because doing so would cause several laws which interfered with privacy to be withdrawn from the Committee's jurisdiction.[43] It observed that the Australian government had on its part already conceded that criminalizing homosexuality had the opposite effect i.e. it caused gay people, who were most vulnerable to HIV/AIDS to go into hiding for fear of discrimination.[44] The Committee also stated that Tasmania had failed to show any connection between continued criminalization of homosexuality and the effective control of the spread of HIV/AIDS.[45]

Agreeing with Toonen, the Committee found sections 122 and 123 of Tasmania's Criminal Code to be in violation of the complainant's right to privacy.[46] As a result of this case, Tasmania overhauled its discriminatory law while the whole country was forced to commence a review of its laws.

Similarly, in *Norris v Ireland* which was brought before the European Court of Human Rights, the ECHR held that the Irish law criminalizing same-sex relationships between consenting adults was in violation of the right to private and family life guaranteed by Article 8 of the European Convention.

The right to family life is an offshoot of the right to privacy. It is guaranteed under Article 16 of the Universal Declaration and Article 23 of the ICCPR. In *Valianatos and others v Greece*,[47] the ECHR held that the legal recognition given to civil partnerships of different-sex couples to the exclusion of same sex couples was incompatible with Article 8 of the European Convention on Human Rights. The requirement is that the contracting parties must be of full age and must have given their free and full consent.

4.2 The right to dignity

Section 34 of the Nigerian Constitution recognizes the right to dignity for every individual. Section 34(1)(a) provides

> Every individual is entitled to respect for the dignity of his person, and accordingly –
>
> (a) No person shall be subject to torture or to inhuman or degrading treatment

The right to dignity is also preserved under the Universal Declaration (Articles 1 and 5), the ICCPR (Article 7) and the African Charter on Human and Peoples Rights (the Banjul Charter) (article 5).

Resolution 275 adopted at the 55th Ordinary Session of the African Commission in Luanda, Angola in 2014 specifically emphasizes the right to dignity for sexual minorities in Africa.[48] Re-emphasizing the relevant provisions of the African Charter,[49] the Commission condemned the spike in violence against sexual minorities, and called on State Parties to put an end to all acts of violence and abuse against sexual minorities, ensure proper investigation and prosecution of perpetrators of violence against them, and establishing

working judicial procedures while providing an enabling environment for activists to work in.

The decisions of the African Commission in *Curtis Doebbler v Sudan*[50] and *Abdel Hadi, Ali Radi and ors v Republic of Sudan*[51] are instructive on the right to dignity and freedom from torture, inhuman or degrading treatment as preserved under Article 5 of the Banjul Charter. The complainants in the *Doebbler* case were university students on a picnic in Buri, Khartoum.[52] While the picnic was ongoing, the police and other security agents swooped in on them, alleging that their dressing and actions were in violation of 'public order' under Sudan's Criminal Law.[53] In addition to paying fines, they were sentenced to between 25 and 40 lashes using a wire and plastic whip which leaves permanent scars.[54] This whipping was carried out in public, with the women receiving theirs on their bare backs.[55] At its 33rd Ordinary Session in Niamey, Niger in May 2003, the African Commission held that the provision on torture, cruel, inhuman or degrading treatment must be interpreted as widely as possible to encompass the widest array of physical and mental abuses possible.[56] Finding Sudan to be in violation of Article 5, the Commission requested that the Sudanese government amend the offending provisions of its Criminal Law, that it abolish the penalty of lashes, and compensate the complainants. In *Abdel Hadi Ali Radi and ors*, a case involving the alleged torture of Sudanese IDPs by the police, the Commission found that the actions of the police were of such a serious nature that it attained the threshold of severity as to amount to torture.[57]

There has been flagrant disregard for the right to dignity of gay people in Nigeria. They are regularly harassed, tortured and publicly shamed. Michael Ighodaro is just one of the many victims of homophobic attacks. Michael told his story in a 2017 interview with a reporter from the Independent Newspapers UK.[58] He had been attacked by anti-gay vigilantes while waiting for a taxi outside his friend's home in the city of Abuja. This attack was predicated on his being featured in an article about an AIDS conference he had attended and facilitated in 2012. On that fateful day, Michael's attackers beat him blue-black and burnt his house and property. Worse still, he chose not to seek proper medical treatment, as he did not want anyone to know the cause of the attack.

The sad story of Olumide Olubunmi Akinnifesi is another which reflects the horrors that gay people go through in Nigeria. Akinnifesi was attacked in broad daylight by a mob in Ondo State, South West Nigeria in February 2016 for being gay.[59] Sadly, he succumbed to his injuries the following day, and to date his attackers have not been brought to book. His case will be reviewed in further detail below.

In its 2016 publication *'Tell Me Where I Can Be Safe' – The Impact of Nigeria's Same Sex Marriage (Prohibition) Act*, Human Rights Watch (HRW)[60] documented several cases of harassment and torture of gay people. HRW conducted both face-to-face and telephonic interviews with many victims. One of such victims was George who described the humiliation he and others were put through following their arrest at a gathering thus:[61]

> … We were all squeezed into the van, sitting on each other's laps. Immediately when we arrived at Apata police station [Ibadan], the police told us to take our clothes off. We had only underwear – boxer shorts – on. The police ... told us to stand in front of the condoms, and gave one of the guys a board written: '21 gay men suspected'. Pictures were taken, the police had called a commercial photographer to take the pictures, but this is normal practice in Nigeria.

Another gay man who was also a victim of police brutality told HRW a sordid tale of humiliation, degradation and extortion. Oscar and his friends were beaten up at the police station, forced to strip and photographed. Before their release, they were loaded onto the back of an open police jeep and paraded around the city.[62]

The Constitutional Court of South Africa weighed in on the right to dignity of gay people in *National Coalition for Gay and Lesbian Equality v Min. of Justice and others*, where it held that criminalization of same-sex relationships violates the right to dignity,[63] and noted that the constitutional protection of human dignity required that the value and worth of all individuals as members of the society be acknowledged.[64] In 2014, the African Commission adopted a resolution condemning all forms of violence based on sexual orientation, deeming them to be human rights violations, most especially the right to life and dignity as guaranteed under the Banjul Charter.[65] The Commission also condemned the persecution of persons based on their sexual orientation or gender identity.[66]

4.3 The right to equality and non-discrimination

The provisions of the Same Sex Marriage (Prohibition) Act is in direct contradiction to the provisions of the Nigerian Constitution and other human right instruments on the right to equality and non-discrimination. Section 42 of Nigeria's Constitution protects the right to equal treatment and non-discrimination. Section 42(1)(a) states as follows:

> A citizen of Nigeria of a particular community, ethnic group, place of origin, sex, religion or political opinion shall not, by reason only that he is such a person
>
> (a) Be subjected…to disabilities or restrictions to which citizens of Nigeria of other communities, ethnic groups, places of origin, sex, religion or political opinions are not made subject;

The above section does not expressly prohibit discrimination based on sexual orientation, like the South African Constitution does. Nigeria has however ratified the Banjul Charter,[67] article 2 of which prohibits discrimination on several grounds. In its General Comment 20 on non-discrimination in the

enjoyment of rights which are found in the ICESCR, the Committee on ESCR has held that these grounds include HIV status and sexual orientation.

It is suggested that Nigeria update its constitution to reflect the right to non-discrimination based on sexual orientation. Section 9(3) and (4) of the South African Constitution – which is the non-discrimination provision – can be used as a guide in this regard. Section 9(3) of the South African Constitution provides:

> The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.

Section 9(3) is all encompassing. By expressly including sexual orientation in its provision on non-discrimination, South Africa sends out a clear statement on its position on the individual's right to their sexuality.

A change can be effected in the Nigerian Constitution by inserting the term 'sexual orientation' as one of the grounds listed in section 42(1). An example would be:

> A citizen of Nigeria of a particular community, ethnic group, place of origin, sex, *sexual orientation*, religion or political opinion shall not, by reason only that he is such a person …

Yet still, if the idea of expressly providing for the protection of people's fundamental rights with regards to sexual orientation is too inconceivable, Nigeria could borrow a leaf from the wordings of Article 2 of the Banjul Charter which includes the phrase 'or other status'. As reiterated by Murray and Viljoen, the inclusion of 'such as' and other status clearly shows that the list in article 2 is not exhaustive.[68] This phrase has been stated to include sexual orientation.[69] Taking such action will be in line with the directive of the African Commission in Resolution 275 that all States enact and apply appropriate laws prohibiting and punishing all forms of violence, including violence against sexual minorities, and that of the UN Committee on Economic, Social and Cultural Rights (Committee on ESCR) in General Comment 22 to the effect that to realize the right to sexual and reproductive health, states must first address laws, institutional arrangements and social practices which prevent individuals from effectively enjoying their sexual and reproductive health.[70] As noted by the Committee, the right to sexual and reproductive health is indivisible from and interdependent with other rights,[71] hence it must be provided for.

The all-encompassing phrase 'or other status' mentioned above could be applied in redrafting section 42(1). Section 42(1)(a) would then read like this:

> A citizen of Nigeria of a particular community, ethnic group, Place of origin, sex, religion, political opinion *or other status* shall not by reason only that he is such a person be subjected … to disabilities or restrictions ….

This way, the fundamental rights of sexual minorities to equality and non-discrimination could be guaranteed by the Nigerian Constitution without assaulting the sensibilities of core traditional, moral or religious anti-gay adherents i.e. the rights of homosexuals to non-discrimination can be preserved without the words 'sexual orientation' being expressly incorporated into the Constitution. This is one of the ways that the elusive 'middle ground' could be achieved in Nigeria. For this to be achievable though, same-sex relationships first have to be decriminalized. It is important to stress that this is by no means a call to outrightly legalize same-sex relationships. Rather, it is a way of reaching a compromise between both extremes.

In addition to Article 2, Articles 3, 18 and 19 of the Banjul Charter provide for the right to equality and non-discrimination for all persons. Murray and Viljoen are of the opinion that the use of the inclusive phrases 'such as' and 'other status' in article 2 suggests that the drafters foresaw and indeed left room for an expansion of grounds under the article.[72] They also put forward another interesting argument that 'sex' as used in article 2 of the Banjul Charter could be understood to include sexual orientation as well, but were quick to concede that such an expansive definition could militate against the more common understanding of the term 'sex'.[73] Be that as it may, the position of the Commission on the right to equality and non-discrimination is clear.

Article 28 also imposes a duty on the individual to respect others without discrimination and to promote, safeguard and reinforce mutual respect and tolerance of all others. In the same vein, articles 1 and 2 of the Universal Declaration in upholding the right to equality and non-discrimination, reiterate that all human beings are born free and equal in dignity and rights. Article 7 of the Universal Declaration provides further for equality before the law and equal protection without any discrimination. Likewise, Articles 2, 3 and 26 of the ICCPR also guarantee the right to equality and non-discrimination.

Resolution 275 strongly condemned the persistence of discrimination and violence against sexual minorities, noting the failure of law enforcement agencies and states generally to address these issues. It has also been lauded for addressing the worsening incidence of discrimination and attacks on sexual minorities and activists and for negating the pervading notion that homosexuality is 'un-African'.[74] In its Concluding Observations to Nigeria, the Commission condemned Nigeria's Same Sex Marriage (Prohibition) Act for its potential to engender violence against sexual minorities in the country, and to drive underground this group which is particularly vulnerable to HIV/AIDS.[75]

In *Young v Australia*,[76] where the applicant had brought a complaint before the Human Rights Committee with regards to Australia's veterans' entitlements law wherein homosexual veterans were not entitled to the same pension as other veterans, the Committee found Australia to be in violation of Article 26 (which guaranteed the right to equality and non-discrimination).

4.4 The right to health

The right to health is another fundamental right which criminalization of same-sex relationships continues to undermine. Criminalization leads to discrimination and stigmatization, driving sexual minorities underground and making it difficult for them to access HIV prevention programmes or treatment, with devastating consequences.[77]

Article 25(1) of the Universal Declaration provides that 'everyone has the right to a standard of living adequate for the health and well-being of himself and of his family including … medical care and other social services…'. Likewise, article 16(1) of the Banjul Charter guarantees the right for every individual to enjoy the best attainable state of physical and mental health, while Article 16(2) enjoins state parties to take necessary measures to protect the health of their citizens and to ensure that they receive medical attention when needed.

The Human Rights Committee has noted the connection between criminalization of homosexuality and the high prevalence of HIV/AIDS among homosexuals.[78] As noted in its Concluding Observations to Nigeria above, criminalizing homosexuality drives the very people who are most vulnerable to HIV/AIDs underground, making it even more difficult to effectively tackle the pandemic.[79] Gay men and other men who have sex with men have been recognized as one of the three major groups driving up the country's HIV/AIDS numbers, with an HIV prevalence of 23%.[80] A study on the impact of the Same Sex Marriage (Prohibition) Act on the healthcare-seeking behaviour of men who have sex with men in Abuja showed that the introduction of the Act negatively affected the healthcare-seeking behaviour of participants, due to the fear of discrimination and stigmatization.[81]

4.5 Freedom of assembly

This is another fundamental right that has been trampled upon by Nigeria's anti-gay law. Section 4(1) of the 2013 Act prohibits the registration of gay clubs, societies and organizations, while section 5(2) prescribes a jail term of ten years for anyone who registers, operates or participates in gay clubs, societies or organizations. This means sexual minorities are banned from forming associations to fight for their cause or advance their rights.

Shockingly, the Act goes further to impose liability on individuals who administer, witness or support the joining of same sex couples, or who support the 'registration, operation and sustenance of gay clubs, societies, organizations, processions or meetings' in Nigeria.[82] Under the section, a jail term of ten years awaits such people on conviction. This is a mindless erosion of fundamental rights. In effect, families and friends who show support for gay people can be arrested and jailed for doing so. The same fate awaits licenced marriage officiators or religious leaders who choose not to discriminate by joining same-sex couples.

This freedom is guaranteed under section 40 of the 1999 Constitution. Section 40 entitles every person to 'assemble freely and associate with other persons', and to form or belong to any association for the protection of his interests. Thus, in terms of the section, gay people are entitled to form associations if they so wish to protect or advance their interests. To take this right away is to undermine their constitutional rights. The provisions of the Constitution are superior to any other law, and where there is a clash between the provisions of the Constitution and any other law, the Constitution will prevail.[83]

In addition to the Nigerian Constitution, the freedom of association and assembly is also guaranteed under Article 20(1) of the Universal Declaration, Articles 21 and 22 of ICCPR and Articles 10 and 11 of the Banjul Charter. Nigeria's stance under the 2013 Act is incompatible with its very own Constitution as well as its obligations as a state party to the above human rights instruments. In its Concluding Observations on Nigeria's 5th periodic Report on the implementation of the African Charter,[84] the Commission called on Nigeria to review its Same Sex Marriage (Prohibition) Act, put an end to discrimination against sexual minorities, ensure the protection of their rights,[85] and put in place measures to ensure freedom of expression.[86]

5 Case studies from Nigeria

Several examples abound of Nigerians who have suffered injustice for no other reason than being gay. Two of such cases will be considered briefly under this heading.

5.1 Olumide Olubunmi Akinnifesi

One of the most heartrending of all is that of Olumide Olubunmi Akinnifesi, who was viciously attacked by a mob in Ondo State on 17 February 2016, and who died as a result of that attack.[87] Olumide was allegedly caught pants down with another man. Badly beaten and left for dead, he died the following day from internal bleeding. Fearing for his life, Olumide's alleged lover went into hiding. There were reports of harassment, and vandalism experienced by the families of the two men, and of people leaving offensive comments on Olumide's Facebook page. Even in death, Olumide was targeted by the anti-gay brigade.

5.2 Michael Ighodaro

Michael's story has been briefly discussed above.[88] In a sit-down with *The Independent* Newspapers, Michael detailed how he was kicked out of his family home at the age of 17, dropped out of school and forced to survive on the streets, for no other reason than because he was gay. He was attacked and severely injured by unknown assailants after his identity was compromised in

Nigeria, and his house and property burnt. He was forced to flee the country and seek asylum in the United States.

These are just two of the many gay men who have experienced the full force of the homophobic wrath of Nigerians. Some like Michael, have lived to tell their stories. Sadly, others like Olumide have not been so lucky. The introduction of the 2013 Act further exacerbated the problem. In its 2016 publication discussed above, Human Rights Watch documented several instances of persecution experienced by gay people in Nigeria. No individual should be treated in the manner in which Nigeria's sexual minorities are being treated. The 2013 Act would seem to have put the seal of approval on their degradation and dehumanization.

6 Lessons in tolerance – The Father Paul Kelly example.

It has previously been argued that in the absence of an immediate acceptance of same-sex relationships, Nigeria as a country can shift ground to the extent that same-sex relationships are decriminalized, and fundamental rights of gay people in the country are not being violated.[89]

There is no better guidance on the possibility of finding a middle ground in the clash between religion and gay rights than the story of Father Paul Kelly. Father Paul is an Australian Catholic priest who gained national popularity for his role in the movement to abolish the homosexual advance defence (also known as the 'gay panic' defence or the partial defence) in Queensland.[90] The bill to remove the gay panic defence was passed on 20 March 2017.

The background story was that following an altercation on 3 July 2008 in Maryborough, Queensland, Wayne Ruks, an alleged gay man had been beaten and left to die by two men on the grounds of St Mary's Catholic Church.[91] The attack had been caught on the church's CCTV cameras. At their trial, the men alluded to the homosexual advance defence to show provocation in terms of section 304 of the Queensland Criminal Code, thereby getting manslaughter convictions as opposed to murder. The partial defence of provocation found in section 304 reduces criminal responsibility for murder to manslaughter, and had created a loophole whereby people accused of murder could claim provocation due to an unwanted sexual advance.[92] This defence was used for the first time in Australia in *R v Murley*,[93] and had been controversially entrenched in *Green v the Queen* where the court had found, on appeal, that sexual advances of a non-violent nature were sufficient to establish provocation.[94]

A month after the attack on Ruks, another man, Stephen Ward, who was a hitchhiker was also bashed to death and his body dumped close to Maryborough.[95] Ward's attacker also relied on the 'gay panic' defence, claiming that Ward had made a sexual advance at him.[96] At the time of these two murders, the defence had been abolished in all jurisdictions in Australia, except Queensland and South Australia.

To Father Paul, these two incidents occurring so close to each other, signified a call to action. He then created a Change.org petition, which gained

almost 290,000 signatures.[97] On why he took up the campaign to change the law, Father Paul said:[98]

> The more I thought about it, I thought, this didn't make any sense. It got me fired up. I realised that this really was a terrible loophole and should be closed.

Father Paul has been celebrated for the role he has played in changing the law,[99] even being referred to as an LGBTI hero.[100] Drawing from some of the teachings of Pope John Paul II, the priest has however said that stopping the homosexual advance defence 'is the gospel'. In his words 'this is real Christian teaching. They make it about homophobia when I'm trying to protect human dignity'.[101] The priest acknowledged that his fight to put an end to the gay panic defence could be confused with fighting for gay rights, and has clarified that he remained aligned to the church's view on same-sex marriage.[102] For Father Paul, the aim ultimately was to put an end to laws that tolerated violence against particular groups.[103]

It is remarkable that no religious leader in Nigeria has spoken out against the unending attacks on homosexuals in the country or tried to call their followers to order. Rather, they have been vocal in condemning sexual minorities, fuelling the raging homophobia in the country. Nigeria can learn a lot from Father Paul Kelly with regard to showing respect, compassion and tolerance for the causes of gay people. He has shown that it is possible to accept and understand others whose orientation or beliefs are different from the norm without outrightly supporting their orientation or beliefs.

It is submitted that the journey to changing attitudes towards sexual minorities begins with trying to understand them and their struggles. The words of His Lordship, Justice Ackerman in the *National Coalition for Gay and Lesbian Equality* case[104] to the effect that 'To understand "the other" one must try as far as is humanly possible, to place oneself in the position of "the other"' are of great significance to this discussion.

7 Conclusion and recommendations

This chapter has discussed Nigeria's Same Sex Marriage Prohibition Act 2013 in detail, and has examined how the Act, and Nigeria's other anti-gay laws encroach on the fundamental rights of gay people in Nigeria. It has shown how religious and cultural influences have shaped the demonization of same-sex relationships in Nigeria.

The chapter has also proposed ways in which a compromise can be reached between the two extremes i.e. respecting the rights of sexual minorities without necessarily legalizing same-sex relationships. Although this could be considered as taking baby steps by the liberal world, it would be considered a major victory for gay activists and the gay community in Nigeria.

To show that a compromise is possible in the midst of cultural, moral or religious sentiments, the chapter has discussed the inspirational story of Rev. Father Paul Kelly as a lesson in tolerance in spite of opposing beliefs. Following in the priest's footsteps in this regard will change the perception of homosexuality in Nigeria.

Notes

1 Cap C38, Laws of the Federation 2004.
2 These are Bauchi, Borno, Gombe, Jigawa, Kaduna, Kano, Katsina, Kebbi, Niger, Sokoto, Yobe and Zamfara.
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4 Sec 129 of the Kano State Shariah Penal Code Law and section 131 of the Zamfara State Shariah Penal Code Law.
5 Sec 134 of the Bauchi State Shariah Penal Code Law.
6 Sec 132 of the Kebbi State Shariah Penal Code Law.
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17 *Oloka-Onyango & Others v Attorney General*, Uganda Constitutional Petition No 08 of 2014, 6.
18 Sec 153 of the Penal Code Act of Malawi. Malawi however suspended its anti-gay laws in November 2012.
19 Sec 162 of the Kenyan Penal Code.
20 Sec 9(3) of the South African Constitution decriminalizes homosexuality by including 'sexual orientation' as one of the grounds for equality/non-discrimination.
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22 Sec 7.
23 'Same-sex marriage, civil unions and domestic partnerships in South Africa: Critical reflections on an ongoing Saga' (2007) *South African Law Journal* 815.

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25 Sec 2(2).
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31 As above.
32 P De Vos 'A judicial revolution? The court-led achievement of same-sex marriage in South Africa' (2008) 4(2) *Utrecht Law Review* 173–174.
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37 Art 17 ICCPR.
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39 (Application no. 10581/83) European Court of Human Rights, 26 October 1988.
40 Para 1.
41 Paras 2.1–3.1.
42 Para 8.4.
43 Para 8.6.
44 Para 6.5.
45 Para 8.5.
46 Paras 9–11.
47 (Application nos 29381/09 and 32684/09) European Court of Human Rights, 7 November 2013.
48 Resolution 275 entitled 'Resolution on Protection against Violence and other Human Rights Violations against Persons on the basis of their real or imputed Sexual Orientation or Gender Identity'.
49 Arts 2, 3, 4 & 5.
50 AHRLR 153 (ACHPR 2003).
51 Communication 368/09.
52 Para 1.
53 Para 2.
54 Paras 5, 30.
55 Paras 30 & 32.
56 Para 37.
57 Paras 73–77.
58 This is discussed further in 5.2 below (Gander (n 89)).
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64 Para 28.
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78 Para 9, Human Rights Committee Concluding Observation on Kenya CCPR/C/KEN/CO/3 adopted at its 105th session, 9–27 July 2012.
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10 A case for removing barriers to legal recognition of transgender persons in Botswana

Kutlwano Pearl Magashula

1 Introduction

Botswana has seen a steady rise in progressive decisions on the rights of LGBTI persons. Most markedly, in a unanimous decision poised to set the pace for juridical recognition of LGBTI rights in Africa, the Botswana High Court decriminalized same-sex sexual practices between consenting adults in private.[1] The Court in *Letsweletse Motshidiemang v Attorney General,* determined that the 'regulation of conduct deemed indecent, done in private between consenting adults, is a violation of the constitutional rights to privacy and liberty'. In another landmark ruling, the Botswana Court of Appeal affirmed the constitutional rights of LGBTI persons to assembly, association and expression and asserted that equal protection of the law extended to everyone without distinction. Similarly, in *ND v Attorney General* (the *Gender marker* case), the High Court found that a refusal by the Registrar of National Registration to change the gender marker on a transgender (trans) applicant's identity document had interfered with his constitutional rights. This was a momentous decision that allowed trans people to alter their official identity documents to align them with their experiences of gender (legal gender recognition).

It remains apparent however, that progressive judgements alone, outside the backing of a comprehensive legislative or policy framework, are inadequate for the protection of rights. Moreover, approaches that fail to consider the lived experiences of the wider community beyond individual applicants can add barriers to the realization of rights. In the *Gender marker* case for example, based on the applicants' circumstances, the Court made gender-affirming surgery and hormonal therapy prerequisites for legal gender recognition notwithstanding the restricted access to such services within the Botswana public health management system. This effectively excludes self-identified trans people who have not transitioned medically from legal recognition.

This chapter explores the implication of the *Gender marker* case on the lives of trans persons in Botswana. It proposes more inclusive approaches to legal gender recognition that safeguard plurality and diversity. The chapter considers the different discursive models on trans identities, including the historical conceptions of gender diversity in Africa broadly and in Botswana. It critically

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analyzes the *Gender marker* case unpacking the inherent biases in the Court's approach. The case is evaluated using identity-based critiques of dominant cultural practices to show how it reinforced exclusionary norms.

2 Part I: Understanding trans identities

While it is common to assume that being trans involves some kind of medical procedure or treatment, many trans people either cannot afford to transition medically or opt not to.[2] Furthermore, access to appropriate and adequate hormone therapy and surgery in Africa is often difficult. A 2015 report by the World Health Organization (WHO) indicates that there are still very few appropriate and accessible health services available to trans patients.[3] This is often due to a lack of professional training and relevant health system standards. For trans people who wish to transition medically, the lack of access to gender-affirming services can contribute to feelings of dysphoria. As a result, some trans persons reportedly self-administer hormones obtained through illicit sources without medical supervision or guidance.[4] This can result in a myriad of health complications and contribute to poor mental health and increased exposure to sexual risk.[5] In a context where medical transition is a requirement for legal gender recognition, the lack of access to gender affirming treatment can present an insurmountable barrier.

Trans activists advocate that there should not be any qualifications placed on the term 'transgender' based on the ability to pass for another gender or societal standards of appearance, hormone levels or the state of one's genitals.[6] This is an important assertion as such qualification results in the erasure of the distinctiveness of the community. However, many people, including mental health professionals, still view the society as a strict binary composed of biological men and women. This is presented through the strict socio-political classification of gender as either male or female. This gender essentialist approach leaves little room for gender fluidity or for non-conformity and can result in precarious legal statuses for individuals who have not undergone any physical alterations resulting in institutional discrimination.

2.1 History of the medical conceptualization of trans identities

Many terms used to describe trans people today were virtually unknown or not in existence as recent as ten years ago. In fact, most terms widely used then are now considered outdated or offensive. Like homosexuality, the medical study of gender diversity began in earnest in the 19th century albeit with a conflation of gender identity and sexual orientation.[7] The attribution of gender variance as a psychopathology has been credited to Krafft-Ebing (1886); however, the 'surgical construction' of gender was popularized by George Jorgensten who went to Denmark as a man and returned to the United States as a trans woman in 1967.[8] Many physicians and psychiatrists at the time perceived transness as a delusional condition requiring psychotherapy and reality testing.[9] It was

in this cultural context that research on gender identity made its way into scientific analysis. Despite these prevailing negative framings, physicians like Harry Benjamin are credited for popularizing the term 'transsexual' as it is currently understood and for raising awareness on trans identities within the medical profession.[10] Benjamin was among the first physicians to experiment with hormonal and surgical therapy for the treatment of individuals with gender dysphoria.[11]

Modern medicine and psychology remain at the forefront of investigation on trans identities and medical experts continue to shape perceptions on gender diversity.[12] This stems from the conception of medicine as authoritative, thorough and objective although historically, medicine has been manipulated to perpetuate oppression such as justifying slavery. Similarly, influences of oppositional sexism and essentialist assumptions about the connection between sex and gender continue to be evident in medical discourses about gender identity.[13] The pathologization of trans experiences still plays a role in reinforcing gender hierarchies and disparities between normative genders and non-normative identities.[14] Trans people throughout the world continue to have their access to basic human rights curtailed or denied on that basis.[15] While some physicians have demonstrated a commitment to creating a safer, more inclusive world for non-normative identities, others have served to erase them.[16] The legacy of these latter experts has resulted in the perception of trans experiences as abnormalities and psycho-pathologies.[17] They are responsible for the slow change in attitudes about gender and invalidating the authenticity of gender-variant identities. While it has been argued that the medical model has facilitated access to health care services for trans persons, there are many issues that attach to the diagnoses of trans identities as mental disorders.

Trans people were first pathologized by the WHO through its International Statistical Classification of Diseases and Related Health Problems manual (ICD-9) in 1975. This is a manual used by clinicians and researchers globally to diagnose and categorize mental disorders. It is one of the key instruments that influenced views about trans persons along with the Diagnostic and Statistical Manual of Mental Disorders (DSM-III of 1980), published by the American Psychiatric Association. Both these manuals classified 'transgenderism' as a medical condition and mental disorder that could be treated through counselling, hormonal therapy, gender reassignment surgery and social and legal transition. The various editions of the DSM since DSM-III have approached gender diversity from the view that a discrepancy between the assigned sex (physical sex) and the psychological sex or gender, signal a psychiatric disorder.[18]

The diagnosis of 'gender identity disorder' in the DSM was maintained until May 2019 when it was reclassified as 'gender incongruence' and categorized as 'gender dysphoria' in DSM-V. The replacement of the diagnostic name was done with the aim of reducing stigma against trans people whilst ensuring clinical care to persons who feel they are a different gender to their assigned sex.[19] Prior to its adoption, a Work Group on Sexual and Gender Identity Disorders was convened to consider revising the diagnoses. The Work Group declined to

do so stating that this would jeopardize access to health care.[20] It however, recommended the abandonment of binary terms such as 'opposite sex' and 'anatomic sex' in the definitions of gender incongruence and replacing them with terms like 'experienced gender' and 'assigned sex.[21] A similar working group was set up by the WHO in the development of ICD-11 (Working Group on Sexual Disorders and Behaviours). The working group received recommendations from civil society organizations, activists and governments of member states to remove gender diversity from its classification of mental disorders. Criticisms levelled against the continued pyscho-pathologization of trans identities centred on the stigmatization that accompanies being labelled as mentally ill in most cultures.[22] The working group acknowledged that there is substantial evidence of the link between stigmatization and the classification, contributing to challenges with acquiring legal recognition, human rights abuses and restricted access to healthcare.[23] Nonetheless, they too recommended retaining gender incongruence in ICD-11 to safeguard access to health.[24] The principal difference between the two expert groups was that the WHO working group recommended removing gender dysphoria from categorization as a mental and behavioural disorder to 'conditions related to sexual health' whilst the DSM work group retained it as a mental condition. Whilst still pathologizing, the recommendations of the WHO working group are arguably more progressive and responsive to the needs and experiences of trans persons. The reclassification of gender dysphoria as a sexual health issue rather than a mental illness is demonstrative of a growing sensitivity to gender diversity. Nonetheless, the failure to de-pathologize demonstrates a resistance to the full acceptance of gender variant experiences. Retaining such classification is not only stigmatizing, it makes trans people objects of science rather than autonomous subjects. This places medical practitioners as paternalistic gatekeepers of legal gender recognition.

2.2 Trans identities in Africa

African cultures throughout the continent have a history of recognizing and accepting gender non-conformity, or at the most remaining apathetic.[25] Although varying in degrees of acceptance, 'gender crossing' was common in communities like the Nigerian *Hausa bori* cult, the *Maale* of Southern Ethiopia and the Swahili speakers on the coast of Kenya.[26] With the advent of colonialism and the formulation of 'African sexualities as primitive and backwards and in need of taming and civilizing',[27] attitudes grew steadily repressive. Now riddled with transphobia, stemming from a context which criminalizes same-sex behaviour between consenting adults, attitudes towards the trans community are more hostile.[28] Across Africa, trans people face prevalent stigma and discrimination every other day, including at work, at home and using public facilities.[29] In addition, they are continuously exposed to the threat of violence. Trans people are often required to disclose intimate and personal details to access routine services, violating their privacy and dignity. Moreover, having

a gender identity that is not reflected in official identity documents effectively denies trans people rights to citizenship.[30]

The degree of recognition of trans individuals in Africa varies from country to country, with countries like Sudan and Mauritania being the most repressive and South Africa the most progressive.[31] Although many of the laws used are meant to punish homosexuals, they invariably affect trans people because of the common conflation of gender identity and sexual orientation. South Africa remains the only country in Africa with express legislation that recognizes and protects trans persons. The Alteration of Sex Description and Sex Status Act of South Africa (ASDSS Act) was enacted to enable trans and intersex persons undergoing gender-affirming treatment to change the names and gender-markers on their identity documents. The only other African country that has expressly affirmed the right to legal gender recognition for trans people is Kenya. In *Republic v Kenya National Examinations Council,* the Kenya High Court issued an order compelling the Kenya National Examinations Council to recall the certificate of a trans applicant and issue her with a new one bearing her preferred name and devoid of a gender marker.

2.3 Trans identities in Botswana

Like other African countries, the absence of a legal framework for the recognition and protection of sexual minorities in Botswana has exacerbated social exclusion, stigma in social institutions and the denial of rights.[32] A research report on the mental health and wellbeing of LGBTI people in East and Southern Africa, shows that trans people in Botswana experience violence more often than the general population.[33] Similarly, experiences of sexual violence are significantly higher among trans and gender non-conforming people than with other sexual minorities.[34] Although there is no law in Botswana which makes it illegal to identify as homosexual and indeed trans, and despite clarifications to this effect by the High Court, trans people continually face harassment and are subjected to arbitrary arrest and detention.[35] Public officials have been known to use laws such as the Penal Code, which contains provisions which criminalize same-sex sexual practices, to harass individuals. In addition, police have been known to charge trans persons under offences relating to nuisance, idle and disorderly conduct and vagrancy, especially those who are also sex workers. In 2019, however, the Botswana High Court declared sections 164 and 165 of the Penal Code *ultra vires* the Constitution as they violate rights to privacy and liberty. The Attorney General has filed an appeal on the basis that the High Court exceeded its jurisdiction by overruling the decision of the Court of Appeal in *Kanane v the State* which fortified the notion that Batswana are not ready to embrace homosexuality.

The Rainbow Identity Association of Botswana (RIA), an organization that advocates for the recognition and inclusion of trans and intersex persons in Botswana, has noted some of the challenges faced by trans persons in obtaining documents reflecting their gender identity. In a contribution to a

stakeholder report submitted to the second cycle of the Universal Periodic Review of Botswana, RIA noted that the procedure for legal gender recognition is unsystematic and unclear.[36] It criticized the requirement on applicants to submit to courts, medical reports concerning their gender identity without the benefit of the cooperation of the Ministry of Health.[37] In addition, Botswana does not offer gender affirming surgery as part of national health services. Hormone therapy is available at government hospitals but given at the discretion of medical practitioners who often display transphobic attitudes and consider being trans a lifestyle choice rather than an inherent part of identity.[38]

3 Part II: A critical analysis of the case

The Court in the *Gender marker* case was seized with a challenge by a trans man, against the refusal to alter the gender marker on his national identity document (*omang*) to reflect his self-identified gender. The applicant who had been diagnosed with gender identity disorder (gender dysphoria), had undergone hormonal therapy and gender affirming surgery to make his body congruent with his gender identity. These procedures altered his physical and outward appearance and gave him a masculine appearance. Because of the divergence in the information contained in his *omang* and his physical appearance, the applicant applied to have his gender marker altered. The request was denied on the basis that sex assigned at birth determines the contents of one's *omang*. The applicant then lodged an application with the High Court arguing that the refusal violated his constitutional rights to equal protection of the law, right to freedom from inhuman and degrading treatment, right to privacy, right to freedom of expression and the right to protection from discrimination. The Registrar of National Registration (Registrar) argued that his wide-ranging discretion was limited in this case as Botswana employed a system where sex was determined at birth. He argued that identity documents issued by the state reflect sex and not gender identity and that the applicant sought to change his sex and not gender. He argued further, that there was no conclusive medical or legal position that could determine when a person's sex has changed. The Registrar argued that the law did not make provision for such changes and in the absence of an enabling statute the change could not be allowed. He insisted that the decision to undergo gender re-orientation was that of the applicant and as result no state responsibility arose. On violation of rights, he stated that by denying the application, he was in fact, upholding the applicant's right to equal treatment and freedom from discrimination as he does not register and change particulars based on individual desires alone or coupled 'with an unproven medical or legal threshold as to what constitutes a change in particulars'.

In response to the Registrar's submissions, the Court observed that an exercise of discretion should consider all the relevant circumstances to make a decision that is reasonable and justifiable. Relevant circumstances were said to

include the medical evidence presented plus the recommendations made by physicians that the gender marker should be altered to align it with his male identity. The Court noted that the National Registration Act (the Act), which allows for changes in particulars, does not state whether the changes to a person's particulars should be involuntary or can be 'self-inflicted'. Rejecting the argument that the absence of a law on legal gender recognition meant that the change could not be made, the Court cited comparative case law which establishes that in the absence of legislative guidance, courts must take into account medical evidence establishing the gender of the applicant. The Court found that the state has a duty to uphold the fundamental rights of every person and to promote tolerance, acceptance and diversity within a constitutional democracy. It found that this includes taking all necessary legislative, administrative and other measures to ensure that procedures exist for all state-issued identity documents which reflect a person's gender or sex to reflect their self-defined gender. It found that having an identity document that correctly reflects self-identified gender is fundamental to the right to dignity and freedom of expression. The Court expressed that by permitting changes to gender markers, the Registrar would be giving effect to the spirit and purport of the Constitution and extending much-needed help to vulnerable trans persons. It found that non-recognition of the applicant's gender identity denied him equal protection of the law, thereby leaving him extremely vulnerable to harassment and violence in both public and private spheres. It observed that this can result in extreme discrimination in all societal spaces, especially in the areas of employment, education and healthcare.

3.1 Significance of the case

This case gave legal gender recognition to trans people in Botswana in a context rife with systematic exclusion of non-normative identities. Faced with arguments that changing the applicant's gender marker would compromise the integrity of the National Identification Register, the Court stayed faithful to its role in the protection of rights and stated that rights could not be limited on the basis of mere conjecture and speculation. The Court applied a liberal construction of the Act, opening up its interpretation to include self-determined gender, albeit supported by medical evidence. In arriving at its decision, the Court considered the prevalent discrimination, stigma and harassment faced by trans people whose gender identity is not recognized. In this regard, the Court emphasized the state's and indeed wider society's duty to respect and uphold the individual right to dignity notwithstanding any difference in views. Furthermore, the Court took note that sex cannot always be accurately identified at birth and must be viewed in light of gender identity. Responding to the scarcity of local authorities on gender identity, the Court opened itself to guidance from jurisprudence from international comparative case law and referred to international human rights instruments and related documents. This demonstrates a growing judicial openness to the transfer of experiences, learning and development. This approach

allowed the Court to interpret the Constitution as a living document that grows and evolves in response to the changing needs and values of society.

3.2 Critique of the case

A critical interrogation of the decision exposes some inherent biases which disregarded the complexity of gender identity and the diversity of the trans community. The principal critique of the case is that it had the effect of pathologizing trans people and perpetuating the perception that they suffer from mental conditions. It further created a restrictive medical criterion for legal gender recognition that disregards autonomy to self-determine gender. By placing emphasis on the applicant's physical and outward appearance and expression, the Court made the physical embodiment of, or 'passing' for the gender one identifies as, a requirement for legal gender recognition. This is a restrictive and exclusionary criterion that reinforced gender binaries and cis-normative biases which benefit those who fit into dominant ideas of what it means to be male or female while ignoring those who cannot afford gender affirming treatment or who choose not to transition medically.

The Court's approach comports with a theory advanced by Stella Nyanzi,[39] who in interrogating the various theoretical approaches to governing sexuality makes reference to the model of the 'charmed circle', a sexual hierarchy concept developed by the feminist scholar, Gayle Rubin.[40] This is a metaphorical tool through which identity is appraised according to a hierarchical system of sexual value influenced by religion, psychiatry, popular culture and politics.[41] The position in the value metrics determines which sexual practices are rewarded with social approval and which ones are denigrated as vice.[42] The 'charmed circle' comprises of 'good', 'normal' and 'natural' sexualities and the 'outer limits' include 'bad', abnormal' and 'unnatural' sexualities.[43] Individuals whose behaviour ranks higher in the hierarchy, such as married heterosexual reproductive couples, are rewarded with certified mental health, respectability, legality and institutional support.[44] Individuals whose sexual behaviour places them lower on the scale are subjected to a presumption of mental illness, criminality, restricted social and physical mobility and loss of institutional support.[45] Although the theory has been critiqued by various scholars, Nyanzi argues that it is important because it helps understand how dominant ideologies construct, control and constrain sexualities.[46] She contends that it is a useful tool for scholars of African sexualities involved in the examination of the hegemonic control of diverse sexualities by social powers such as religious, biomedical, heteronormative or patriarchal influences. It is evident that the Court in this case did not escape the influences of normative understandings of gender. As a result, it created a protected category of trans persons who by virtue of their class and 'passing' privileges are proximate to what is considered 'normal' and acceptable and are therefore rewarded with recognizability and legal gender recognition.

This theory is similar to Charles Ngwena's contention that 'natural categories' are used to legitimize the institutional exclusion of non-heteronormative sexualities.[47] Charles Ngwena calls for moving from oppressive generalizations and capturing the sexualities of Africans in their diverse social groupings and individual subjectivities.[48] The overriding goal, according to Ngwena, is overcoming social or status subordination arising from sexual hierarchy-related exclusionary laws and practices.[49] Status subordination is viewed as imposing a single or over-simplified group identity that ignores particularities and assumes a conformity of interests.[50] Ngwena views the failure to see a multiplicity of identities or to accommodate intersectionality and struggles within social groups seeking affirmation as paradoxically rendering equality oppressive.[51] He reiterates that sexuality should be understood not as sameness but as relational and non-hierarchical difference and that people must be able to articulate different needs without being required to assimilate to a normative standard.[52] The failure of the Court in this case to recognize diversity in gender expression resulted in a form of status subordination that necessarily dictates that those who seek legal gender recognition must assimilate to normative standards of gender. This essentially forces trans individuals seeking recognition to conform to performative gender norms, such as dress, mannerisms and to undergo medical treatment to alter their bodies or risk losing institutional support.

A further critique of the case is that although the Court found that an absence of laws to ensure a clear process for legal gender recognition exposed the process to the exercise of unfettered discretion, it made no related orders pending enactment of the necessary legislation. With the understanding that in a constitutional democracy, courts must be wary of taking over the legislative function and not be prescriptive in their remedial orders, the Court ought to have provided some guidance, more so that this was an exercise in constitutional adjudication. The Court as the ultimate interpreter and arbiter of the Constitution had a duty to ensure that the rights of the wider trans community, were effectively protected in the absence of clear legal guidance. It has been established that the interpretation of legislation or Acts of parliament is an interpretation of the Constitution as laws are enacted to serve the public good or public interest. This is buttressed by section 26 of the Interpretation Act of Botswana, which states that 'every enactment shall be deemed remedial and for the public good and shall receive fair and liberal construction as will best attain its object according to its true intent and spirit'. Accordingly, the courts are mandated to interpret the Constitution, and by extension legislation, as a living and dynamic document of progressive human rights. In this spirit, the Botswana Court of Appeal has held in *Attorney General v Dow,* that 'the Constitution…is meant to serve not only this generation but also generations yet unborn…the primary duty of judges is to make the Constitution grow and develop in order to meet the just demands and aspirations of an ever developing society…' The Court ought to have accorded a generous and broad interpretation of the Act which would render it inclusive of all forms of gender identity and expression.

4 Part III: International human rights law & standards on legal gender recognition

International human rights law makes provision for the right to legal gender recognition and sets standards for gender registration. The Court in the *Gender marker* case considered these standards however not in their entirety. The following discussion demonstrates how an extensive consideration of these standards would have benefitted the trans community in Botswana.

4.1 The Yogyakarta Principles

The Court referenced the Yogyakarta Principles, which are a set of 29 internationally recognized principles developed by a team of human rights experts for the protection of the rights of LGBTI persons. They state in their definition of gender identity that it 'may involve *if freely chosen*, modification of bodily appearance or function by medical, surgical or other means…' (emphasis added). Principle 3 explicitly states that, no one shall be forced to undergo medical procedures including sex reassignment surgery and hormonal therapy as a requirement for the legal recognition of their gender identity. In addition, the Court had regard to the supplementary Yogyakarta Principles (YP+10). Principle 31 of the YP+10 provides for the right to change gendered information in identity documents while gendered information is included. The principle calls on states to ensure that official identity documents only include personal information that is relevant, reasonable and necessary as required by the law for a legitimate purpose, thereby ending registration of sex and gender in identity documents. It further calls on states to ensure access to mechanisms to change names based on the self-determination of the applicant. Where sex and gender continue to be registered, the principle requires states to ensure access to mechanisms that legally recognize and affirm each person's self-identified gender identity, make available a multiplicity of gender marker options, and ensure that no eligibility criteria is used as a prerequisites to change information. Similarly, Principle 32 provides for the right to bodily and mental integrity, autonomy and self-determination. The YP+10 call on states to ensure access to gender affirming healthcare, provided by the public health system or if not so provided, that the costs be covered or reimbursable under private and public health insurance schemes.

Both sets of principles make express provision for the right to legal gender recognition without any eligibility criteria. They recognize that requirements for medical or psychological interventions as prerequisites to change name, legal sex or gender are unnecessary. The trans community would have benefited from a liberal application of the principles to the *Gender marker* case.

4.2 The United Nations human rights framework

UN special procedures and treaty bodies have spoken out against the pathologization of trans identities in legal gender recognition. In 2015, a selection of

UN agencies released a joint statement calling for legal gender recognition without stringent and abusive requirements.[53] The Committee on Economic, Social and Cultural Rights (Committee on ESCR), in General Comment 22, has also found that regulations requiring trans persons, to be treated as mental or psychiatric patients, or requiring that they be 'cured' or 'treated', violate rights to sexual and reproductive health. The Committee on ESCR further found that laws and policies that indirectly perpetuate coercive medical practices, including hormonal therapy and surgery or sterilization requirements for legal gender recognition, constitute violation of state responsibility to respect human rights. The UN High Commissioner for Human Rights has stressed that states must respect the physical and psychological identity of trans persons by legally recognizing self-identified gender without additional requirements that may violate rights.[54] This sentiment has been echoed by various treaty bodies, in their recommendations to specific countries, including the Committee on the Elimination of all forms of Discrimination against Women which criticized Switzerland for the persistence of gender reassignment surgery targeting trans persons, including involuntary medical treatment. In 2017, the Human Rights Committee dealt with its first individual case on the right to legal gender recognition in *G v Australia*. The Committee held that Australia's policy forcing married trans persons to divorce as a requirement for legal gender recognition violated their rights to privacy, family life as well as the right to be free from discrimination. In a later review of Australia, the Committee stated that the state should take necessary measures to remove surgery and marital status requirements for sex marker changes on official documents.

In 2017, the Independent Expert on protection against violence and discrimination based on SOGI stated that the prevalent practice of denying trans persons recognition of their self-identified gender, even with gender realignment surgery, leads to violence and discrimination.[55] In the report, the Independent Expert made an invitation to destigmatize and depathologize trans identities to ensure respect for all persons without distinction.[56] Similarly, in 2019, the Independent Expert recommended that states enact gender recognition laws concerning the rights of trans persons to change their names and gender markers on identification documents.[57] He called on states to enact procedures that are quick, transparent and accessible, without abusive conditions and respectful to the principle of free and informed choice and that of integrity.[58] Although the 2019 report postdates the *Gender marker* case, it merely reinforced that requirements for surgical and hormonal treatments as prerequisites for legal gender recognition violate human rights principles. A consideration of this framework would have undoubtedly resulted in a different approach by the court in the *Gender marker* case.

4.3 The African human rights system

There is no express mention of legal gender recognition within the framework of the African human rights system. However, through the issuance

of Resolutions, General Comments and other communications, the African Commission has affirmed the freedom from discrimination based on gender identity. Protection of trans people against violence and discrimination in Africa is anchored on two binding treaties: The African Charter on Human and Peoples' Rights (African Charter), 1981, and the Protocol to the African Charter on the Rights of Women in Africa (Maputo Protocol), 2003. The African Charter observes the rights to equality and equal protection of the law, freedom from discrimination and the rights to life, dignity and integrity. The Maputo Protocol imposes obligations on states to take specific measures to combat violence against women regardless of their sexual orientation or gender identity. In 2014, the African Commission on Human and Peoples' Rights (African Commission) adopted Resolution 275, which expresses grave concern about the increasing violence and other human rights violations against persons based on their real or perceived sexual orientation or gender identity. The Resolution urges states to take action to stop violence and ensure adequate remedies are provided to victims of violence. Building on this framework, the African Commission included in its 60th session agenda, items pertaining to sexual orientation, gender identity and sex characteristics, including 'corrective' rape to ensure protection of human rights defenders. In 2018, the African Commission held a joint dialogue with the Inter-American Commission on Human Rights and the UN human rights mechanisms on sexual orientation and gender identity.[59] This was a follow up to a similarly themed dialogue held in 2015.[60] The participants of the dialogue emphasized the applicability of human rights standards to LGBTI persons and highlighted states' obligation to create an enabling environment for the effective enjoyment of rights.[61] The Court in the *Gender marker* case missed an opportunity to fully operationalize Resolution 275.

5 Comparative jurisprudence and legislation

Comparative case law provides guidance on approaches to legal gender recognition that are inclusive and not burdensome. For example, the Indian Supreme Court in *National Legal Services Authority v Union of India* has found that self-determination of gender is an integral part of self-autonomy and self-expression and falls within the realm of personal liberty. It found that self-identified gender can be either male or female or a third gender and that the rights of trans persons have to be protected irrespective of chromosomal sex, genitals, assigned birth sex or implied gender roles. The self-determination approach employed by the Court in this case demonstrates that legal gender recognition can be granted outside of restrictive medical requirements. Similarly in *1 B v R* the German Federal Constitutional Court found that the requirement in the Civil Status Act of Germany (2007), for every person's sex to be entered on the birth register, outside of the availability of a third option for intersex persons, was unconstitutional and amounted to discrimination based on sex. It further found that the requirement for every person to be registered as either

male or female deprived those who fall outside of the binary, the opportunity to be identified in their innate gender. The judgement has been welcomed as a milestone in the protection of the rights of intersex persons, for providing for a third gender option, a radical challenge to dominant ideas of sex and gender.[62] These two cases demonstrate an awareness of the unpredictability of sex and gender and that trans people are characterized by differences in gender expression and not all fit neatly into binary gender categories. An openness to gender diversity beyond traditional understandings of man and woman is critical for ensuring inclusivity and plurality.

Like case law, different countries employ differing approaches to legislation on gender recognition. While the medical approach remains prevalent, many countries have made a move towards the depathologization of gender diversity. Notably, Argentina and Malta both have model laws on legal gender recognition. The Human Rights Committee has lauded the Gender Identity Act of Argentina (2012) as a best practice for legal gender recognition. The law was celebrated for its simple administrative processes for modification of sex markers without any requirements of medical diagnosis and medical treatment. The Act does however, allow for access to gender affirming surgical interventions and hormonal treatments for those who are desirous of transitioning medically. It obligates the state to either provide or ensure access to gender affirming health care. The Act requires neither judicial interventions, nor a diagnosis with gender dysphoria, demonstrating that gender diversity can be depathologized without hampering access to gender affirming healthcare. Similarly, the Gender Identity, Gender Expression Sex Characteristics Act (GIGESC Act) of Malta (2015) encompasses both legal recognition and protection against discrimination for trans and intersex persons. This radical combination sets Malta apart from other gender identity laws. The GIGESC recognizes the right to bodily integrity and physical autonomy as an immutable part of the right to gender identity. It recognizes the right to gender identity and to be treated according to one's gender identity, including the right to be identified in that way in identity documents. Like the Argentinian Act, the Act does not require proof of medical procedures. The Act also recognizes foreign decisions on gender identity including gender markers other than male or female or no gender at all. The GIGESC Act explicitly denounces the pathologization of any form of gender identity or expression and states that the nullification of classification under the ICD or any other classification shall not impact the provision of any healthcare service related to sex or gender negatively. Other non-pathologizing gender recognition laws can be found in Colombia, Denmark, Ireland and Norway. These prove that a legal and administrative framework can be established to facilitate legal gender recognition without restrictive conditions. Borrowing from this progressive comparative legislation, Botswana can develop a framework for legal gender recognition that not only ensures that trans people are depathologized but that expressly makes provision for self-determined gender.

5.1 Emerging models of gender recognition

There are other emerging models to gender recognition such as ending gender registration as envisaged by Principle 31 of the YP+10. The principle calls for the curtailment of collection of gender and sex information where possible, considering issues of national security and other legitimate concerns. While acknowledging that data on gender and sex may be necessary for national development initiatives such as ensuring gender equity, such information can be collected without the need to include it on official identity documents. The recording and visible display of gender markers in identity document as already demonstrated, can infringe rights to privacy and the freedom from discrimination. Furthermore, in the face of technological advancements and the use of bio-metric data, the use of gender markers has grown increasingly obsolete and unnecessarily invasive. There are other means of identity verification such as the unique identification number in *omang* cards which ensures robustness of the national identity system and capturing of gendered data without express registration.[63] Ending gender registration would be an important step towards building a society that accepts gender as personal.

Another emerging approach is the recognition of gender plurality, including the adoption of a third gender or 'x' as a viable gender marker. This ensures social and cultural participation for those who do not conform to normative conceptions of gender or who fall outside of those gender constructs. With the understanding that personal autonomy and self-determination are core to individual conceptions of gender, it follows that non-binary persons or gender non-conforming persons should be allowed to use gender markers that are representative of their gender identities. The recognition of gender plurality will of course necessitate a dismantling of conformist considerations of gender and a deliberate effort to build understanding of plurality and acceptance of difference. This is important for ensuring equality before the law as well as equal protection of the law. Jurisprudential comparisons provide an evidential basis for this assertion, especially Justice Sikri in *National Legal Services Authority v Union of India* that equality is anchored on two complementary principles, non-discrimination and reasonable differentiation, are particularly instructive. The Judge observed that equality is not just about preventing discrimination, but about ending systematic discrimination. He emphasized that reasonable differentiation speaks to creating a gender classification that would accommodate non-binary gender experiences and bring them within the fold of rights enjoyed by traditional male and female genders. While acknowledging the administrative difficulties and uncertainties that may come with implementation of a third gender category, jurisprudential comparisons provide an in-depth evidential basis for learning and improving.[64] Besides, administrative challenges cannot suffice as justification for limiting the enjoyment of rights. Other gender-inclusive models for gender recognition include the opt-in model where the gender of all new born babies on birth certificates is indicated

with an 'x' and upon attaining the age of 16, they choose their sex descriptor.[65] This model, which comports with the self-identification approach, is premised on the understanding that every form of gender identity expression is legitimate and therefore should be recognized.[66]

Conclusion

The *Gender marker* case affirmed that trans people form part of the diversity of Botswana and acknowledged that the ability to access proper identification, that is representative of one's self-determined gender, is at the core of humanity and dignity. Although not establishing a framework for administration of requests for changes in gender markers, it helped clarify that this was a constitutionally enforceable right.

The approach adopted by the Court however, created a restrictive requirement for legal gender recognition predicated upon essentialist conceptions of gender. This is notwithstanding that international human rights law calls for the repeal of discriminatory practices that hinder access to legal gender recognition. Moreover, comparative jurisprudence and legislation provide guidance on alternative approaches to legal gender recognition that are not unnecessarily burdensome and respect the rights of trans persons to self-determination.

It is important to emphasize that the recommendation for the removal of medical requirements for legal gender recognition is not to dismiss the importance of ensuring access to gender affirming services for those who are desirous of transitioning medically. This is critical for alleviating experiences of gender dysphoria and ensuring access to health. Access to gender affirming healthcare services must be facilitated for trans people who wish to transition medically. To ensure accessibility, it should be provided by the public health system or covered by private and public medical aid schemes.

Notes

1 F Viljoen 'Botswana court ruling is a ray of hope for LGBT people across Africa' (2019) http://theconversation.com/botswana-court-ruling-is-a-ray-of-hope-for-lgbt-people-across-africa-118713 (accessed 2 September 2019).
2 J Serano *Whipping girl: A transsexual woman on sexism and the scapegoating of femininity* (2007) 11 at 31.
3 World Health Organization *Sexual health, human rights and the law* Report (2015).
4 S Winter et al 'Synergies in health and human rights: A call to action to improve transgender health' (2016) 388 *The Lacet* 318–321.
5 As above.
6 Serano (n 2) 11.
7 J Drescher 'Transsexualism, gender identity disorder and the DSM' (2010) 14 *Journal of Gay and Lesbian Mental Health* 111.
8 As above.
9 As above.
10 Harry Benjamin was an endocrinologist and sexologist known for his clinical work with trans persons.

11 Drescher (n 7).
12 Serano (n 2) 115.
13 G Ansara 'Cisgenderism in medical settings: Challenging structural violence through collaborative partnerships' in I Rivers & R Wards (eds) *Out of the ordinary: LGBT lives* (2012) 93–111.
14 As above 96.
15 J Theilen 'Depathologisation of transgenderism and international human rights law' (2014) 14 *Human Rights Law Review* 327–342.
16 Serano (n 2) 115.
17 As above 116.
18 P Cohen-Kettenis & F Pfäfflin 'The DSM diagnostic criteria for gender identity disorder in adolescents and adults' (2009) 2 *Archives of Sexual Behavior* 499–513.
19 DSM-V Fact sheet on gender dysphoria, American Psychiatric Association (2013) https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/dsm-5-fact-sheets (accessed 20 June 2019).
20 As above.
21 As above.
22 G Reed et al 'Disorders related to sexuality and gender identity in the ICD-11: Revising the ICD-10 classification based on current scientific evidence, best clinical practices, and human rights conditions' (2017) 16 *World Psychiatry Journal* 209.
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11 Advancing the rights of sexual and gender minorities under the African Charter on Human and Peoples' Rights

The journey to Resolution 275

Berry D. Nibogora

1 Introduction

The advocacy paths around protection of individuals from violence and other violations of human and peoples' rights based on sexual orientation, gender identity and expression and sex characteristics have been a struggle. Two steps forward, one step backward. This is true for a number of areas in which the rights discourse faces more controversies on the African continent (abortion, women's rights, child rights, etc.), be it due to lack of written documentation or the state of denial that exists in a number of countries.[1]

This chapter is divided in five sections. After the introduction, the second section discusses the application of international human rights law to sexual and gender minorities[2] in Africa with a focus on the role of the Commission. The third section explores strategies implemented to achieve the adoption of the resolution on protection against violence and other human rights violations based on real or imputed sexual orientation and gender identity (Resolution 275). Section four deep-dives into the context around the passing of and the reactions to Resolution 275. The fifth and last section concludes with the way forward in the struggle for equality in Africa.

This introduction looks at the challenges faced by sexual and gender minorities in Africa. Firstly, 33 countries explicitly criminalize same-sex sexuality and gender non-conforming identity generically referred to as homosexuality.[3] Documented evidence has shown that criminalization of same-sex sexual conduct forces homosexual persons of all ages to live in absolute fear of harassment, torture, extortion, mob violence and denunciation.[4] Arguably, criminalization deprives people of their dignity and most basic rights, rendering them utterly vulnerable and, in some cases, effectively disenfranchized.[5] Using Kenyan context as a case study, Shaw describes criminalization as a dignity taking, directly through forced anal examinations, and indirectly through state-sanctioned violence.[6]

Secondly, even in countries where there is no anti-homosexuality laws or where protective laws do exist such as South Africa, public sentiments led by religious[7] conservatism and homophobia create a social environment that

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actively oppresses LGBTIQA individuals within their families, at school, at workplace and in the broad community.[8] In most African countries where there is no specific law criminalizing homosexuality, there is generally an unspoken rule of tolerance called by Kerrigan the 'don't ask, don't tell' code: as long as LGBTIQA are silent and discreet about who they are and what issues they face, they will be tolerated.[9] Rudman sees it not as tolerance of one's sexual life but as deliberate ignorance of a hidden behaviour.[10] The knowledge by family members, neighbours, school teachers, employers and the broad community of one's homosexuality leads to far-reaching consequences ranging from being disowned, bullied, physically and verbally abused, stigmatized and discriminated against, etc.[11]

Thirdly, violations of human rights of LGBTIQA persons in many African countries seem to be justified by the criminal label associated with their identity. The general public, under religious and homophobic influence, sees violation of LGBTIQA rights not as illegal but rather as 'a crime of honour' that enjoys flagrant impunity.[12] This makes access to justice inefficient in most African countries for LGBTIQA victims of ordinary crimes as perpetrators' tactics to raise their (homo)sexuality turn them into targets of prosecutions in instances where they appeared first as victims.[13]

Fourthly, the challenges faced by sexual and gender minorities are heightened by a systematic social exclusion from development programmes, be it within the 2030 United Nations sustainable development agenda or the African Union Agenda 2063. Poku et al. describe the continental experience of LGBTI exclusion from markets, including housing, employment, economic opportunity, participation in family or community credits schemes, religious and cultural spaces, etc.[14] They conclude that although it is strategic and opportune to push for social inclusion of sexual and gender minorities in the development progammes as unconditional requirement for 'leaving no one behind', 'data are still needed to understand the ways in which sexuality and gender interact with other facets of identity to create multiple and interlocking forms of exclusion' of LGBTIQA people across Africa.[15]

Given the protection gaps of LGBTIQA rights at national and sub-national levels, regional and international human rights bodies have repeatedly stressed the importance of state compliance with the obligation to respect, protect and fulfil human rights for LGBTIQA persons, recalling that human rights principles are applicable to sexual and gender minorities.[16] In the next section, we focus on the particular role of the Commission.

2 Application of human rights law to sexual and gender minorities in Africa and the role of the Commission

2.1 International human rights law and the protection of sexual and gender minorities

Despite different biases that drive the opposition to the applicability of human rights to sexual and gender minorities in Africa,[17] the legal obligations of states to safeguard human rights of sexual and gender minorities are well established

under international human rights law, be it within the framework of the Universal Declaration of Human Rights or subsequent human rights instruments ratified by member states. The jurisprudence of human rights bodies has been unequivocal: all people irrespective of sex, sexual orientation or gender identity, are entitled the protection provided for by international human rights law, including the rights to life, security of person and privacy, non-discrimination, association, peaceful assembly and freedoms from torture, arbitrary arrest and detention, of expression, etc.[18]

The United Nations (UN) treaty bodies asserted states obligations in relation to human rights of sexual and gender minorities on numerous occasions. As early as 1994, in the case of *Toonen v Australia* (*Toonen case*), the UN Human Rights Committee held that the criminalization of same-sex conduct between consenting adults breaches the state obligation to protect individual privacy and to guarantee non-discrimination.

In the case of *X v Colombia*, the same Committee held that the prohibition against discrimination under Article 26 of the International Covenant on Civil and Political Rights (ICCPR) comprises also discrimination based on sexual orientation.

In the same vein, the UN Committee on Economic, Social and Cultural rights (Committee on ESCR) stated in General Comment No 20 that

> states parties should ensure that a person's sexual orientation is not a barrier to realising Covenant rights, for example, in accessing survivor's pension rights. in addition, gender identity is recognised as among prohibited grounds of discrimination; … .

Similarly, the Committee on the Elimination of all forms of Discrimination against Women (the CEDAW Committee) stressed that 'discrimination against women based on sex and gender is inextricably linked with other factors that affect women, such as … sexual orientation and gender identity'.

Further, the Committee against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment (Committee against Torture) held that

> states parties must ensure that, in so far as the obligations arising under the Convention are concerned, their laws are in practice applied to all persons, regardless of … sexual orientation (or) transgender identity.

Other regional human rights mechanisms have made similar explicit pronouncements. The European Court on human rights has moved from the negative-obligation approach to sexual orientation and gender identity based on the right to privacy to a more positive approach by striking down anti-sodomy laws using anti-discrimination provision and further cementing the entitlement to equality regardless of one's sexual orientation or gender identity.[19] Similarly, the Inter-American human rights monitoring bodies repeatedly made it clear that the scope of non-discrimination clauses undoubtedly

include sexual orientation and gender identity. In the landmark case of *Karen Atala and Daughters v Chile* (Atala Case) the Court concluded:

> Bearing in mind the general obligations to respect and guarantee the rights established in article 1(1) of the American Convention, …the sexual orientation of persons is a category protected by the Convention. Therefore, any regulation, act or practice considered discriminatory based on a person's sexual orientation is prohibited. Consequently, no domestic regulation, decision, or practice, whereby states authorities or individuals may diminish or restrict, in anyway whatsoever, the rights of a person based on his or her sexual orientation.

It is argued that the above jurisprudence applies within the African context given that the Commission, in interpreting the provisions of the African Charter draws inspiration from international law and takes into consideration other general or special conventions in determining the principles of law.

Although some scholars considered that the questions of sexual orientation and gender identity have remained on the margins of international human rights law and outside the consideration of the Commission,[20] this is no longer the case given that international human rights bodies' jurisprudence and the Commission's practice have unequivocally asserted sexual orientation and gender identity as protected grounds from discrimination.[21]

2.2 The role of the Commission in advancing LGBTIQA rights in Africa

The Commission played a key role in advancing human and peoples' rights of sexual and gender minorities in Africa. Over the years, it indirectly recognized that the African Charter prohibits violence and discrimination on the basis of sexual orientation and gender identity. This submission is based on the following arguments.

Firstly in 2006, in the case of *Zimbabwe Human Rights NGO Forum v Zimbabwe,* the Commission stated that Article 2 of the African Charter provides for 'equality of treatment for all individuals irrespective of … sexual orientation'.

Secondly, in its first general comment adopted in 2012 on Article 14 (1) (d) and (e) of the Protocol to the African Charter on the Rights of Women in Africa, the Commission stated that:

3. Given the susceptibility of women to HIV and related rights abuses in Africa, the African Commission recognises that the societal context based on gender inequalities, power imbalances and male dominance has to be addressed and transformed in order for women to meaningfully claim and enjoy freedom from violence....
4. According to the African Commission, there are multiple forms of discrimination based on various grounds such as: race, sex, sexuality, *sexual orientation*...

Read together, these two paragraphs suggest that the Commission acknowledged that, on one hand, the root causes of gender inequalities affecting women reside in the power imbalance and male dominance. On the other hand, for women to meaningfully enjoy the rights in the Protocol and be free from violence, discrimination based on race, sex, sexuality and sexual orientation, age, disability, harmful customary practice and religion must be addressed. Garrido argues that the Commission's inclusion of sexual orientation as a prohibited ground of discrimination as well as LGBTI amongst the vulnerable and disadvantaged groups in the 2011 Guidelines and Principles on Economic, Social and Cultural rights was the most relevant recognition of the African human rights systems.[22]

Equally, in its General Comment No 4 on the right to redress for victims of torture and other cruel, inhuman and degrading punishment or treatment under Article 5 of the African Charter, the Commission acknowledged that:

> …Acts of sexual violence against men, boys, persons with psychological disabilities, and lesbian, gay, bisexual, transgender and intersex persons are of equal concern and must also be adequately and effectively addressed by State parties.

Thirdly, the Commission has raised concerns over violence and discrimination targeting sexual and gender minorities in countries under review not only during the interactive dialogue between commissioners and state delegates but also and most importantly in the concluding observations and recommendations to states.

Fourthly, the Commission issued in 2014 the resolution on protection against human rights violations against persons on the basis of sexual orientation or gender identity. Resolution 275 urges member states to end all acts of violence committed by states or non-state actors by:

> …enacting and effectively applying appropriate laws prohibiting and punishing all forms of violence including those targeting persons on the basis of their imputed or real sexual orientation or gender identities, ensuring proper investigation and diligent prosecution of perpetrators, and establishing judicial procedures responsive to the needs of victims.

This resolution was adopted within the mandate of the Commission, which is two-fold: promotion and protection of human and peoples' rights enshrined in the African Charter. The protective mandate of the Commission is contained in Article 45(2) and detailed in Articles 47 to 55, whereas the promotional mandate is in Article 45(1) of the African Charter. An interpretation of Article 45(1) allowed the Commission, in its efforts to 'formulate and lay down principles and rules aimed at solving legal problems relating to human and peoples' rights', to adopt resolutions to address various human rights issues. Resolutions issued by the Commission can be classified in three types:

(1) thematic resolution, (2) administrative resolutions and (3) country-specific resolutions.

Thematic resolutions elaborate in greater details the states' obligations in respect of a specific right and describe the standard set by the Charter. Administrative resolutions deal with the Commission's procedures, internal mechanisms and relationship between the Commission and other stakeholders. Country resolutions address pertinent human rights concerns in member states.

As the centre-piece of this chapter, Resolution 275 is a thematic resolution articulating states' obligation to end violence and other human rights violations against persons on the basis of their real or imputed sexual orientation or gender identity.

Part of the challenges related to the protection of LGBTIQA rights is that the binding nature of the Commission's resolutions has been questioned by states and enforcement has been elusive over the years.[23] Further, the Commission has been divided on the issue of sexual orientation as some commissioners do not see it as a human right issue, but rather a matter that hits their moral and religious stand.[24] The adoption of Resolution 275 was a culmination of strategic and tireless efforts.

3 The road to Resolution 275: strategic choices and key moments

Struggles for human rights to equality and non-discrimination of African LGBTIQA must be understood as part of the liberation process. Liberation of our minds, of our bodies, and of our sexuality from a third-party control or simply from oppression. As argued by Heyns, 'human rights are not dependant on recognition by the state. People can claim them even when the law, whether made by a dictator or by the majority, denies those rights'.[25] Moreover, the denial against LGBTIQA rights is deeply influenced by religion and morality, which perpetuate patriarchal and capitalistic gender inequalities, as one of the feminist scholars explains:[26]

> As one of the most important forces that influence the belief systems that African people have, shaping and defining the deepest values that they hold, religion heavily impact on issues of sexual morality. The sexual morality espoused by most religions and the law perpetuates gender hierarchies, thereby depriving certain groups of their full citizenship.

Given the hostility of national contexts, activists turned to supra-national human rights bodies – such as the Commission – to achieve equality and no discrimination in respective African countries. Indeed, despite their legal limitations 'there is no doubt that [resolutions passed by the Commission] remain important soft law to hold government accountable to their obligations under the African Charter and other international human rights instruments'.[27]

For the purpose of this section, I will focus on the advocacy process that was deliberately followed to get Resolution 275 adopted. It can be summarized by the following cycle:

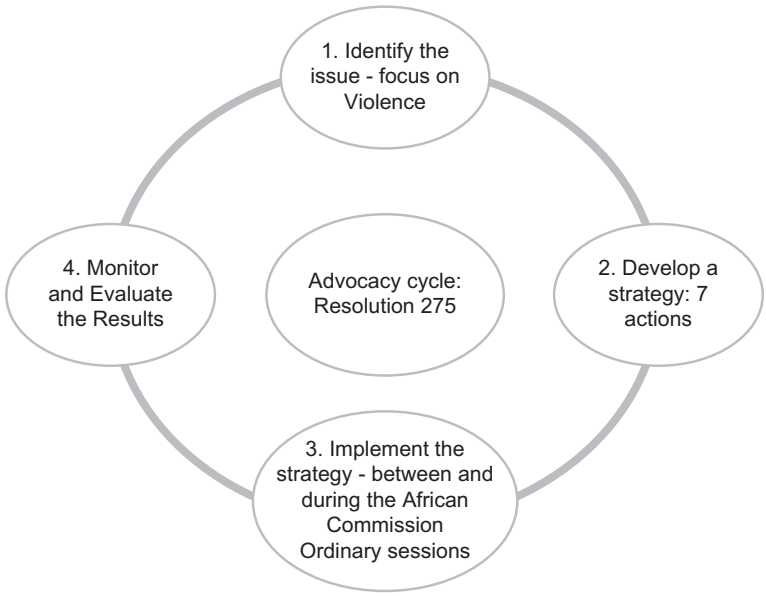

Figure 11.1 Making a strategic choice: why a resolution on violence?

The first step of the advocacy cycle for Resolution 275 was to identify the issue; which for the purpose of this journey was rather a choice of what to push for between a complaint before the Commission to obtain jurisprudence; a general comment; or a resolution to achieve recognition that sexual and gender minorities in Africa are indeed protected within the existing African human rights framework.[28]

The choice of a resolution was a logical conclusion for a number of reasons. First, the development of a general comment was not in the practice of the Commission before 2012. Second, exploring the litigation avenue has been an option that activists and researchers consistently cautioned about given the uncertainty of the outcome and the risk of a negative precedent that will take years to reverse.[29]

The choice of a resolution was, therefore, strategic given the likelihood of success, the relatively easy process to table it and get it adopted by the Commission. More strategic was the focus on violence and the reasons why it took precedence over other issues. Firstly, violence faced by LGBTIQA people in Africa was well-documented through shadow reports and newspaper articles. Secondly, violence is unanimously rejected and the least controversial theme even to those most homophobic. Lastly, by targeting not only

those who self-identify as member of the LGBTIQA community but also their human rights defenders or family members, violence leaves none outside the protection gap, hence taking action was overdue.

3.1 Developing and implementing an advocacy strategy: taking stock of decisive moments

The second step was to develop a strategy, which consists of 'a plan of actions designed to achieve a long-term or overall aim'.[30] The plan consisted of a series of coordinated actions, processes or messages 'intended to persuade or produce a particular corrective action',[31] in this case the adoption of a resolution.

Below are a series of key processes undertaken between 2011 and the adoption of Resolution 275 in May 2014. The 1st action consisted of building a critical mass for each Commission's session to ensure visibility and disruption. The investment in physical participation and visibility of LGBTIQA people in all sessions shifted the mind of the general public and the Commission. The 2nd action was to document human rights violations based on SOGIESC. Civil society organizations such as the African Men for Sexual Health and Rights (AMSHeR) have been involved in documenting not only violations faced by the LGBTIQA persons but also positive contributions they bring to the society.[32] Documentaries, web-series, short films emerged as powerful tools to mobilize solidarity from the general population.

In accordance with Rule 79(3) of the Commission,

> Institutions, organizations or any interested party wishing to contribute to the examination of the Report and the human rights situation in the country concerned, shall send their contributions, including shadow reports, to the Secretary at least 60 days prior to the examination of the Report.

Activists working on Resolution 275 invested in shadow reporting to ensure evidence is brought to the attention of commissioners and state delegates during the review. This was successful in a number of cases, despite that submission of shadow reports as a strategy may not be all times efficient.[33]

The 3rd action consisted of alliances with mainstream civil society organizations. Countering hegemonic sexual discourses and addressing the protection gaps faced by sexual and gender minorities in Africa requires intersectionality[34] and building alliances among organizations through the NGO Forum[35] or other meaningful ways. In 2012, LGBTIQA rights activists introduced the practice of side-events during the NGO Forum for civil society organizations to deep-dive into issues of specific interest to their work. This practice allowed SOGIESC activists to build alliances whilst evolving as credible partners within the civil society spectrum at the Commission.

The 4th action was to map key stakeholders using what was referred to as the 'traffic-light-exercise'. This exercise targeted the eleven commissioners who adopt resolutions either by consensus or by simple majority vote. The

'traffic-light exercise' consisted of colouring commissioners in green – for allies who would vote in favour of a resolution condemning violence, in orange – for commissioners whose stand was not known either for not having engaged with them or for being new in the space, and red – for non-allies. The purpose of this session was to further devise strategies for engaging those in green to remain green, and those in orange and red to become green.[36] One of such engagements consisted of side meetings with commissioners during ordinary sessions.

The above actions not only required coordination but also built on key opportunities that created momentum or milestones that marked the pathway towards the adoption of Resolution 275.

The first key moment is the decision to engage the Commission on LGBTIQA issues. In May 2006, the International Gay and Lesbian Human Rights Commission ('IGLHRC') in conjunction with CAL, Behind the Mask ('BTM') and All Africa Rights Initiative ('AARI') conducted an exploratory mission to Banjul, The Gambia. The mission was meant to study the space and establish challenges and opportunities to engage the Commission. However, when activists learnt that Cameroon was up for review, a small group was formed to draft accounts of violations based on SOGIESC, and submitted to the Commission an alternative statement to the state report. The statement informed the Commission's concluding observations raising concerns around an 'upsurge of intolerance against sexual minorities'.

The momentum was also gained through the growing role of the NGO Forum in adopting 'resolutions' subsequently submitted to the Commission for consideration. At the beginning, there was resistance from conservative NGOs. But due to the resiliency of activists, the Forum adopted its first-ever resolution with reference to SOGI ahead of the 41st session in 2007 and in subsequent sessions. However, the Commission did not endorse those resolutions and removed the words 'lesbians and bisexual' women.[37]

The second key moment is the denial of observer status to the Coalition of African Lesbians (CAL) and the wave of solidarity that followed from civil society organizations. The application was submitted by CAL in May 2008, the Commission took the decision to deny observer status to CAL on 20 October 2010. The reasons for denial were made public later stating that 'the activities of the said organization do not promote and protect any of the rights enshrined in the African Charter'.[38] An outcry of civil society solidarity marked the following session in November 2010, as most observers included in their statements a paragraph condemning the Commission's decision.[39]

The third key moment is the adoption of resolution 17/19 on human rights, sexual orientation and gender identity by the United Nations' Human Rights Council on 14 July 2011. The resolution mandated the office of high commissioner to conduct a study

> documenting discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity, in all regions of the world, and how international human rights law can be used

to end violence and related human rights violations based on sexual orientation and gender identity.

Subsequent to this resolution, a series of regional meetings were held in various regions of the world but no such meeting was held in Africa.[40] The process culminated in an international conference held in Oslo, Norway from 15 to 16 April 2013 and the co-chair meeting notes recognized an 'increased attention paid to the issues (of SOGIESC) by the African Commission …'[41]

The fourth decisive moment was the launch of the report on violence based on sexual orientation and gender identity in Africa, jointly authored by AMSHeR and CAL, documenting instances of violence across Africa.[42] A commissioner was attending the NGO Forum and participated in the launch of the report.[43] A draft resolution was adopted by the Forum condemning the instances of violence documented in the report. The same draft resolution was submitted to the Commission for consideration during the private session. It was not considered due to time constraints,[44] but postponed for consideration at the following 55th ordinary session.

4 The passing of Resolution 275: context, content and usefulness

The 55th session was held in Luanda, Angola from 28 April to 12 May 2014. As usual, activists held side events and engaged various stakeholders around SOGI issues, with the majority leaving after one week into the session.[45]

Circumstances played on the activists' side though. The session's schedule was light and postponed resolutions from the 54th session were tabled for consideration. Further, the Chairperson of the Commission Kayitesi Z. Sylvie, whose stand is well-known to be strongly opposed to SOGI issues, had to leave just after the opening of the private session due to personal reasons, leaving the co-chair role to Commissioner Alapini Gansou. Gansou's leadership and out-spoken support for equality and non-discrimination should not be underestimated given the powers of the Chair and Vice-chair of the Commission in terms of order of precedence, directing the conduct of business, moving motions, and closing discussion on matters before the Commission as a collective deliberating body. This factor played in favour of the adoption of Resolution 275.

Following the news of the adoption of Resolution 275, a wave of celebration followed, and messages flowed from the four corners of the globe commending the Commission.[46] Sexual rights activists issued supportive statements to the extent that the International Human Rights Day, 10 December 2014, celebrated the passing of Resolution 275.

Adopting resolution 275 was an unprecedented move by the Commission. It sent a strong message that LGBTIQA people, like any other African, are fully entitled to protection provided by the African Charter against discrimination and violence.

The content of Resolution 275 is three-fold. The first part gives the legal basis that the Commission used as a legitimate foundation of its action. This is Article 2 prohibiting distinction of any kind in the enjoyment of rights enshrined in the Charter by every individual; Article 3 prescribing equality and equal protection of the law; and Articles 4 and 5 read together, which in essence make life, dignity and integrity of the person sacred, including prohibition of torture and other forms of exploitation or cruel and inhumane treatment.

The second part sends an alarming warning due to instances of violence based on persons' real or perceived sexual orientation or gender identity. It lists different forms of violence, classifies the perpetrators of such violence and equally condemns them regardless of their category – state and non-state actors – and the motivation behind such violence. This paragraph also provides for protection of activists working on issues of sexual orientation and gender identity, and calls on states to ensure an environment free from violence, attacks and reprisals against them.

The third and last paragraph is the executive part directing different stakeholders – primarily states as duty bearers – what to do to comply with their obligations towards sexual and gender minorities. These obligations include stopping violence and abuses, and creating an enabling environment free of stigma, reprisals or criminal prosecution for human rights defenders. For avoidance of any doubt, the Commission clarified that ending violence requires positive obligations on the part of the states, including enacting and effectively applying appropriate laws prohibiting and punishing all forms of violence including those targeting persons on the basis of their imputed or real sexual orientation or gender identities, ensuring proper investigation and diligent prosecution of perpetrators, and establishing judicial procedures responsive to the needs of victims.

These three positive obligations are related to legislative reforms and access to justice, including remedies for the victims. As such, it is argued that they are not subject to progressive realization but rather immediate enforcement given their nature of the rights they seek to protect and respect. Further in terms of Resolution 275, African States are arguably obligated to decriminalize same-sex relations and adopt protective laws that ensure that adults engaging in consenting same-sex relations or those with non-conforming gender identity live in full enjoyment of their rights, free from hatred, violence and discrimination. That is the minimum content of the phrase 'enacting and effectively applying appropriate laws prohibiting and punishing all forms of violence including those targeting persons on the basis of their imputed or real sexual orientation or gender identities' contained in the first part of Resolution 275(4).

Further, by virtue of Resolution 275(4) and given the plight of violence, impunity and the access to justice across Africa, states should consider creating LGBTIQA crime investigation units to ensure perpetrators are brought to book diligently and in a manner that is responsive to the needs of the victims.

That is also the core meaning of the phrase 'ensuring proper investigation and diligent prosecution of perpetrators, and establishing judicial procedures responsive to the needs of victims' contained in the last part of Resolution 275(4).[47]

Despite the fact that the above steps are yet to be undertaken in any country across Africa, Resolution 275 has been used to educate and sensitize LGBTIQA community members, policy makers, other civil society organizations and the general public. In police trainings, before parliaments or technical groups such as law reform commissions, Resolution 275 has been used in ways that were not anticipated before.[48]

Two dialogues between African and the Inter-American human rights systems with UNAIDS and the United Nations mandate holders have resulted in reports that are used to educate various stakeholders[49]. These interventions serve to continuously identify ways of making progress in addressing the protection gaps faced by LGBTIQA with context-tailored approaches.

In March 2016, the first regional seminar to find practical solutions for ending violence and discrimination based on SOGIE in Africa was held in response to the call from Resolution 275.[50] A final declaration clarifying different obligations and recommendations was adopted and published.[51]

Finally, the Commission has also been using Resolution 275 in states review and subsequent norms development work (general comments, guidelines and concluding observations).

5 Conclusion

The journey to Resolution 275 was long and the promises it brought to Africans is a manifestation of the virtues of Africa's historical traditions and the values of a civilization based on humanness 'Ubuntu', inclusiveness and respect for human dignity in our differences.

The adoption of Resolution 275 by the primary body in charge of protecting and promoting human rights in Africa is a culmination of tireless advocacy, educational and lobbying efforts. By adopting Resolution 275, the Commission simply did its overdue job. It sent a message that it does not exist to reflect the prejudices of member states, but to hold states accountable when they fail to observe the required human rights standards for all their citizens.

However, not all the Commission's work is rosy. The recent Decision 1015 of the African Union Executive Council[52] and the response of the Commission – which withdrew CAL observer status in application of the above decision, without appreciating the impact of such move on its independence – are cause for concern. Further, given the contemporary criticism against human rights by left and right-wing regimes,[53] the future of protection of sexual minority rights in Africa is uncertain and the likelihood of reversing the gains is high.

As a way forward, it is suggested to amplify advocacy around Resolution 275 given the lesser influence states have in the drafting and adopting resolutions.

Further, it is urgent to get African states to speak out against the project of dismantling the accountability mechanisms that still exist on the continent. The African Charter is among the most ratified instruments and, therefore, enjoy a full commitment from states parties to realize the Charter's rights with the guidance of the Commission, including the authoritative interpretations formulated through resolutions, general comments, recommendations and decisions. It is only by doing so that Resolution 275 and other standards set by the Commission will deliver 'the Africa we want'.

Notes

1 V Balogun & E Durojaye 'The African Commission on Human and Peoples' Rights and the promotion and protection of sexual and reproductive rights' (2011) 2 *African Human Rights Law Journal* 373.

2 In this chapter, the terms sexual and gender minorities are used as an umbrella expression to design persons who, due to their diverse sexual orientation (homosexuality) or gender identity (transgender), are referred to as LGBTIAQ+: lesbian, gay, bisexual, transgender, intersex, asexual, queer and others whose sexuality or gender identity is still under self-questioning. Given the evolving and complex nature of human sexuality and gender self-identification, we acknowledge that all identities may not be exhaustively captured in the LGBTIAQ+ acronym. The expressions sexual orientation, gender identity or expression and sex characteristics (SOGIESC) are generically used to qualify a ground of discrimination or other human rights violations. In this chapter, these expressions are used interchangeably.

3 International Lesbian, Gay, Bisexual, Trans and Intersex Association, A Carroll & L Mendos 'State sponsored homophobia 2017: A world survey of sexual orientation laws: Criminalisation, protection and recognition' (2017) 81 106.

4 Such incidents have been documented and reported by AMSHeR and local African LGBTI organizations to the African Commission on Human and Peoples' Rights in an attempt to ensure steps are taken by the African Commission to protect the rights of sexual and gender minorities in Africa. These reports include reports on Cameroon, Senegal, Nigeria, Liberia, Malawi, South Africa, Namibia, Burundi, Sierra Leone, and Eritrea (on file with the author).

5 A Rudman 'The protection against discrimination based on sexual orientation under the African human rights system' (2015) 15 *African Human Rights Law Journal* 5.

6 A Shaw 'From disgust to dignity: Criminalisation of same-sex conduct as a dignity taking and the human rights pathways to achieve dignity restoration' (2018) 18 *African Human Rights Law Journal* 691–698.

7 K Kaoma 'The Vatican anti-gender theory and sexual politics: An African response' (2016) 6 *Religion and gender* 282, 292.

8 A study on health care provision to sexual and gender minorities in South Africa found that the lack of responsive mechanisms, combined with lack of training and knowledge about sexual and gender minority health … and the complexity of healthcare providers' decision-making perpetuates the marginalization and invisibility of sexual and gender minority patients in health system. A Muller 'Health for all? Sexual orientation, gender identity and the implementation of the right to access health care in South Africa' (2016) 18 *Health and Human Rights Journal* 2 2014.

9 The Danish Institute for Human Rights, F Kerrigan 'Getting to rights: The rights of lesbians, gays, bisexuals, transgender, intersex persons in Africa' (2014) 123.

10 In discussing the limitations of the use of the right to privacy, Rudman argues that the use of the right to privacy to claim protection of sexual and gender minorities would

leave the stigma completely untouched and the state would have no positive obligation towards homosexual persons. Rudman (n 6) 18.

11 For an account of violence based of one's sexuality, see report by AMSHeR & CAL 'Violence based on perceived or real sexual orientation and gender identity' (2013) 11 44.

12 T Monica & W Matthew 'Africa and the contestation of sexual and gender diversity: Imperial and contemporary regulations' in EB Michael et al (eds) *The Oxford handbook of global LGBT and sexual diversity politics* (2020) 207.

13 AMSHeR et al 'Alternative Report to the human rights situation of LGBT people in Cameroon' submitted for the review of the third periodic report of the Republic of Cameroon at the 54th ordinary session of the African Commission held in Banjul, The Gambia from 22 October to 5 November (on file with the author).

14 N Poku et al 'Sustainable development and the struggle for LGBTI inclusion in Africa: Opportunities for accelerating change' (2017) 27 *Development in Practice* 2, 435.

15 As above 440.

16 UN OHCHR 'Born free and equal: Sexual orientation and gender identity in international human rights law' (2012) HR/PUB/12/06 8.

17 Balogun & Durojaye (n 2) 373.

18 UN OHCHR (n 17).

19 Rudman (n 6) 11.

20 M Wayne 'Queering international human rights law' (2000) *Sexuality in the legal arena* 208–227 (Carl Stychin & David Herman eds) in R Murray & F Viljon 'Towards non-discrimination on the basis of sexual orientation: Normative basis and procedural possibilities before the African Commission on Human and Peoples' Rights and the African Union' (2007) 29 *Human Rights Quarterly* 1 87.

21 UN OHCHR (n 17) 9.

22 R Garrido 'Patterns of discrimination based on sexual orientation in Africa: Is there a Lusophone exception?' (2019) 3 *African Human Rights Yearbook* 93–118 http://doi.org/10.29053/2523-1367/2019/v3a5? (accessed 21 April 2020).

23 G Mukundi & A Ayinla 'Twenty years of elusive enforcement of the recommendations of the African Commission on Human and Peoples' Rights' (2006) 6 *African Human Rights Law Journal* 471, 478.

24 In the debate around the granting of observer status to CAL, the vice-chair referred to homosexuality as an 'imported virus to distract Africans from the real problems of poverty and corruption' https://www.youtube.com/watch?v=USc4anKo3-8 at 42:35 (accessed 14 January 2019). See also Rudman (n 6) 7, quoting the commissioner acting as rapporteur in the case of *Curson v Zimbabwe* (2000) AHRLR 335 (ACHPR 1995). The rapporteur in the case wrote: '[B]ecause of the deleterious nature of homosexuality, the Commission seizes the opportunity to make a pronouncement on it. Although homosexuality and lesbianism are gaining recognition in certain parts of the world, this is not the case in Africa. Homosexuality offends the African sense of dignity and morality and is inconsistent with positive African values'. E Ankumah *The African Commission on Human and Peoples' Rights: Practice and procedures* (1996) 174 in F Viljoen *International human rights law in Africa* (2012) 265. See also A Ibrahim 'LGBT rights in Africa and the discursive role of international human rights law' (2015) 15 *African Human Rights Law Journal* 273.

25 C Heyns 'A 'struggle approach' to human rights' in C Heyns & K Stefiszyn (ed) *Human rights, peace and justice in Africa: A reader* (2006) 16.

26 S Tamale 'Exploring the contours of African sexualities: Religion, law and power' (2014) 14 *African Human Rights Law Journal* 175, 176.

27 H Hillgenberg 'A fresh look at soft law' (1999) 10 *European Journal of International Law* 499 in Balagon & Durojaye (n 2) 379.

28 Murray & Viljon (n 21) 100 111.

29 Ibrahim (n 25) 272.

30 Oxford online dictionaries https://en.oxforddictionaries.com/definition/strategy (accessed 14 January 2019).
31 United Nations, OHCHR 'Manual on human rights monitoring' (2011) 4.
32 See Alternative reports to states periodic reports submitted before the African Commission on Cameroon, Togo, Nigeria, Malawi, Namibia, Liberia, Sierra Leone, Burundi, etc. (on file with the Author). On positive narrative queer people in Africa, see AMSHeR 'Voices of Freedom' (2014) https://www.amsher.org/the-voices/ (accessed 21 December 2018).
33 Low compliance with the reporting obligations by states, uncertainty about the review schedule, etc. e.g. the review of the periodic report of Rwanda postponed at the 60th ordinary session after the 60th public session in Niamey had already started.
34 Temale (n 27) 170.
35 The NGO Forum is a three-day gathering organised ahead of each session to facilitate participation of non-governmental organizations with observer status to the session of the Commission.
36 This included invitation of Commissioners to intersession workshops on SOGI issues or using connections activists had with specific commissioners from their countries or based on common a history of working, studying or worshiping together.
37 For a full account of the responses of the Commission to SOGI resolutions submitted through the NGO Forum, see S Ndashe 'Seeking the protection of LGBTI rights at the African commission on human and peoples' rights' (2011) 15 *Feminist Africa 19*.
38 28th Activity report of the African Commission (2009), para 33 http://www.achpr.org/files/activity-reports/28/achpr47eo8_actrep28_20092010_eng.pdf (accessed 14 January 2019).
39 Ndashe (n 38) 31.
40 No country accepted to come forward and host such a meeting and speculation have been ongoing that despite its legal framework and historical leadership on non-discrimination issues, South Africa did not want to take the lead as it would lose the support it needed from the Africa bloc to get a seat at the UN Human rights council. See e.g. E Jordaan 'South Africa and sexual orientation rights at the United Nations: Battling for both sides' (2017) 1–26 http://ink.library.smu.edu.sg/soss_research/2079 (accessed 21 December 2019).
41 Outcome document of the Oslo international conference on human rights, sexual orientation and gender identity (2013) https://outrightinternational.org/sites/default/files/Co-Chairs%20Summary%20of%20Conclusions.pdf (accessed 21 December 2019).
42 The report was authored and presented by African organizations was deliberate and aimed at countering the argument of SOGIE issues being un-African.
43 The Special rapporteur on the situation of human rights defenders, Reine Alapini Gansou attended the NGO Forum and co-launched the report.
44 This inside information was received off the record from the Secretariat staff. This was confirmed by friendly commissioners during side interactions in subsequent sessions.
45 Owing to the cost of staying in Luanda – one of the most expensive cities in the world – and the light programme of the session.
46 The then UN Secretary General, Ban Ki Moon and the High Commissioner for Human Rights expressed their congratulatory messages to the Commission for such a step in the right direction.
47 For a detailed description of action required to states and non-state actors arising from Resolution 275, see the booklet by AMSHeR & Centre for Human Rights 'Resolution 275: What does it mean for states and non-state actors in Africa?' (2018) 1 http://www.chr.up.ac.za/images/researchunits/sogie/documents/resolution_275/resolution_275_eng.pdf (accessed 14 January 2019).
48 See AMSHeR activity reports from resolution watch sessions (On file with the author).

49 See the Report of the first joint dialogue https://www.ohchr.org/Documents/Issues/Discrimination/Endingviolence_ACHPR_IACHR_UN_SOGI_dialogue_EN.pdf (accessed 21 December 2018).
50 Opening remarks by the Chair of the South African Human Rights Commission, Regional Seminar on finding practical solutions for ending violence and other human rights violations based on sexual orientation and gender identity or expression, held on 5th March 2016, in Ekurhuleni, South Africa.
51 Ekurhuleni Declaration (2016) https://www.oursplatform.org/wp-content/uploads/EKURHULENI-DECLARATION-FINAL.pdf (accessed 21 December 2018).
52 Executive Council Decision at the 33rd ordinary session, 28–28 June 2018. EX.CL/1015(XXXIII) (2018).
53 M Langford 'Critiques of human rights' (2018) 14 *Annual Review of Law and Social Science* 83.

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12 Lessons from litigating for sexual and reproductive health and rights in Southern Africa

Tambudzai Gonese-Manjonjo and Ebenezer Durojaye

1 Introduction

This chapter focuses on lessons learnt from the experiences of the Southern Africa Litigation Centre (SALC) in instituting and supporting strategic litigation on sexual and reproductive health rights in Southern Africa. Strategic litigation in this context focuses on litigation with the potential to positively impact women's sexual and reproductive health and rights(SRHR), by broadening the interpretation of the rights and working toward positive legal or other reforms in line with such interpretation. It accordingly consists not simply of the filing of a legal case, but also involves substantial research to ensure an effective outcome and sustained advocacy to support the case. Strategic litigation should lead to eventual reforms. Developing a strategy to ensure a tactical impact requires knowledge of the specific needs of women in the country, the laws and jurisprudence affecting these needs, and the extent to which litigation can have impact depending on the composition of the judiciary and the prevailing socio-political conditions in the country.

Strategic litigation has steadily gained momentum in many African countries. Some of the cases filed include challenges to violation of rights related to the right to health including sexual and reproductive health and rights. Thus, jurisprudence has emerged on issues such as maternal mortality, HIV testing, denial of life-saving medications, child marriage and adolescent sexuality. This emerging trend in social rights litigation in Africa would seem to be a positive development. While challenges remain, this development is capable of paving way for a more accountable and just society in the region.[1]

For strategic litigation to have an impact, there are several factors to consider:

- Does the social or societal problem have a legal issue requiring adjudication?
- Would a court be receptive to the arguments? Is the judiciary sufficiently progressive and independent?
- Would a positive judgment be implemented? Are the authorities receptive enough and are there resources?
- Is it worth it even if a positive judgment will not be implemented?

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Roa and Klugman in their useful article have identified some important considerations for a successful strategic litigation.[2] These include:

- An existing rights framework – implying that the existing law in a country guarantees recognized rights for which redress can be sought.
- An independent and knowledgeable judiciary – the court is often referred to as the last hope of the masses. To effectively play this role, the judiciary must be proactive and independent from any form of interference.
- Civil society organizations with the capacity to frame social problems as rights violations and to litigate– public interest litigation is often initiated by civil society. Consequently, rights litigation will thrive in a society where the civil society groups are active, conversant with the issues and able to challenge human rights violations.
- A network to support and leverage the opportunities presented by litigation – successful social litigation requires the involvement of many stakeholders fighting for the same cause including media, health care professionals, economists and community groups.

2 Litigation Strategy

Having decided to litigate after this consideration, it is important to develop a litigation strategy. This will include an assessment of the jurisprudence, legal framework and litigation options in each country. Sexual and reproductive health rights are not often directly protected. Where they are, it is usually done in a restricted manner. For example, the Zimbabwean Constitution protects the right to health, inclusive of reproductive health. Yet, policies and laws more directly address issues like maternal mortality and general family planning and do not cover the broad spectrum of SRHR, including access to safe abortion. In this instance, strategic litigation might be aimed at broadening the scope of protection and promotion of sexual and reproductive rights including the provision of safe abortion.

In appropriate cases and where time and resources permit, it is beneficial to use prior research to inform possible litigation. Research, especially field research, will help in identifying the social gaps, and may indicate the possible reception by the public or respondents of any changes or developments. For example, in Malawi, after encountering a case involving the detention of pregnant learners, SALC filed a judicial review and instituted research with the Malawi Human Rights Commission on the implementation and impact of the official learner pregnancy management policy.[3] The outcome of the research helped formulate a strategy for litigation. The research was necessary because it showed that most learners, and even implementers, were not aware of the official policy. Therefore, the application of the policy was arbitrary in most of the cases and dependent on the institution and implementers. The research report was used to contribute to the government review of the learner pregnancy policy.

SALC uses a very effective method of an incremental approach to strategic litigation, using small or indirect cases to pave the way for bigger or higher-impact and more complex cases. This enables building of jurisprudence that can be used in future. Considering the often sensitive issues around SRHR, some courts take time to become receptive to certain issues and the incremental approach helps to generate gradual understanding.

Strategic ligation or social rights litigation can play an important role in advancing the rights of vulnerable or marginalized groups. It is important in providing avenues to redress human rights violations, empowering marginalized groups to obtain justice,[4] serving as a means of accountability,[5] serving as a catalyst for change in society, helping to create awareness on an issue and serving as a tool for social justice in society.[6] Despite these positive aspects of strategic litigation, some commentators have expressed concerns about the impact of such litigation. For instance, regarding health rights litigation in Brazil, it has been argued that social rights litigation does not advance the right of the poor but tends to favour the middle class[7]. Others have lamented the danger of placing too much hope in litigation given the various challenges facing the court system in Africa.[8]

3 Some case studies

Valuable lessons have been learnt from the experience of litigating cases that highlight the issues around sexual and reproductive health and rights, like pregnancy, safe abortion, and how complex court procedures affect the realization of sexual and reproductive health rights. Three of SALC's cases are discussed in more detail below: The first case relates to the dismissal of pregnant women from the Lesotho Defence Force; the second relates to the provision of emergency contraceptives to rape survivors, and the third relates to prescription in medical negligence cases. Each of these cases is illustrative of the many possible ways in which strategic litigation can be developed.

3.1 Mokhele and Others v Commander, Lesotho Defence Forces and Others

The right to decide if, when, and how to bear children is at the heart of reproductive autonomy, in line with international and regional standards. It can only be interfered with, if at all, for rational and reasonable practical considerations. International Labour Organisation (ILO) Standards have generally recognized the right of women workers to be accorded room to bear children without having to give up their careers. The standards laid out, for example, in the Maternity Protection Convention 183,[9] include the right to paid maternity leave, protection from hazardous work during pregnancy, and childcare and protection from discrimination on the basis of maternity. In addition, the standards call for protection from the loss of employment due to maternity and paid maternity leave for the pregnant woman if there is need for protection of maternity in hazardous employment. This has translated, at a national level in

the Southern African region, into the enactment of maternity protection policies, including fully or partially paid leave and protection from discrimination.

The dilemma is with balancing the right to reproduce with the practical considerations attendant with the chosen profession, especially for women in non-traditional roles and hazardous employment. This is well illustrated in a case SALC supported in Lesotho regarding reproductive rights in the military, the case of *Mokhele and Others v Commander& Lesotho Defence Forces and Others*.[10] In this case, 3 female soldiers in the Lesotho Defence Forces were dismissed from the army for falling pregnant in contravention of a Standing Order imposed by the Commander of the Lesotho Defence Forces. The Standing Order, communicated to the applicants at their passing-out parade, prohibited female soldiers of less than 5 years' service from falling pregnant, with the penalty of dismissal. The three applicants, two of whom were married and one of whom had suffered a miscarriage, were charged with violating the Standing Order. Instead of subjecting them to court martial or summary trial in line with the army regulations, the Commander dismissed them under a section of the Lesotho Defence Forces Act, which allowed the Commander to discharge members 'in the interest of the army'.

SALC supported local lawyers Phoofolo Associates and Advocate Monaheng Rasekoai in filing judicial review of the dismissals and the Standing Order in the High Court. FIDA-Lesotho supported the advocacy initiatives at the court. The applicants' arguments were both procedural and substantive, challenging the process by which they were discharged, the basis for the dismissals and the lawfulness of the Standing Order.

The applicants argued the decisions of the Commander to enact the Standing Order and discharge the applicants were contrary to public policy and common law principles of reasonableness, legality, and rationality. The charges did not raise any issues with the physical capacity of the applicants but were merely based on the non-compliance with the Standing Order. The respondents failed to consider the individual circumstances of each soldier and made blanket discriminatory assumptions that female soldiers would be negatively affected by pregnancy and birth. It was also argued that the Standing Order had a disproportionate impact on, and unduly interfered with, intimate family life and sexual and reproductive rights to choose methods and timing of family planning.

It was acknowledged that for practical considerations, there may be reason for certain restrictions but the provisions for reasonable accommodation in line with international best practice should be implemented. Reasonable accommodation would consider individual circumstances. The standard practice is to allow pregnant women to undertake modified duties, provide leave options, and enable them to return as soon as they are able. It was also argued on behalf of the applicants that the Standing Order was unlawful in that it amounted to class discrimination, because the army already has provisions for maternity leave for female soldiers in terms of the Defence Forces Act and Regulations and the Standing Order purported to arbitrarily take this right away from female soldiers of less than 5 years' service.

The respondent argued that the army was entitled to impose whatever restrictions deemed necessary for discipline. They claimed applicants could not enjoy their rights like civilians, relying on the case of *Thabang Hlapisi and Anor v The Commander & Botswana Defence Force & 4 Others*[11] and the provisions of section 24(3) of the Constitution. In justifying the Standing Order, they argued that pregnancy interfered with army discipline and the applicants' ability to be effective as army recruits, and interfered with partaking in military activities and strenuous physical activity like rolling, and combat-readiness. In addition, the Commander as 'guardian' to the recruits argued that recruits were becoming pregnant at an alarming rate and needed guidance, and thus the restriction on falling pregnant. The argument was also made that pregnancy has a negative impact on a soldier, and therefore pregnant female soldiers would no longer be effective compared to their male compatriots. Even though all of the applicants were adults and two of them were married at the time of the pregnancy, due to the possibility of contraceptive failure, the respondents argued that they should have abstained from sex as a foolproof way of preventing pregnancy. The arguments were contradictory in that the applicants were deemed to be mature enough for combat training, including handling firearms, but not mature enough to make reproductive choices.

The Lesotho Constitution prohibits discrimination based on sex (in terms of section 18) and provides for equality and equal protection of the law. The decisions of the respondents and the effects of the Standing Order could ordinarily have been challenged as breaches to the Bill of Rights. However, the provisions of section 24(3) allow for the limitation of most of the Bill of Rights by military law, rendering it difficult to file a direct constitutional challenge. It was therefore decided to file judicial review based on the usual grounds of lawfulness, rationality, and reasonableness. It was argued that decisions that amount to unfair discrimination, and decisions made for improper purposes are included in the definition or consideration of the unreasonableness of administrative action. Amongst the principles of state policy in the Lesotho Constitution are the values of equality, non-discrimination and justice and just and favourable work conditions, including maternity protection.

In reviewing the reasonableness of the Commander's decisions, the lawfulness of the Standing Order itself, and the decision to discharge the applicants, the Court made very progressive findings on women's reproductive rights. The Court held that by virtue of the provisions of international instruments like CEDAW and the 2000 International Labour Organisation(ILO) Maternity Protection Convention,[12] women in the army were entitled, like other women, to the rights enshrined therein, and that the army, like every other entity, had the duty to ensure that their rights were protected. The Standing Order was held to be *ultra vires* the enabling legislation (the Defence Forces Act and Regulations), which did not prescribe pregnancy as a ground for discharge. The Court held the Commander could not make regulations which had the effect of disenfranchising a whole section of the army. This was the province of parliament. The Court also found that there was no basis

for differentiating between women recruits and women who were entitled to maternity leave in the army. Therefore, the court found that the Commander's decisions in enacting the Standing order and instituting the process of discharge of the applicants were arbitrary and irrational. The Court cited with approval the cases presented by the applicants, like the United States case of *Crawford v Cushman*[13] in which it was held that the policy of discharging pregnant women violated their right to due process under the 5th Amendment because it created an irrebuttable presumption that a pregnant woman would be permanently unfit for duty, despite the fact that pregnancy is temporary and not a permanent disability. The Court stated:

> The contention by the Commander that pregnant soldiers must be discharged because they compromise the army's operational capacity and jeopardize military discipline is not only an argument in *torrorem populi* but a throw-back to the patriarchal view that pregnant women are not fit to work and, therefore, are a disposable workforce. The view that soldiers need permission to be pregnant — which permission is obtainable after five years' service — is merely mentioned to be rejected.[14]

In agreement with the decision of the European Court of Justice in *Brown v Rentokil*,[15] the court also decided that dismissal on account of pregnancy is direct discrimination on the grounds of sex, because pregnancy is a condition that affects only women. The Court aptly characterizes the true nature of the case thus:

> This case is, therefore, about the applicability and observance of the values espoused by these international instruments in relation to the laws governing military service in the Kingdom. Although, in form the case is about the legality of the decision of the Commander of the Lesotho Defence Force to discharge pregnant soldiers, it is in substance a challenge to the culture of patriarchy in the military and an assertion of sexual and reproductive rights in military service. What is being contested is the idea that female soldiers are incapable to bear arms and babies at the same time and, on that account, are not fit for military purpose.[16]

Despite the worldwide existence of maternity protection in line with ILO standards, the international and regional standards laid out in CEDAW, and the Maputo Protocol, maternity protection does not always amount to proper recognition of women's rights to reproductive choices, especially in the interpretation of the courts. The Lesotho judgment is a good example in this respect. A recent South African Labour Court case regarding maternity protection restrictions in hazardous employment environment, however, achieved the opposite result.[17]

The conflicting results in the above two cases show the difficulties in litigating for reproductive rights in the context of employment and disciplinary or

hazardous contexts, where traditional patriarchal norms in the guise of practical or health concerns limit women's autonomy. The way these practical or health concerns are handled betray the underlying disregard for the rights of women. Nonetheless, it is encouraging that the courts are beginning to liberalize and dismantle the patriarchal system.

3.2 Mapingure v Minister of Home Affairs and Others

SALC provided some technical support to Zimbabwe Women Lawyers Association (ZWLA) on the Zimbabwean case of *Mapingure v Minister of Home Affairs & Others*.[18] The case illustrates the courts' treatment of reproductive autonomy in the context of the right to safe abortion. Abortion is only legal under limited circumstances in Zimbabwe, including in cases where the pregnancy is the result of rape or incest, or where it poses a danger to the life or physical health of the woman.

Zimbabwe is a state party to and has ratified the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW). Article 12 of CEDAW mandates member states to eliminate discrimination against women in healthcare and to ensure equal access to health services, including reproductive health services. In terms of General Recommendation 24 of the CEDAW Committee on Article 12, it is discriminatory for a state to refuse legal provision of reproductive health services for women.[19] In the case of conscientious objection to the performance of such services, an alternative for their provision should be made. To respect, protect, and fulfil women's rights to equal access to health services, states are mandated to ensure this is achieved through legislation, policy executive action, and an effective judicial system. States are also urged to respect women's right to access healthcare by not putting up barriers through means of obstructive laws that impact services only sought or needed by women, including criminalization and punishment.[20]

The obligation to protect women's rights to healthcare entails enacting laws and policies binding on public and private entities, like hospitals, to address violence against women and the provision of appropriate healthcare. Although CEDAW does not explicitly refer to the right to safe abortion as part of states' obligations to ensure equal access to health care by women, this is implicit in the reference to services that are specifically needed by women.

In the case of *LC v Peru*,[21] decided by the CEDAW Committee, a 13-year-old girl was denied an abortion after falling pregnant because of sexual abuse. She became permanently disabled from the lack of timely treatment after suffering serious injuries from a suicide attempt. This took place even though the Peruvian Penal Code allowed for access to abortion where the pregnancy posed a danger to her health. She brought a Communication before the CEDAW Committee and alleged violation of her right to health, dignity, and freedom from discrimination in the access of health services. The CEDAW Committee interpreted General Recommendation 24 in this case, stating the denial by the state hospital of an abortion and the requisite emergency services constituted

discrimination. It also found that, although LC was entitled to a legal abortion in terms of the Peruvian Penal Code, the state legal and health systems had failed in implementation to realize the rights conferred by the law. Therefore, the state had failed to establish legal protection of women's rights as envisaged in Articles 2(c) and 2(f).

Zimbabwe, as a state party to CEDAW is obliged to protect, promote, and fulfil the rights of women to healthcare services. By implication, Zimbabwe is mandated to provide safe abortion where it is required, specifically by the effective implementation of laws that allow for access to safe abortion. The CEDAW Committee's Concluding Observations in 2012 made recommendations to Zimbabwe to liberalize its abortion laws, decriminalize, and ensure access to safe abortion by simplifying the procedures required to access it.[22]

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women (Maputo Protocol) in its Article 14(1) defines the rights of women to health and reproductive health, including the right to control their own fertility, to make free decisions on child rearing and child spacing, to have family planning education, and to make choices of contraception. Article 14(2) directly specifies measures to be taken by states to realize the rights in Article 14(1), which includes access to safe abortion as one of the requisite measures. It can be argued that in specifying legal abortion on limited grounds, Article 14(2) (c) limits the rights conferred in Article 14(1). However, the explicit mention of the right to access safe abortion in the Protocol is a progressive move and imposes a peremptory obligation on member states to provide for safe abortion. The African Commission on Human and Peoples' Rights has elaborated on the provision of Article 14 (2) (c) explaining that states are obligated to remove all barriers to safe abortion services for women.[23] According to Ngwena,[24] this elevates the right to access safe abortion as a recognized human right, which imposes obligations on member states.

Mapingure's case illustrates the extent to which safe abortion is available where it is legally permissible, and to what extent the international obligations of Zimbabwe are achieved. This was a case challenging the government's failure to provide emergency contraception to prevent pregnancy and its subsequent failure to assist in procuring a legal abortion after rape.

The applicant in the matter was gang-raped at her house and promptly sought assistance from the doctor who treated her, for emergency contraceptives to prevent pregnancy. The doctor declined to assist without a formal police report, which the police delayed in supplying until the crucial 72-hour period expired. She had already fallen pregnant by this time. After discovering the pregnancy, the applicant approached a prosecutor for advice and assistance in obtaining a lawful abortion, provided for in terms of the law. She was erroneously advised that she had to wait for the criminal case to be completed before she could be issued with the Magistrate's certificate. By the time she obtained the certificate, the pregnancy was at an advanced stage and the medical professionals declined to perform the abortion, judging it unsafe.

She issued summons against the Ministry of Home Affairs (for the police), the Ministry of Health and Child Welfare (in charge of doctors), and the Ministry of Justice Legal and Parliamentary Affairs (in charge of the courts) for breach of their duty of care in failing to prevent the pregnancy and in failing to provide a lawful abortion. She sought damages occasioned from the physical and mental anguish caused by the respondents' negligence and breach of their duty of care. She further characterized the case as a wrongful pregnancy and birth issue,[25] and sought damages for the financial and psychological costs of having and raising the child.

The High Court dismissed the claim on the grounds that the respondents' duties of care towards the applicant did not extend to the termination of pregnancy outside any stated obligations in the Termination of Pregnancy Act. The Court stated that the Police, although admittedly negligent in their dilatoriness in rendering assistance to the applicant, could only be considered to have been 'negligent in the air', and thus attracted no liability. The Court also stated that the doctor had no obligation to terminate the pregnancy in the absence of authorization in the form of a certificate from a Magistrate in terms of the law. This was despite the fact that emergency contraception administered within 72 hours of the sexual assault would have prevented, not terminated, the pregnancy, and therefore would not have needed an authorization. The doctor and, apparently, the Court were clearly mistaken about the law and facts in this instance. In dismissing the claim against the court officials who had given erroneous advice, the Court held that the laws were clear that it was the applicant's duty to take steps to obtain the requisite authorization. Therefore, the fact of erroneous advice from the court officials did not raise liability because they 'were not her legal representatives'. The Court found that the applicant's predicament was caused by her own ignorance of the procedures she had to follow, and therefore her ignorance of the law could not be an excuse to find the respondents liable.

On appeal, the Supreme Court found the state (the Police and the Ministry of Health) liable for failure to facilitate and provide emergency contraceptives to prevent the pregnancy. However, the Court found the state was not liable for failure to provide a legal abortion, as the Court decided that the responsibility to procure the abortion lay on the applicant. The basis upon which the court found the Police and the doctor liable was that the police's duty of care extended beyond their statutory duties to arrest and investigate crime, and the doctor's duty of care extended beyond his duties to administer the emergency contraceptive drug or to advise her where to get it, even though the drug was apparently obtainable over the counter in pharmacies. Their failure to exercise this extended duty of care resulted in harm to the Appellant, for which they were liable.

It is not clear why the court officials could not be held to the same standard as the police and be found liable for failure by the appellant to obtain a lawful abortion, especially since they volunteered wrong legal advice, which the Appellant probably relied upon, causing the delay. Feltoe[26] argues that once

the court officials had volunteered legal advice, they put themselves within the ambit of a duty of care towards the Appellant. Further, there might have been a basis for liability if the trial court had called for evidence or the Supreme Court remitted the matter for more evidence to the High court. The Supreme Court held the provisions of the Termination of Pregnancy Act meant that it was the Appellant who had a duty to take measures to obtain the certificate, which included filing an affidavit with a magistrate detailing the grounds for termination.

The Supreme Court in its judgment referenced international norms derived from CEDAW (particularly Article 16, on the right for women to decide on the number and spacing of children and to have adequate access to information in exercising those rights), and the United Nations Declaration on the Elimination of Violence against Women 1993 regarding the duty of states to ensure elimination of violence against women by providing effective redress mechanisms. It also referred to the rights and imperatives in Article 4 of the Maputo Protocol, which require states to establish effective information and reparation systems for women victims of violence; Article 14(1) on reproductive rights; and Article 14(2)(c) on access to safe abortion. This was from the arguments raised by the Appellant. The Court found these international instruments should have persuasive value in the interpretation of statutes and the common law, although not formally binding because of non-domestication. However, as far as the Court was concerned, the extent to which these norms were relevant was in the state enacting laws to enable termination of pregnancy where appropriate and providing the necessary information and facilities within the available state resources. It did not extend to a duty to initiate Court proceedings on behalf of the victim.

The Court found, however, in passing, that the law as written was unclear in the required steps to be taken by a victim of rape who requires termination and the relevant duties of state actors in the process. The Court stated that, to bring the state in compliance with its international obligations, it must amend the law to ensure effective assistance to rape victims. This is an admission by the Court of the ineffectiveness of redress mechanisms put in place through legislation.

The Court decision on abortion is illustrative of the limitations to women's access to abortion occasioned by conservative application of the law. The Court fails to affirm a women's right to safe abortion and the obligations of the state, including the judiciary, to uphold this right as recognized in legislation. In addition, the new Zimbabwe Constitution of 2013 had already been passed when the matter was argued, with provisions on the right to health. The provision of the Constitution on the right to health ought to have been considered by the Court in this case. Section 76 of the Constitution provides for the right to basic healthcare services, including reproductive healthcare, and requires the state to put in place measures for the progressive realization of the right. When the provisions of the constitution are read together with the provisions of Article 14 of the Maputo Protocol, the right to safe abortion

is therefore constitutionally guaranteed. A provision in section 48, however, limits this right by restricting abortion through the protection of the life of the unborn child. Abortion is only allowed in terms of the provisions of an Act of Parliament.[27]

The Court completely overlooked the provisions of the Constitution in its interpretation of the Termination of Pregnancy Act in the context of the acts complained of and the right of access to reproductive healthcare. This is despite that in terms of section 46(2), the Court is supposed to be guided by the spirit and objectives of the Bill of Rights in its interpretation of legislature. Some of the relevant human rights contained in the Bill of Rights which the court should have applied include the right to bodily and psychological integrity,[28] which encompasses the right to make reproductive choices, the right to equal protection of the law, and non-discrimination on the basis of sex and gender[29] in addition to health rights. In this case, the court found problems with the law but declined to take up the challenge.

This submission is made mindful of the fact that the case had not been brought on a Constitutional basis, but in delict. This, of course, made it difficult to make constitutional arguments or have the court make constitutional findings. However, the Court is empowered in terms of section 176 of the Constitution to develop the common law in line with justice and the constitution, which it could have done on its own. For example, the High Court in the case of *S v Jeri*[30] applied constitutional imperatives in a murder case where a woman had been killed because she had rejected the sexual advances of the man accused. In convicting the accused, the court concentrated on the gender-based violence dimensions of the offence and the constitutional provisions that militate against it. The Court applied the provisions of sections 51(right to dignity) and 52(b) (right to freedom from violence) to contextualize the duties of the court in assessing the facts relating to the motivations, given the defences to the killing. The Court determined the accused had violated the deceased's rights. The Court said:

> As courts, it is our duty to be alive to the constitutional imperatives and to make the gender connections from the everyday cases that we deal with. The motivations for the assault were clearly gendered and to fail to speak to the gender dimensions of this case would be to legitimise gender-based violence within the criminal justice system. Our efficacy as courts in addressing gender-based violence rests in ensuring that the criminal justice system speaks to the lived realities and experiences of all its victims.[31]

According to Feltoe,[32] the Jeri judgment is a good example of how the courts should approach cases involving violence against women:

> The judgment in the *Jeri* case shows how the courts should approach cases involving gender-based violence. The courts have an obligation to base their judgments in such matters squarely on the constitutional provisions

> on the rights of women. They need to make it quite clear that violent behaviour arising from erroneous male misconceptions and prejudices about their right to dominate women will be severely dealt with.

It is possible that the court in the *Mapingure* case might have made different conclusions had the matter been brought as a constitutional challenge under the provisions of the new constitution. However, when the case was initially filed in 2007, the Zimbabwe Constitution, 1979 did not contain health rights or some of the other progressive rights present in the new Constitution. It could have been possible to bring a claim alleging discrimination based on sex, but without guarantee of success. The major complication with cases of this nature is that they are often delictual and subject to rigid common law principles that are often difficult to discharge. With the new Constitution, it is hoped that a new kind of jurisprudence relating to the direct protection of rights, including sexual and reproductive rights, will emerge in Zimbabwe and ensure justice for women.

Nevertheless, the judgment as it stands affords some relief to victims of sexual violence with regards to the duties of the police and other officers with a direct duty of care. Another positive aspect of the judgment was the court's acknowledgment of the lack of clarity in the law, bringing attention to the need for law reform and giving room to advocacy. This effectively leaves room for future development.

The applicant was subsequently awarded damages against the police and health ministry. Despite this positive outcome at court in this matter, the applicant took years to receive payment from the state. This highlights the need for persistent follow-through and advocacy at the domestic level to the point of implementation to ensure that, in addition to the greater good coming out of a precedent-setting judgment, the individual on whom the case is predicated actually receives remedies.

3.3 GMJ v Attorney General of Botswana

Many countries in Southern Africa do not have stand-alone mechanisms for the protection of sexual and reproductive health rights. In seeking redress for violations of sexual and reproductive rights, women must turn to the civil litigation system and, more commonly, file medical professional negligence claims. In addition to the complexities of the medical field which many marginalized and vulnerable women have little knowledge about, women have to contend with navigating the rather tenuous road of legal and court procedures.

The complexities often lead to failure to access justice and redress for violations of sexual and reproductive health. One common barrier to the effective vindication of women's rights in this area is the concept of extinctive prescription. This is the concept that, due to the passing of time, certain rights either become extinguished or are no longer enforceable. Prescription is often set

out in national legislation, providing for specific periods within which certain rights can be vindicated. After the specified period passes, the rights become unenforceable or are extinguished.

The case of *GMJ v Attorney General,*[33] decided in the Botswana Court of Appeal on 26 October 2018, illustrates how the laws of prescription act to limit access to redress for sexual and reproductive health violations for women, and how court decisions can be used to clarify and simplify the requirements of access.

The appellant (GMJ) had undergone a surgical procedure for removal of the womb resulting in severe complications which completely disrupted her life and physical and mental well-being. She issued summons against the Respondent, claiming damages for medical negligence and lack of proper post-operative care. The Respondent filed a special plea of prescription on the grounds that the claim had prescribed. The Respondent argued the claim was filed after 3 years from the date of the cause of action, when the plaintiff first noticed symptoms and became aware of the injury. In terms of the Botswana Prescription Act,[34] a claim for damages prescribes after 3 years from the date of knowledge of the injury giving rise to the claim. The question to be answered was the time a person would be considered to have knowledge of the injury, or the facts giving rise to the claim. The High Court agreed with the State and decided she obtained knowledge of the facts giving rise to the claim the moment GMJ experienced the symptoms of her problem, and therefore the claim had prescribed.

GMJ filed an appeal with the Botswana Appeals Court and argued the point of knowledge of the facts giving rise to her claim could not have been the point when she became aware of the symptoms she had, in line with decided South African cases and based on similar prescription provisions.[35] The South African Constitutional Court in *Links v Member of the Executive Council, Department of Health, Northern Cape Province*[36] held that in cases involving medical professional negligence, the party relying on prescription has the duty to show that the plaintiff had enough facts to cause them to conclude there was fault on the part of the medical staff that caused their injury. The Court said:

> It seems to me that it would be unrealistic for the law to expect a litigant who has no knowledge of medicine to have knowledge of what caused his condition without having first had an opportunity of consulting a relevant medical professional or specialist for advice. That in turn requires that the litigant is in possession of sufficient facts to cause a reasonable person to suspect that something has gone wrong and to seek advice.[37]

The Botswana Court of Appeal issued a judgment in favour of GMJ and reinstated her claim. The Court ruled that the suspicion of the cause of the Appellant's injury was insufficient to constitute knowledge because she did not know for a fact what had caused the symptoms, and ruled the knowledge of

the cause of her condition was a material fact for the purpose of determining who was at fault. Thus, the relevant date for the purposes of prescription was not the date she noticed the symptoms, but the date she became aware of the cause for the symptoms.

Although the decision was solely grounded in the law of delict and concerned civil law and procedure, the decision is very significant in the realization of women's sexual and reproductive health and rights when it comes to accessing justice. In line with CEDAW Committee General Recommendation 24 on Article 12 of CEDAW, Botswana is obligated to respect, protect and fulfil women's right to reproductive health services through effective legislation, policy, implementation and judicial action. This judgment is a step towards this obligation.

Many women who have experienced violations, such as coerced or forced sterilization and other reproductive rights violations, are unable to obtain redress because of prescription, whether due to the lack of medical or other technical knowledge, the lack of access to legal advice, or personal circumstances. This case is an important step towards the realization of effective redress for violations, but it is only a start. A total elimination of prescription laws when it comes to violations of women's rights would be the ultimate victory, either through constitutional interpretation or the creation of a totally different cause of action based on the rights afforded through international and national laws.

4 Challenges

From the cases discussed above and other experiences, the results of strategic litigation can be rewarding, but are not without challenges, both general, content-specific, and dependent on geographical location. Litigation takes time, and delays in the conclusion of cases from the judicial system, state responses, and handing down judgments are common. The delays are less of an issue in some countries than others. *Mapingure*'s case was initially filed in 2007 and the Supreme Court judgment was only issued 7 years later, in 2014. However, judgments are handed down quickly in other countries like Botswana.

A major challenge to instituting strategic litigation is often associated prohibitive costs, including lawyer fees, engagement of experts, court and messenger/sheriff costs[38]. In addition, the risk of getting an adverse costs order in the event of an unsuccessful suit is daunting and may affect the decision to litigate in uncertain cases. In some cases, it may be possible to convince the Court not to award costs, especially in cases with important constitutional or national interest value. The High Court in *Mapingure* dismissed the claim but declined to award costs against her because of the national importance of the case. GMJ, however, had to deposit security for costs for the appeal and was in danger of having an adverse costs order against her, had she not succeeded in the case.

The implementation of judgments sometimes depends on State goodwill or resources. In many jurisdictions, judgments cannot be enforced in the traditional ways and clients may not ultimately get the actual relief granted by the

Court. For example, when the applicant in the *Mapingure* case in Zimbabwe was awarded damages by the Court she was not paid for a long time. She could not issue out process to attach State property to satisfy the award. Effectively, changes in law/policy can be of limited benefit for women.

There are often difficulties in mobilizing affected clients to attend court or in maintaining the client's involvement and interest, due to fear of stigmatization and inadequate information. These difficulties also include lack of personal resources to attend court and the unavailability of adequate funding. A major issue affecting the efficacy of strategic SRHR litigation is general ignorance and negative attitudes towards SRHR by the public and courts.[39] In addition, as illustrated above, prescription laws are often an issue in SRHR cases where it is intended to sue for damages or litigate against the State.

Most importantly, the nature of cases relating to sexual and reproductive health and rights can be very traumatic to clients. The cases often relate to distressing experiences which continue to have a significant impact on their lives. They also relate to very personal issues which create additional stress relating to how such issue will be perceived in court and in the public domain. It is thus essential to provide clients with psycho-social support throughout the litigation process.

5 Lessons Learnt

It is important to explore ways in which some of the challenges outlined above can be mitigated. It helps to ensure that local lawyers and partner organizations maintain regular communication with clients, and to ensure that all decisions relating to the case are made with client's consent and best interest.

Collaboration is also a very strong tool in effective strategic litigation, as social movements identify cases and sustain advocacy. Sustained advocacy around the case is essential at the hearing and after judgment. Sustained advocacy ensures the case becomes a catalyst for similar cases in other countries and ensures the value of judgments for continued advocacy; litigation cannot always provide redress to all.

For efficiency, there should be thorough research of submissions to present the best arguments that will enable the judge to write judgments without fear of negative repercussions. The research of submissions should also ensure sufficient evidence is obtained, including expert evidence to support technical arguments around health and SRHR.

Where possible, it is also important to choose the best clients for strategic litigation and protect their privacy by obtaining confidentiality orders in advance where necessary. The use of confidentiality orders is an important factor in ensuring that vulnerable clients can co-operate without fear of stigma or other negative repercussions. It is also important to utilize complaints mechanisms and other non-litigious measures before proceeding to institute litigation. Litigation should be used as a last resort.

6 Conclusion

Strategic litigation is a very effective tool for reform, especially by highlighting the gaps in the law and the effect of the gaps on the lived realities of women's lives. It also serves as an important means of holding states accountable to realize SRHR. Nevertheless, strategic litigation can be challenging, especially considering differing interpretations and unwillingness of some courts to embrace international norms that promote sexual and reproductive rights. The value of the major role of the law in social change and cohesion cannot be overlooked, however, and it is important to have an integrated approach with litigation, advocacy, and other non-litigious means to achieve social change.

Notes

1 E Durojaye *Litigating the right to health in Africa: Challenges and prospects* (2016).
2 M Roa & B Klugman 'Considering strategic litigation as an advocacy tool: A case study of the defence of reproductive rights in Colombia' (2014) 44 *Reproductive Health Matters* 31–41.
3 SALC & MHRC *Towards a human rights-based approach to learner pregnancy management in Malawi* (2017) http://www.southernafricalitigationcentre.org/2017/07/31/salc-research-report-towards-a-human-rights-based-approach -to-learner-pregnancy-management-in-malawi (accessed 16 October 2020).
4 E Durojaye 'Relevance of health rights litigation in Africa' in E Durojaye (ed) *Litigating the right to health in Africa: Challenges and prospect* (2016) 3.
5 S Gloppen 'Litigating as a strategy to hold governments accountable for implementing the right to health' (2008) 10 *Health and Human Rights* 21.
6 M Pieterse 'The potential of socio-economic rights litigation for the achievement of social justice: Considering the example of access to medical care in South African prisons' (2006) 50 *Journal of African Law* 118.
7 O Ferraz 'Harming the poor through social rights litigation: Lessons from Brazil' (2011) *Texas Law Review* 1643; see also, G Rosenberg *The hollow hope: Can courts bring about social change?* (2008).
8 A Yamin & S Gloppen *Litigating health rights: Can courts bring more justice to health?* (2011).
9 ILC (2000)
10 *Mokhele and Others v Commander, Lesotho Defence Force and Others* (CIV/APN/442/16) [2018] LSHC 2 (14 February 2018).
11 MAHGB-000301.
12 C183 – Maternity Protection Convention, 2000 (No. 183).
13 531 F.2d 1114(2d Cir.1976).
14 See para 12 of judgment.
15 C-394/96.
16 See para 23 of judgment.
17 *Tshegofatso Manyetsa v New Kleinfontein Gold Mine (Pty) Ltd* www.safli.org/za/cases/ZALCJHB/2017/404
18 (2014), Judgment No. SC 22/14, Civil Appeal No. SC 406/12.
19 CEDAW Committee General Recommendation 24 on women and health para 9.
20 As above.
21 *LC v Peru*, Communication 22/2009,CEDAW/C/50/D/22/2009 (2011).
22 See CEDAW Committee Concluding observations to Zimbabwe *CEDAW*/C/ZWE/CO/2-5, 23 March *2012*.

23 General Comment No. 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa adopted by the African Commission on Human and Peoples' Rights during its 54th Ordinary Session in November 2014.
24 C Ngwena 'Inscribing abortion as a human right: Significance of the Protocol on the Rights of Women in Africa' 32 (2010) *Human Rights Quarterly* 810.
25 Defined by N Liu 'Wrongful life: Some of the problems' (1987) 13 *Glasgow University Journal of Medical Ethics* 69–73 as claims consisting of parents alleging that, had the defendant not been negligent, they would either have avoided conception or terminated the pregnancy.
26 G Feltoe 'Case note on the case of *Mapingure v Minister of Home Affairs & Ors* S-22-14 2017' *Zimbabwe Electronic Law Journal* 1.
27 Section 48(3) states that abortion may be allowed in terms of an Act of Parliament that protects the life of an unborn child.
28 Section 52.
29 Section 56.
30 HH 516/17.
31 As above.
32 As above.
33 CVHGB-003267-15 http://www.southernafricalitigationcentre.org/2018/06/15/botswanachallenging- prescription-in-medical-negligence-claim/ (accessed 20 October 2020).
34 Section 4(2)(iv) as read with section 6(1)(a)(1).
35 *McLeod v Kweyiwa* 2013 ZASCA 28,*Sibiya v the Premier of the Province of KwaZulu Natal* 2008(1)All SA 295, *Links v Member of the Executive Council, Department of Health, Northern Cape Province.* [2016]ZACC *10*
36 *Links v Member of the Executive Council, Department of Health, Northern Cape Province.* [2016]ZACC *10*
37 As above para 47.
38 Durojaye (n 1) 5.
39 See J Odikpo & E Durojaye 'Litigating health rights issues:The Nigerian experience' in E Durojaye (ed) *Litigating the right to health in Africa: Challenges and prospec*t (2016) 141; E Durojaye 'Litigating the right to health in Nigeria' in M Kilander (ed) *International law and domestic human rights litigation* (2010) 149.

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13 Experiences from the Kenya National Commission on Human Rights (KNCHR) on the promotion and protection of sexual and reproductive health and rights

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1 Introduction

The Kenya National Commission on Human Rights (KNCHR) is a National Human Rights Institution (NHRI) established under both the Constitution and Statute laws of Kenya. The Commission's core mandate of protecting and promoting human rights was further enhanced under the Prevention of Torture Act (2017) to investigate complaints of torture, cruel and inhuman and degrading treatment or punishment within the country.

KNCHR enjoys 'A' status accreditation under the United Nations Paris Principles which were adopted by the General Assembly in 1993. They provide for the mandate of NHRIs to protect human rights through *inter alia*, receiving, investigating and resolving complaints; mediating conflicts and monitoring activities. Further, NHRIs are obliged to promote human rights observance through public education, outreach, media engagement, publications, training and capacity building as well as advising and assisting the government in respect thereto. Based upon these guidelines, the mandate of KNCHR is stipulated under its constitutive Act and implementation of the same has led to its above referred to accreditation as per the six criteria of the Paris Principles (broad mandate based on international human rights norms ad standards, autonomy from government, guaranteed under constitutive law, pluralism, adequate resources and adequate powers of investigation). More information about KNCHR may be found on its official website.

2 Understanding Sexual and Reproductive Health and Rights

Sexual and Reproductive Health and Rights (SRHRs) are said to encompass all of those rights regarding ones' sexual and reproductive health and by extension, life itself. Sexual and reproductive health rights cannot be actualized in

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isolation as they are closely linked to other human rights such as the right to bodily integrity, the right to human dignity, the right to health/ highest attainable standard of health, the right to life, the right to privacy and freedom from violence and all forms of discrimination, amongst others.

According to information available on the website of Choice for Youth and Sexuality.[1]

'The term SRHR combines four separate but interrelated concepts: Sexual Health (SH), Reproductive Health (RH), Sexual Rights (SR), and Reproductive Rights (RR). Sexual and Reproductive health and rights cover the right to decide if, when and how often to have children, the right to live free from disease, the right to have access to accurate, comprehensive and confidential information etc; while Sexual Rights cover the right to sexual pleasure, the right to sexual expression, the right to sexual privacy, the right to have access to the full range of contraceptives and the right to choose your partner amongst others'.

The World Health Organization (WHO) has defined sexual health as 'a state of physical, emotional, mental and social well-being in relation to sexuality'[2] while the International Conference on Population and Development (ICPD) Programme of Action described reproductive health as concerning peoples' ability to reproduce and the freedom to make informed, free and responsible decisions about their reproductive behaviour based on access to a range of reproductive health data, goods, facilities and services.

It is noteworthy that although internationally recognized, SRHR are still considered controversial and also contentious. This is especially so when issues of sexual and gender diversity that have not been fully embraced in many communities are mixed into the discussion. SRHR rest on the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children. In addition, parties should have the information and means to do so, plus the right to attain the highest standard of sexual and reproductive health. SRHR also encompass the right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in several human rights documents.[3] It should also be noted that just as the right to the highest attainable standard of health does not only mean absence of disease and infirmity but also includes the right to the provision of preventive, curative and palliative health care, including underlying determinants of health,[4] the same is applicable to the right to sexual and reproductive health. It extends beyond sexual and reproductive health care to the underlying determinants such as access to safe and potable water, adequate sanitation, adequate food and nutrition, adequate housing, safe and healthy working conditions and environment, health-related education and information, and effective protection from all forms of violence, torture and discrimination amongst other human rights violations that have a negative impact on the actualization of the right to sexual and reproductive health.

The Committee on Economic, Social and Cultural Rights[5] has rightly observed that numerous legal, procedural, practical and social barriers seriously restrict people's access to the full range of sexual and reproductive health

facilities, services, goods and information and that full enjoyment of this right remains a distant goal for many in the world, especially women and girls. The Committee singled out lesbian, gay, bisexual, transgender and intersex persons and persons with disabilities as individuals and groups that experience multiple and intersecting forms of discrimination. These groups' situation is further exacerbated by their exclusion in both law and practice which places further restrictions on their full enjoyment of the right to sexual and reproductive health.

3 Kenya's Normative Framework on Sexual and Reproductive Health Rights

Sexual and Reproductive Health and Rights are fundamental human rights that are guaranteed in various international and regional human rights instruments as well as national laws and policies[6] in Kenya. As a matter of fact, the supreme law of the country provides for the application of international treaties and conventions that Kenya has ratified alongside domestic law. Though there is currently no human rights instrument under international law that provides specifically for sexual and reproductive health and rights, there exists a plethora of provisions housed in various international and regional instruments which are geared towards the advancement of these rights. As was rightfully noted during the International Conference on Population and Development (ICPD) Programme of Action);-

> *…sexual and reproductive health rights are not a new set of rights; rather they are rights already recognised in human rights instruments.*[7]

Amongst the instruments with specific protections on sexual and reproductive health rights are the Covenant on Economic, Social and Cultural Rights (1966); Covenant on Civil and Political Rights (1966); Convention on the Elimination of all forms of Racial Discrimination (1966); Convention on the Elimination of all forms of Discrimination against Women (1979), Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984); Convention on the Rights of the Child (1989) and Convention on the Rights of Persons with Disabilities (2006). At the African regional level, the chief instrument that provides for sexual and reproductive health and rights is the African Charter on Human and Peoples' Rights (1981)[The African Charter] which states that every individual shall have the right to enjoy the best attainable state of physical and mental health. Similar provisions are contained in the African Charter on the Rights and Welfare of the Child (1990) and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa popularly known as the 'Maputo Protocol' (2003).

The international Convention on the Elimination of all forms of Discrimination against Women (CEDAW) promotes the right to health, including family planning. The CEDAW Committee in its general recommendation

24 has also clearly indicated that women's right to health includes their sexual and reproductive health thus implying that States have obligations to respect, protect and fulfill rights related to women's sexual and reproductive health. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health maintains that women are entitled to reproductive health care services, goods and facilities. The same ought to be availed in adequate numbers, be physically and economically accessible, without discrimination, and be of good quality.

The CESCR General Comment 14 explains that the provision of maternal health services is comparable to a core obligation which cannot be derogated from under any circumstances, and that States have the immediate obligation to take deliberate, concrete, and targeted steps towards fulfilling the right to health in the context of pregnancy and childbirth. The Committee considers the right to health in all its forms and at all levels to contain the following in every particular State party;-availability of functioning public health and health-care facilities, goods and services, as well as programmes in sufficient quantity; accessibility physically, economically and to information in non-discriminatory terms; acceptable and of quality which entails, inter alia, skilled medical personnel; scientifically approved and unexpired drugs and hospital equipment; safe and potable water plus adequate sanitation. In its General Comment 22, the Committee has affirmed that the enjoyment of the right to health includes SRHR. The Committee further affirms that states must ensure the realization of the SRHR of women and girls on a non-discriminatory basis.

The Children's Convention also provides strong protection on their right to access sexual and reproductive health services together with the rights to equality and non-discrimination. This includes protection of girls' rights as a result of the stigma surrounding sexuality in most societies and the attendant discrimination and inequalities that they face daily in life. The Committee on the Rights of the Child (CRC) in its general comment 4 has also advocated for the realization of children's right to sexual and reproductive health services and obliged states to ensure universal access to sexual and reproductive health interventions. Such realization would include adolescent access to short and long-term contraceptive methods, emergency contraception, safe abortion and post-abortion care services irrespective of whether abortion itself is legal in the state parties' jurisdiction. The CRC has on several occasions strongly condemned and called for the eradication of socio-cultural practices that jeopardize children's reproductive rights such as child marriage and female genital mutilation.

The adjudication of several cases on children's rights to sexual and reproductive health services by various International and regional human rights bodies is an indication of the strong advocacy for this right for children. For example, the United Nations Human Rights Council Committee held in *KL v Peru* (UNHRC 2005) that denying abortion services to a child who was carrying a pregnancy that posed a risk to her life and mental wellbeing amounted to a violation of her right to privacy, and also to cruel, inhuman and degrading treatment, inter alia. The European Court of Human Rights (ECtHR) also

made similar findings in *R and S v Poland* (ECHR 2008) where a child had intentionally been obstructed from accessing abortion services.

At the continental level, there exists a normative and institutional framework in Africa for the promotion, protection and realization of SRHR, which continues to evolve and become stronger. Amongst these are the Maputo Protocol already cited above, the Solemn Declaration on Gender Equality in Africa, the Continental Policy Framework on SRHR, and the Maputo Action Plan. Further to the above are the African Charter on the Rights and Welfare of the Child, the African Youth Charter and the AU Gender Strategy.

The Africa Charter which is the foundation of the African human rights system and the parent treaty of the Maputo Protocol enshrines the principle of non-discrimination on all grounds including on the basis of sex. It also obliges states to eliminate discrimination against women and girls and to protect their rights. It was the key determinant in the creation of the Special Rapporteur on the Rights of Women in Africa mandate and guarantees women's right to health, including sexual and reproductive health. The adoption of the Maputo Protocol by the African Union in 2003 ushered in a new era in the advancement of women's human rights, including SRHR in Africa.[8] The Maputo Protocol also calls upon States Parties to take all appropriate measures to 'protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus. This provision has been hailed as affirming a substantive equality approach to addressing the sexual and reproductive health and rights of women in the region.[9]

Women's rights to sexual and reproductive health enumerated therein include the rights to control their fertility, the number and spacing of children, choice of contraception method, and access to family planning education. It is noteworthy that this is the first 'international human rights instrument to recognize abortion as a women's right that should be enjoyed without restriction or fear of being prosecuted under certain conditions. Many African countries are however, yet to undertake the necessary legislative reforms needed towards domesticating the relevant provisions of the Maputo Protocol especially in the area of women's sexual and reproductive rights. The practical reality is therefore that many women and girls continue to have limited access to family planning and accessing safe and available abortion services even in cases where it is legal.

Three General Comments have been adopted with regard to the Maputo Protocol two of which are by the African Commission on Human and Peoples' Rights and explain their normative content. The comments also articulate measures which states should undertake to fulfil their obligations under the Protocol. The first general comment on Article 14 (1) (d) and (e) with regard to women's rights and HIV, and the second general comment concerns the rights to reproductive freedom, family planning and safe abortion. The latter may also be utilized to guide drafting and presentation of State periodic reports particularly when reporting on legislative and other measures taken to promote and protect the sexual and

reproductive health of women and girls. The Third General Comment, adopted in 2017, jointly by the ACHPR and the African Committee of Experts on the Rights and Welfare of the Child focuses on ending child marriages and refers to both the Maputo Protocol and the African Children's Charter.

The revised Continental Policy Framework on SRHRs translated into the Maputo Plan of Action provides guidance to African states on how to implement the ICPD Programme of Action (UN 1994) and the Abuja Declaration (AU 2001). Of the Fifty-two countries that have signed the Maputo Protocol, only forty have ratified it and seven of these with reservations, which mostly touch on women and girls' SRHR particularly with regard to marriage and access to safe abortion. The import of this is that many factors still impede women's enjoyment of the provisions of the Maputo Plan of Action. Its implementation is further hampered by factors such as inadequate health legislation and infrastructure, weak political commitment and leadership, inadequate financing and high donor dependency, coupled with poor women empowerment. The situation is further exacerbated by cultural norms and practices in highly patriarchal societies, which continue to entrench and justify violation of women's rights.[10]

Another component of the continental legislative and normative framework is the Solemn Declaration on Gender Equality in Africa which reaffirms African states' commitments to gender equality and parity and the protection of women and girls' rights. Further, the African heads of state endorsed the Continental Policy Framework on Sexual and Reproductive Health Rights (CPF) in January 2006. It offers guidance to policy formulation by member states in the implementation of the ICPD Plan of Action (PoA) and the Millennium Development Goals (MDGs). The CPF identified the following eight core strategic areas which it called for mainstreaming and harmonization into all development initiatives-maternal mortality and morbidity, infant and child mortality, contraceptive use and family planning services, unsafe abortion, sexually transmitted infections and HIV and Aids, Adolescent Reproductive Health, Female Genital Mutilation and Gender-based Violence. The CPF also identified the challenges highlighted above and sought to strengthen implementation of the recommendations of the Abuja Declaration of the 2001 Summit of Heads of State and Government to increase resources for the health sector as a means to realization of SRHR on the continent.

With specific regard to youth and adolescents, the two main regional frameworks are the African Charter on the Rights and Welfare of the Child and the African Youth Charter which both seek to prioritize youth development and empowerment through their participation in debates and decision-making.

Further, Africa's first Gender Equality and Women's Empowerment Strategy reaffirms its commitment to advancing gender equality and is expected to contribute to attaining Agenda 2063 visions for gender equality. During the consultative process on the formulation of the strategy, child marriage, FGM, gender-violence against women, eradication of maternal mortality and HIV and AIDS were given priority. Further, attention was also given to ensuring

affordable and accessible SRHR especially for the youth in terms of adolescent pregnancies, commercial sexual exploitation, lack of youth-friendly SRHR services and sexual violence/harassment in schools.

3.1 Kenya's Domestic Legal and Policy Framework

Kenya's domestic law contains provisions for the right to the highest attainable standard of health, which includes the right to reproductive health care for every person. Provision for emergency medical treatment has also been made in absolute terms and on condition that it should never be denied. The State is further obliged to provide social security as appropriate, to persons who are unable to support themselves and their dependents. To realize this right, the Kenyan government has put in place several statutory provisions and policies amongst which is the Prohibition of Female Genital Mutilation (FGM) Act, 2011. This Act prohibits the practice of FGM, safeguards against violation of a person's mental or physical integrity through the said act and other connected purposes. It defines what constitutes FGM, provides for the forms of crimes and punishments thereunder and also aims to reduce the scale of the practice with the target of eliminating it wholly. Methods of assisting the survivors of FGM in terms of medical assistance and actions that the government is supposed to undertake to eradicate the practice are also given. This law has rendered the practice of FGM a crime against the State and punishable by imprisonment and /or fines. Constitutional guarantees in Kenya for women and children to be free from all forms of discrimination are also available, with the right to dignity and physical integrity safeguarded. Further, freedom from violence; the right to health and the right not to be compelled to undergo any harmful cultural practices have been protected.

Kenya also has the Sexual Offences Act 2006 which came into force in July 2006 and makes provision for sexual offences, their definition, and prevention. It provides protection to all persons from harm, unlawful sexual acts and similar conduct. The law was hailed for bringing clarity on the definition and types of sexual offences apart from introducing more strict sentencing guidelines based on provision of 'minimum sentences'. It also provides for the management of medical treatment and court processes that protect the dignity of victims. Unfortunately, however, the criminal justice system in Kenya has faced various challenges in addressing the plight of victims and survivors of sexual offences thus putting a dent to the expected achievements of this law. Further, few convictions in relation to the number of reported cases and the perceived high incidence of sexual crimes in the country point to constrain in the prosecution of sexual offences and thus the expected impact of this law.

The 2001 Children's Act of Kenya aimed to domesticate the Convention on the Rights of the Child (CRC) and the African Charter on the Rights and Welfare of the Child. Among its provisions is prohibition of harmful cultural practices such as child marriages, FGM and sexual offences

There are also several policies in addition to the above laws that have been developed such as the National Adolescent Sexual and Reproductive Health Policy, the Contraceptive Commodities Security Strategy (2007–2012), the Contraceptive Policy and Strategy (2002–2006), Reproductive Health Policy of 2015 and an institutional framework to promote and protect the sexual and reproductive health rights of Kenyans. The Adolescent Reproductive Health and Development Policy, 2003, aims at enhancing SRH status of adolescents in Kenya and contributes towards realization of their full potential in national development. The Policy seeks to bring adolescent sexual and reproductive health and rights issues into the country's mainstream health and development agenda. This is in line with the country's international and regional obligations which include the Ministerial Commitment on Comprehensive Sexuality Education and SRH Services for Adolescents and Young People in Eastern and Southern Africa (ESA, 2013), the Convention on the Rights of the Child and the Program of Action of the International Conference on Population and Development. Added to these and other instruments already listed above is the Millennium Development Goals (MDGs) approved by the World Summit on Sustainable Development in September 2000. The implementation of the Adolescent Reproductive Health and Development Policy is guided by the principles of respect for human rights and fundamental freedoms, responsiveness to the varying sexual and reproductive health needs of adolescents and provision of holistic and integrated ASRH information and services. The policy also recognizes the critical role parents, guardians and communities play in the promotion of SRHRs; involvement of adolescents in the planning, implementation, monitoring and evaluation of ASRH programs plus the utilization of evidence-based interventions and programming.

The National Condom Policy and Strategy (2009–2014) on the other hand seeks to ensure adequate national supply of and access to condoms, coupled with public education and advocacy to increase use among those in need but not utilizing condoms. The policy and strategy was based on the findings of a study by the National AIDS Control Council (NACC) which estimated that about 1.5 million people had died of AIDS as of June 2000 since detection of the pandemic in Kenya in the early 1980s. The pandemic had resulted in more than 1 million children being orphaned, and a suspected significant drop in life expectancy at birth. The objectives of the Policy and Strategy provide that no barriers should exist to access and use condoms by those who need and want to use them. Further, that user charges and revolving funds in public service delivery points should be established bearing in mind equity considerations plus the cost of condoms by providers and users. Another objective is to have in place an effective management of condom supply pipeline.

The National Reproductive Health Policy, 2007 consolidates efforts by the government to enhance the reproductive health status of all Kenyans by increasing equitable access to reproductive health services and by improving the quality, efficiency and effectiveness of services provided at all levels. The policy focuses on service delivery to the wider public and the promotion of healthy

lifestyles of individuals and communities in tandem with the Millennium development goals (MDGs). Its purpose is to improve maternal health, reduce neonatal and child mortality, reduce the spread of HIV/AIDS and promote women's empowerment and gender equality. The policy was developed as a result of the response to the ICPD in 1994 which called for the development of comprehensive reproductive health policies, programmes and implementation plans. It emphasized the strategic roles of information, education and community mobilization and participation in promoting and protecting SRHR.

On the other hand, the National Reproductive Health Policy is guided by principles of respect for human rights and freedoms and provides for the freedom of couples and individuals to decide responsibly the timing, number and spacing of their children. The right to have access to requisite information and education for making informed decisions is also protected. The Policy further calls for all people to freely and responsibly decide on all aspects of their sexuality, including the right to be free from conditions that interfere with their sexual health. Other aspects are protection from harmful practices, sexually acquired infections, complications associated with menopause and andropause, and coercion into sexual acts and other forms of sexual violence. The policy provides priority actions in Safe Motherhood, Maternal and Neonatal Health, Family Planning and Adolescents/Youth Sexual and Reproductive Health. Gender Issues, Sexual and Reproductive Rights, HIV and AIDS, Reproductive Tract Infections, Infertility, Cancers of Reproductive Organs and Reproductive Health for Elderly Persons are also provided for.

The above discussion indicates that clearly, Kenya is obliged by virtue of her legal regime to enforce the right to the highest attainable standard of health for its citizenry (including SRHR) and to take steps towards progressively realizing the rights recognized in the CESCR. This right has been interpreted variously including non-confinement to not only the right to health care only but expansion to include the right to control one's health and body, the right to access essential health information and freedom from interference with one's health, among others

3.2 Access to SRHR goods and services in Kenya

Apart from the legal framework available in Kenya with regard to the realization of sexual and reproductive health rights, it is important to briefly discuss the status of health facilities and healthcare services in the country, which form part of the operating environment for KNCHR's advocacy work.

Provision of health care services in Kenya has on several occasions been crippled and even grounded due to industrial action by its more than 600 doctors demanding for better terms of service, improvements to dilapidated public health facilities and for the government to address the prevailing huge shortage of doctors. The worst of these strikes went on for more than a hundred days and affected over 2500 public health facilities resulting in the death of

many patients due to lack of medical care.[11] In January 2018, doctors, under the umbrella body known as the Kenya Medical Practitioners, Pharmacists and Dentists Union once again gave a strike notice and threatened to down their tools by February over alleged failure by universities and medical colleges to pay allowances due to their members.[12] Fortunately, the industrial action was averted when the doctors' body reached an agreement with the government over their terms of service.

In addition to the doctors' strikes, the provision of health care services is often further negatively impacted through frequent downing of tools by other medical practitioners especially nurses. Recently, one of their strikes went on for over one hundred and fifty days.[13] Added to the situation are also strikes by university lecturers, which indirectly impacts health care provision due to their role in medical schools and affiliated referral hospitals. In the premises, the Kenyan public is many times left in a precarious position with regards to accessing health care services taking into account already existing numerous impediments that have to be surmounted.[14] At the core of the many doctors' strikes has always been the contention about devolution of health care services to county governments under the devolved system of government that was ushered in by the 2010 Constitution. Doctors preferred to have a national body responsible for management of their services and a scheme of employment as opposed to this *status quo*.

4 The Experiences of KNCHR in Addressing Sexual and Reproductive Health and Rights

The Paris Principles which came into effect in 1993 and on which the establishment of National Human Rights Institutions (NHRIs) is grounded, bestow on them a national mandate to protect and promote the respect for human rights. This may be undertaken through various activities such as receiving, investigating and resolving complaints of human rights violations; mediating conflicts, monitoring and observing the national human rights landscape, promoting observance of human rights through public education, outreach, the media, publications, training and capacity building as well as advising and assisting governments concerning the promotion and protection of human rights. NHRIs form an integral part of the international human rights mechanisms and have an essential role in promoting the implementation by states of international obligations with regard to actualization of human sexual and reproductive health rights. More importantly, NHRIs can play a crucial role in advancing SRHR at the national level through its promotional and protective activities.[15] KNCHR, being no exception to other NHRIs, has likewise been endowed with a broad national mandate[16] which it has exercised in various ways. The following activities are illustrative of KNCHR's work with specific regard to the realization of reproductive and sexual health rights.

4.1 A Public Inquiry into Violations of Sexual and Reproductive Health Rights

The 2008–09 Kenya Demographic and Health Survey (KDHS)[17] findings were quite disturbing. They contained indications that most Kenyan women's first sexual intercourse was forced and against their will especially for women aged between 15 and 49 years (12%). The study further revealed that one in five Kenyan women (21 %) has experienced some form of sexual violence. In addition to the above, evidence from the Kenya Police Crime Report and Data for 2007 indicated 876 rape cases, 1,984 cases of defilement, 181 cases of incest, 198 cases of sodomy, 191 cases of indecent assault and 173 cases of abduction. In 2008, The Kenyan Police force listed 'Offences against morality' as making up 5% of the total reported crimes across the country. It was against this backdrop that in 2009, the Federation of Women Lawyers (FIDA) – Kenya and the Centre for Reproductive Rights of the United States of America (CRR),[18] filed a complaint with KNCHR regarding systematic violation of women's reproductive health rights in many public health facilities. FIDA and CRR's chief complaint was based on the findings of a joint study they had conducted between November 2006 and May 2007 regarding *Pumwani* Maternity Hospital, which is Kenya's largest maternal health care facility. The complaint prompted the Commission to launch an expanded Inquiry into the extent of violation of sexual and reproductive health and rights within the country in line with its mandate as an NHRI, to investigate or research matters in respect of human rights violations and make recommendations to improve the functioning of State organs. The objective of the Inquiry was to establish the extent and nature of violation of sexual and reproductive health and rights in the country and provide appropriate recommendations and redress measures.

The nationwide public inquiry was conducted in 2011 and proved to be a benchmark on the extent of the enjoyment of sexual and reproductive health and rights as per Kenya's 2010 Constitution. Other objectives of the inquiry were to:

- establish the adequacy and efficacy or otherwise of the legal and policy framework governing the implementation of sexual and reproductive health rights in Kenya;
- assess the extent to which the government and non-state actors comply with their obligations relating to sexual and reproductive health rights,
- determine the extent of awareness and pursuit of sexual and reproductive health rights in Kenya and
- identify and document cases of violation of sexual and reproductive health rights in Kenya.

In summary, the inquiry revealed that SRHR in Kenya are violated on several grounds amongst which are unavailability of essential sexual and reproductive health services, difficulties in accessing the services owing to distance and/or

cost, high charges levied on the services- making them beyond the reach of majority indigent persons, poor quality of the available services and the lack of sensitivity to the cultural norms and beliefs of the people in service delivery. Further, the State was found to have failed to comply with its international and regional obligation to dedicate the requisite minimum of its available resources to progressively realize the right to sexual and reproductive health, especially under the Abuja Declaration already mentioned above.

With regard to sexual violence, a WHO Report has documented that various forms of sexual violence take place in Kenya under differing contexts.[19] The contexts include rape by strangers, within marriage and dating relationships plus systemic rape during armed conflict. Unwanted sexual advances also known as sexual harassment at the work place (such demand for sex in return for favours, services or promotion at work), defilement and sexual abuse of persons with disabilities, forced marriage or cohabitation including child marriages, denial of the right to use contraception or the choice to use other measures to prevent unwanted pregnancy and sexually transmitted diseases, forced abortion, forced prostitution and trafficking of persons for purposes of sexual exploitation, and violent acts against the sexual integrity of mainly women through such acts as female genital mutilation and forced virginity inspections being some of the other contexts. The KNCHR inquiry received a lot of witness submissions on the issue of sexual violence. Of particular note were presentations from areas that had experienced heightened conflicts where it was used as a weapon of subjugation. Reports of incidences of marital rape were also received.[20]

Another finding of the Inquiry was that effects of sexual violence were profound on the victim's reproductive health. This was apart from the resultant unwanted pregnancies and eventual unsafe abortions. Other effects noted were sexually transmitted infections including HIV and AIDS, gynaecological complications, stigma, psychological trauma and in extreme cases disability or even death. Evidence also indicated rejection and abandonment by partners especially for female victims. Factors that perpetuate sexual violence were found to be numerous and amongst those recorded as disproportionately affecting women compared to men included:-

> *'the unequal power relations where laws, policies, community practices and beliefs 'conspire' to deprive women autonomy in private and public spheres*'.[21]

An earlier report[22] that had also made similar findings listed low levels of awareness of the law among the public, socioeconomic barriers amongst women, inability to negotiate safe sex and harmful cultural practices or traditional beliefs together with the culture of impunity that has normalized sexual abuse of females in most societies as key causes of sexual violence. The complexity of the Kenyan justice system from the perspective of the common person, who also finds it intimidating, was also singled out as a perpetuating factor.[23] Among the identified barriers to access remedies by survivors of sexual violence were lack of knowledge about the existence of the services, inaccessibility in terms

of distance and cost, absence of integrated services, difficulty in accessing documentation to prove sexual violation, in particular the notorious P3 Form[24] plus the burdensome and often humiliating justice system which has already been mentioned above.

The KNCHR Inquiry further found that incidents of sexual violence continue despite the various national, regional and international frameworks already in place and aimed at addressing this phenomenon. On this basis, KNCHR made several recommendations to the Kenyan government which would strengthen how to minimize sexual violence and to safeguard reproductive health rights. Key recommendations were for Kenya to;-

- Urgently ratify the Optional Protocol to CEDAW to enable citizens file individual complaints to the Monitoring Committee under its procedures.
- Provide survivors of sexual violence with medico-legal and psychosocial support
- The Ministry of Health to work with stakeholders to disseminate and popularize the Guidelines on Management of Sexual Offences
- Expand the range of health facilities to have capacity to serve survivors of sexual and gender-based violence countrywide
- Remove barriers that hinder access to justice in respect of cases of sexual violence with a review of the prosecution requirements that are of a technical nature

On its part, KNCHR undertook to create awareness on sexual violence, educate the public on procedures to be followed when violation occurs and to continuously monitor and document cases of sexual violence with the aim of holding the duty bearers accountable. The findings from the inquiry were published into a report[25] that continues to be used for advocacy purposes and to inform policy and legislative interventions by various government agencies.

The report also made a number of fundamental recommendations for consideration by other stakeholders.[26] As a follow-up to these recommendations, KNCHR carried out an audit exercise in 2017 to measure the extent to which the state has implemented the same. Of particular concern was progression made towards realizing the highest standard of health as provided for in the Constitution. While the audit exercise is still on-going and has yet to be finalized, preliminary findings indicate a noticeable improvement in several areas. Among these is the provision of free maternal health care in public facilities that has led to an increased number of women delivering in hospitals and thus enhancing safe delivery by pregnant mothers. In addition, a policy on free maternal health care has been formulated and there is an increase in the uptake of family planning facilities and services. Several structural measures have also been put in place to enhance accessibility of family planning facilities and services. These facts not withstanding however, much still needs to be done to enhance the realization of sexual and reproductive rights in Kenya. Still in existence are barriers towards access to justice by survivors of sexual

violence, especially those stemming from political violence and unrest, from defilement cases, and notable delays in the prosecution and finalization of sexual and gender-based violence (SGBV) cases. Added to this is the heavy financial weight that survivors of SGBV bear as currently there exists no public structure to support them financially or even provide them with a safe haven in instances where violations occur domestic relations. Added to the above, sexual minorities continue to face discrimination and stigma in accessing health services while the vulnerable and marginalized groups encompassing adolescents/youth, people with disabilities, people living with HIV and AIDS and refugees have not been prioritized. This gap can be addressed through provision of appropriate services and centres at county level. Preparation of the final audit report is still under way and the findings therefrom will provide another key advocacy tool in Kenya's journey towards the protection, promotion and fulfilment of Sexual and reproductive health rights.

Further to the aforesaid, the commission, in partnership with the Africa Alliance for Women's Reproductive Health and Rights (IPAS)[27] Kenya has embarked on advocacy efforts to move the Kenyan state to lift its reservations under Article 14 (2) (C) of the Maputo Protocol.[28] The advocacy exercise targets members of parliament as critical actors due to their legislative mandate and especially with regard to voting on Kenya's ratification of international treaties and conventions. A component of the exercise will include training and awareness-raising amongst parliamentarians on the effects that this reservation places on Kenyan women and girls especially during conflict times. Joined with this are efforts by KNCHR to lobby the Ministry of Health to enact Guidelines on Abortion as provided for under the Constitution which once adopted shall go a long way in procuring emergency abortion when required.

The above exercises by KNCHR provide an example of how NHRIs can effectively address realization of SRRH in their countries. While the full implementation of KNCHR's recommendations by the state and other actors has proved limited so far, the documentation of evidence-based violations of SRHR in Kenya in 2012 provides a benchmark against which future similar exercises may be measured. Further, the Inquiry report provides a baseline for the government and other actors to monitor and measure improvement of requisite services and goods to the public in actualization of the various relevant rights. It will prove valuable in addressing gaps and trends towards realizing sexual and reproductive health rights in Kenya.

5 Monitoring, Documentation and Redress of Electoral Related Sexual and Gender Based Violence (SGBV) Cases During and after the 2017 Elections

Kenya's history of electoral violence can be traced back to its independence elections and continues to incorporate sexual violence as a weapon. The aim of electoral-related sexual violence is mainly to limit and or punish expression of choice or even intimidate and punish those perceived to have alternative

political views. It should be noted that sexual violence strikes at the core of human dignity and is often accompanied by violation of several other human rights such as the rights to life; dignity; liberty and security of the person. Further, sexual violence infringes on the rights to freedom from torture, cruel, inhuman and degrading treatment; freedom from discrimination; and the right to highest attainable standard of health. The physical and mental consequences attendant to sexual violence have been found to be extremely dire to the survivors, their families and even society at large.

During Kenya's 2007/8 Post election violence, KNCHR, together with other stakeholders including the Commission of Inquiry into Post Election Violence popularly known as the Waki Commission[29] and later the Truth Justice and Reconciliation Commission (TJRC) documented over 900 cases on sexual violence. KNCHR's documentation efforts resulted in its now-famous report titled 'On the Brink of the Precipice'[30] which found that women and children had been particularly targeted for rape on the basis of their ethnicity and thus perceived political affiliation. Opportunistic rape also occurred in the internally displaced persons' [IDP] camps with perpetrators being both security agents and civilians. Though efforts for accountability by KNCHR and other actors suffered a setback when the Office of the Director for Public Prosecutions held that none of the files brought before his office contained sufficient evidence to warrant prosecutions, KNCHR continues to date to press for justice for the survivors of the 2007/08 post-election violence in various ways. First was through filing two cases in court to seek compensation for the 2007/8 sexual violence survivors which are still ongoing, and also through being part of the Transitional Justice Network (TJN) that comprises civil society actors and government agencies working together with the office of the Attorney General to set up a framework for reparations to survivors of sexual violence.

In furtherance of its tradition to monitor and document human rights issues during the electoral period, KNCHR once again worked in partnership with a number of civil society organizations and individuals to document cases of sexual and gender-based violence between April 2017 and April 2018 which surrounded Kenya's 2017 General Elections. The 2017 electoral environment culminated in civil unrest by way of political protests and use of violent force by law enforcement agents. In total, two hundred and one (201) cases were recorded in the commission's publication known as '*Silhouettes of Brutality*'[31] with the conclusive finding that the chief perpetrators were both civilian and the security agents. According to records within the Commission's purview, security agents were responsible for 54.55% and civilian for 45.45% of sexual violence linked to the 2017 electoral cycle.

The type and forms of sexual violence included gang rape and rape at over 71% with the least percentage being of attempted defilement at 1.07%. Sodomy contributed to 1.60% of the reported cases, 9% of the cases affected minors aged between 7 and 17, which further depicts the vulnerability of this category of persons. Incidents of gang-rape involved 2–6 perpetrators and also

affected minors and elderly persons. Sexual assault which accounted for 1.6% of the cases was manifested through beating of men's private parts while women reported being groped on their breasts and private parts.

Cases of sexual and gender-based violence were widespread within the country and covered areas such as Bungoma in western Kenya, the capital City of Nairobi plus Migori and Kisumu in Nyanza region.

A total of Four reports namely: ***Fallacious Vote***, ***Mirage at Dusk***, ***Still a Mirage*** and ***Silhouettes of Brutality*** were produced by KNCHR. They give a human rights account of the 2017 election period in Kenya and record the numerous violations that occurred in the period when Kenyans set out at various stages to exercise their civil and political right to vote. It may therefore be stated categorically and without contradiction that sexual and gender-based violence (SGBV) formed an integral part of the violations experienced.

Included in the abovementioned reports are highlights of the various challenges that KNCHR faced in documenting the cases and also in seeking redress for the survivors. Amongst the recorded challenges are low levels of reporting by the citizenry due to fear of victimization by alleged perpetrators some of whom were community members well known to survivors, and fear of reprisals from security agents some who may still be serving in the locations where they committed the crimes. Another factor that may have contributed to low reporting was scepticism that attaches to the procedure that requires such reports to be made at police stations to colleagues of some of the perpetrators. The possibility that officers may fail to take the reports seriously or make the necessary effort to bring their colleagues to book or even impartially support prosecution of the cases through production of evidence and witnesses are real. Kenya's law also requires that collaborative medical evidence be collected within the recommended 72 hours after commission of a crime. This requirement often acts as an impediment since most victims may not be able to access health facilities within that period due to the attendant insecurity that prevails in the course of violent protests and police shoot outs. KNCHR urges NHRIs to note such and other relevant facts in order to seek ways of ameliorating them in the course of conducting their mandate under similar situations. Indeed in most conservative societies, sexual violence is a taboo subject that victims would rather maintain silence about and find alternative ways of coping with rather than risk exposure and the attendant stigmatization that may occur as a result of seeking medical attention or reporting.

Despite the fact that up to date the SGBV survivors of the 2007/8 election violence in Kenya have yet to achieve justice, there is a lot to learn from KNCHR's exercise of its mandate during times of civil strife and division in society. NHRIs must of necessity step out to undertake proper documentation of the happenings for posterity and for use in seeking accountability at future opportune times. Such impartial objective reports can also be utilized to harness support from well-wishers in addressing sexual violence and thus provide the survivors with a much needed lifeline in their journey towards recovery.

The reports could also form bases for evidence based interventions and formulation of policy and legislative reforms where gaps exist.

6 Conclusion

It remains evident that the right to sexual and reproductive health though not placed in any specific international instrument has still found expression and protection within provisions of various instruments at international, regional and local levels. NHRIs operating in monist states, such as Kenya, can support the realization of this right at national level through various means as the above examples from KNCHR's experiences illustrate. It is pertinent that NHRIs with a different legal framework will likewise find the above examples valuable. As far as it's practicable and within their mandate, it's imperative that NHRIs enhance efforts to advocate for ratification and thereafter domestication of relevant international and regional instruments. Such efforts will contribute to strengthening the protection and promotion of sexual and reproductive health rights at domestic level. This will be especially so when such efforts are complemented with strategies that align national law to each country's international obligations. Such multi-dimensional approaches will definitely prove worthwhile in providing a framework that gives stronger safeguards to the actualization of sexual and reproductive health rights to each NHRIs individual constituency.

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9 C Ngwena 'Inscribing abortion as a human right: Significance of the Protocol on the Rights of Women in Africa' (2010) 32(4) *Human Rights Quarterly* 783–864.
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14 Monitoring implementation of the sexual and reproductive health and rights of adolescents children

The role of the African Committee of Experts on the rights and welfare of the child

Ayalew Getachew Assefa

1 Introduction

The International Conference on Population and Development (ICPD) and the subsequent platform in 1995,[1] Platform for Action of the Fourth World Conference on Women (FWCW),[2] pave the way to galvanize policy and program commitments to better address the Sexual and Reproductive Health and Rights (SRHR) of women in general and adolescent girls, in particular. Though the political commitment was concretely conceived during these two conferences, SRHR of adolescents and States' obligations towards their full realization were already embodied in prior international and regional human rights instruments, including the African Charter on the Rights and Welfare of the Child (the African Children's Charter/the Charter). Focusing on the African regional mechanism created through the African Children's Charter, the current chapter examines the role that the African Committee of Experts on the Rights and Welfare of the Child (ACERWC/the Committee) could play in monitoring implementation the SRHR of adolescents by State Parties of the Charter. In doing so, the chapter attempts to provide a critical reflection on the mandate of the ACERWC and the extent to which the Committee is engaged in addressing matters of SRHR while discharging its monitoring mandate.

Drawing from the 1998 joint statement by the World Health Organization, the United Nations Children's Fund, and the United Nations Population Fund, the chapter defines the term 'adolescents' as group of people between the ages of 10 and 19. With regard to the term 'child', the article recognizes the definition adopted by the African Children's Charter- 'any person under the age of 18'. From these definitions, one may learn that not all adolescents are treated as children, the former clearly extends to include those between the ages of 18 and 19, hence monitoring protection and promotion of their rights may not fall within the mandate of the ACERWC. Therefore, from the onset it should be noted that the scope of the chapter is limited to deal with issues

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of SRHR of adolescents, i.e., those between the ages of 10 and 18. However, in certain instances, the chapter may also include all children, where the rights and protections apply to all, and not only adolescents.

2 Sexual and reproductive health and rights of adolescent children: setting the context

Constituting a significant number globally, adolescents, like many other groups, have specific concerns, which include challenges in relation their SRHR. Though adolescents are 'relatively better educated, healthier, more aware of their rights and better equipped to advocate on their own behalf than the previous generations, many still face threats to their SRHR'.[3] Reports confirm that adolescents, particularly in African countries, are generally uninformed or misinformed about their sexuality and reproductive health promoting behaviors.[4] Lack of an in-depth knowledge about modern contraceptives, safe sex and safe abortion, limited access to adolescent friendly Sexual and Reproductive Health (SRH) services is reported as the major challenge of SRHR of adolescents in Africa.[5] As International Planned Parenthood Federation (IPPF) states, adolescents are 'sexual beings with diverse needs, desires, hopes, dreams, problems, concerns, preferences and priorities, most of which are still unmet'.[6] These unmet needs of adolescents are consequently producing various threats to their rights and welfare, such as child marriage, Female Genital Mutilation (FGM) and various forms of sexual abuse. Due to lack of access to a full range of appropriate and freely chosen contraceptives, adolescent girls experience unwanted pregnancies and sexually transmitted infections (STIs). The challenges are often exacerbated among adolescents who are in vulnerable situation, including children residing in rural areas, children with disabilities, children on the move, and belonging to economically disadvantaged households or socially excluded ethnic groups.

Despite the existing challenges, due to controversies related to adolescent sexuality and the general lack of knowledge about the SRH needs of adolescents, very few countries in Africa have adequately responded and set up the required normative and institutional standards. In fact, most countries have introduced restrictive laws and policies which fail to recognize adolescent children's capacity to make decisions about their sexual and reproductive lives and health. Many still find it sensitive and controversial to relate the discourse of children's rights with SRHR. In some cases, what comes to one's mind when she/he thinks of a 'child', may not allow the person to relate SRHR with the interest of children. Such perspectives, this chapter argues, emanate from the very understanding that society has about children, which usually attaches an unqualified reservation on children's capacity to make informed decisions. Hence, before proceeding to the main part of this article, it would be necessary to provide conceptual clarification on children's rights and how they relate to matters of SRHR.

With regard to addressing the challenges of SRH of adolescents, it can be noted that a consensus has been reached to apply the hybrid model; this can be inferred from the agreement reached during international conferences, such as the ICPD and FWCW. According to the ICPD and FWCW framework documents, the human rights of women and girls include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. In relation to adolescents, the ICPD provides that 'full attention should be given to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality'.[7] Particularly, Chapter VII of the Program of Action of the ICPD states that countries should strive to address 'adolescent sexual and reproductive health issues, including unwanted pregnancy, unsafe abortion, and STDs and HIV/AIDS, through the promotion of responsible and healthy reproductive and sexual behaviour, including voluntary abstinence, and the provision of appropriate services and counselling specifically suitable for that age group'. The document also prescribes that countries must ensure that programs and attitudes of health-care providers do not restrict adolescents' access to the services and information they need. However, recognizing the inevitable challenges that children in this age group could face and the role parents should play in the upbringing of their children, the Program of Action also requires countries, in their attempt to comply with these standards, must safeguard the right of adolescents to privacy, confidentiality, respect and informed consent, while respecting cultural values and religious beliefs as well as the rights, duties and responsibilities of parents.

Looking at these aspirations and call for actions, it is very clear that the principles of autonomy, participation, equality and non-discrimination form the basis of the terms of the consensus reached by the participating States. However, it should also be noted that the framework documents also recognize the respect of cultural values and the roles and responsibilities of parents. This entails that the framework documents advocate for 'a hybrid model' by recognizing both principles of the 'child's autonomy' and 'protection' as explained in the child liberation and child protection approaches respectively.

2.1 Autonomy of adolescent children vis-à-vis parental authority

The discourse around why children must be protected and the extent to which parental, or legal guardians, authority exercised over children has been explained in the three major child rights theories; namely the John Eekelaar's interest theory, the fiduciary theory, and the theory of paternalism.[8] Getting into the details of these theories is not within the scope of this chapter, however; a brief mention on the 'interest theory' would be important as it helps to clearly set the context of the discussions in the forthcoming section of this article.

Drawing inspiration from Joseph Raz's theory of rights,[9] John Eekelaar's interest theory asserts that children have three distinct interests which are

separable from the interests of their parents: basic, development and autonomy interests.[10] Autonomy interests relate to the freedom of the child to choose his or her own lifestyle and to enter social relations according to his or her own inclinations uncontrolled by the authority of the adult world, parents or institutions.[11] Of course, the theory argues that autonomy of the child should be respected by taking into consideration the intellectual understanding, which should also be supplemented by emotional maturity, of the concerned child;[12] a notion which is in line with the concept of 'the evolving capacities of the child' as recognized by international instruments.

In line with Eekelaar's interest theory, this chapter argues that recognizing the role of parents should not impede the rights of adolescent children, subject to their evolving capacities, to make autonomous decisions about their sexual and reproductive health. Practically, however, the application of this principle could rather be challenging due to the widely-held and historically rooted belief that adolescents are incapable of making positive decisions about their own sexual and reproductive health.[13] This notion of rather unregulated parental autonomy led many jurisdictions in the world to hold the position that until a minor attains majority, only parents or legal guardians could provide consent for access to SRH services.[14]

With a view to addressing this tension between parental authority and the child's autonomy, countries tend to use different laws and policies allowing or preventing adolescents' access to SRH Services. The laws and policies may cover various instances where minimum age could be required to get access for various services, such as: legislation for age of medical decision-making like HIV counseling, testing, and treatment without parental consent (and whether the adolescent's status would be reported to her/his parents), contraceptives (with and without parental consent); emergency contraceptives (with and without parental consent); safe abortions and post-abortion care (with and without parental consent); antenatal Care (with and without parental consent); and sexual intercourse (including the age for statutory rape).

The minimum age may vary depending on the nature or seriousness of the treatment. With regard to the age for sexual consent, though majority of the countries in Africa do not have any clear standards in their legislations, there are some with laws and policies regulating age of consent to sex. Countries like Kenya, Uganda, Tanzania, Burundi, Ivory Coast and Equatorial Guinea, have set the age of consent to sex at 18, below which any sexual activity is subject to criminal sanctions. There are also some countries with a lower age of consent such as: Comoros (13), Zambia (14), Algeria (15), Botswana (16), Angola (15), and Mozambique (16). Other countries set a higher age like the case in Namibia (19) and Burundi (20).[15]

Such age-based laws tend to either preclude consent by adolescents below the set age, by requiring parental or guardian consent, or require that they demonstrate maturity to overcome their presumed incompetency. Minimum age laws are often defended on the ground that 'age is an efficient proxy for competency…an easily measured, inescapable attribute and a quality that

everyone has experienced or will experience'.[16] The age-based rule has its own advantage as it allows adolescents over the prescribed age to presumed competent and be treated the same as adults in providing informed consent to matters related to their SRH needs. As IPPF states, 'this avoids the serious problems that arise in discretionary systems where service providers are unwilling to recognize minors' competency, particularly in SRH decision-making'.[17] Recognizing the advantage of the age-based rule, the Committee on the Convention on the Rights of the Child (the CRC Committee) has also encouraged States Parties to give consideration to the introduction of such approaches in their laws.

On the other hand, the age-based approach may preclude adolescents under the prescribed age from being recognized as capable to decide. In setting minimum ages, States should then undertake a balancing act between the need to protect and the desire to empower, and ensure that setting minimum age should aim at promoting rights and not to impede them. It should recognize 'the right of any child below that minimum age and who is able to demonstrate sufficient understanding to be entitled to give or refuse consent'.

The principle of evolving capacity of the adolescent child, therefore, plays a pivotal role in reconciling the competing interests of parental authority and autonomy of the child. Hence, it should be noted that parental decision and authority on issues of SRH of adolescents can be valid so long as it is consistent with the requirement of the evolving capacities of the child. Furthermore, age limits and parental consent should not be applied to all services in relation to SRH services as there are rights that adolescents are entitled to claim without the consent of a parent or guardian, irrespective of age.

3 International and African regional instruments and initiatives on SRHR of adolescents

The principles included in the Program of Actions agreed to at the ICPD and FWCW are recognized in various international and African regional human rights instruments. The rights and protections include: the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, the right to life, the right to privacy, the right to reproductive self-determination, the right to consent to marriage, the right to be free from discrimination, the right to not be subjected to torture or other cruel, inhuman, or degrading treatment or punishment, the right to be free from sexual violence, the right to be free from practices that harm women and girls, and the right to education and information. The application of these general provisions is meant to benefit all persons, hence adolescents are able to enjoy the protections accorded through these instruments as adults.

In addition to these general instruments, specific protections are also provided as they apply to matters of SRHR of adolescents. For instance, the Convention on the Rights of the Child (CRC) states that every child has an inherent right to life and that the States Parties must ensure to the maximum

extent the child's survival and development.[18] States Parties shall also recognize the right of the child to the enjoyment of the highest standard of health[19] and develop family planning education and services.[20] Similarly, at the African level, the African Union (AU) has also adopted various regional instruments which could be relevant to matters of SRHR of adolescents. As discussed in the following sections, the African Children's Charter is one of the key regional human rights documents that contain numerous provisions which could be applicable to matters of SRHR of adolescent children.

In addition to the above-mentioned instruments, there are various documents and initiatives, both at the global and regional level, which provide guidance, primarily for states, on the nature and application of SRHR as they relate to adolescents. At the global level, the CRC Committee has developed General Comments on adolescent health and development in the context of the Convention on the Rights of the Child, and on the Implementation of the Rights of the Child during Adolescence. The 2014 Joint General Comment by the Committee on the Elimination of Discrimination against Women and the CRC Committee on the Rights of the Child on harmful practices also provides relevant standards concerning the notable link between SRHR and harmful traditional practices in line with the rights of adolescent children.

In a similar vein, the African continental bodies such as the African Union Commission (AUC), and the Human Rights Organs have developed policy documents and frameworks on SRHR and adolescent children. These include, the joint General Comment developed by the African Commission on Human and Peoples' Rights' (ACHPR) and the ACERWC on child marriage;[21] the General Comments by the ACHPR on women's human rights and HIV as prescribed under Article 14 (1) (d) and (e) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa;[22] the AU's Continental Policy Framework for Sexual and Reproductive Health and Rights (2005), and the Maputo plan of action 2016–2030 for the operationalization of the continental policy framework for sexual and reproductive health and rights.[23]

3.1 The African Children's Charter

Adopted in 1990 and came in to force in 1999, as of October 2020, the African Children's Charter is ratified by 49 African Countries.[24] Though the adoption of this Charter was influenced by its predecessor child rights instruments, such as, the CRC, the 1924 and the 1959 Declarations, it has revealed itself with some form of peculiarities to advance the protection of children in Africa.[25] Relevant to the theme of this chapter, the African Children's Charter includes provisions that can apply to protect the SRHR of adolescents. For instance, the African Children's Charter states that 'State Parties shall take specific, legislative, administrative, social and educational measures to protect the child from all forms of torture, inhuman and degrading treatment especially physical or mental injury or abuse, neglect or maltreatment, including sexual abuse, while in the care of

the child'. The elements of this provision should be understood as they cover various aspects. Applying the protection under similar provisions in international and regional laws to matters of SRHR, human rights bodies have found that the denial of sexual and reproductive health services to adolescents can amount to cruel, inhuman and degrading treatment. Other protections are also available in the right to education, parental responsibilities, protection against harmful social and traditional practices, the right to health and health services.

The provisions under article 14 have particular relevance. Article 14 (1) of the Charter guarantees every child's right to 'enjoy the best attainable state of physical, mental and spiritual health', while article 14 (2) enumerates illustrative, non-exhaustive list of States Parties' obligations. The illustrations under article 14 (2) covers States' obligations to reduce child mortality, access to health care services to all children, ensuring adequate nutrition, drinking safe water, health education and establishment of health care mechanisms, and resource mobilization for implementation of health care services. Hence, in defining the right to health and health services under article 14 (1), one should consider the elements presented under article 14(2) of the Charter, which then enables States to take a broader approach and include SRH and services in implementing their obligations. In line with this approach of adopting a purposive interpretation of the right to health and health services, the CESCR Committee states 'the right to health as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health'.[26] This entails, .implementation of the obligations under article 14 of the African Children's Charter ensures the existence of accessible health care services to all, which also respond to the SRH needs of adolescent children. Moreover, it should also be noted that States obligations under the right to health goes beyond provision of goods and services, and include ensuring 'both freedoms and entitlements, including the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference'.

Drawing inspiration from the CRC Committee, the ACERWC has also identified what it calls 'general principles' of the Charter which aim at ensuring a common philosophical approach to the spectrum of areas addressed by the Charter. The principles of non-discrimination, the best interests of the child, the right to life, survival and development, and respect for the views of the child, set the underlying and fundamental values that are relevant to the realization of all children's rights, including SRHR.

4 The Role of the ACERWC in Monitoring the implementation of SRHR under the African Children's Charter

The African Children's Charter establishes the ACERWC to promote and protect the rights and welfare of the child. Drawing it mandate from article 42

of the African Children's Charter, the ACERWC monitors implementation of the Charter. Accordingly, the ACERWC may receive and consider State Party Reports on the status of implementation of the African Children's Charter, receive and consider Communications, and resort to any appropriate method of investigations to address any matter under the Charter.

4.1 The role of the State Party reporting mechanism within the ACERWC

In line with article 43 of the Charter, State Parties shall submit reports to the ACERWC on measures that they have taken to give effect to and implement the provisions of the Charter. The Reports serve as the basis for the Committee's evaluation of the degree to which the Charter is implemented by the respective State Parties. Hence, the Reports should contain information which enables the Committee understand the administrative, judicial and other measures that the Government has taken to implement the Charter, and indicate factors and difficulties that are affecting the fulfilment of the obligations contained in the charter.

According to the Committee's Procedure of Consideration of State Party Reports, the Committee considers State Party Reports during one of its Ordinary Sessions in the presence of representatives of the concerned county.[27] Once the Committee finalizes its discussion with the State Party concerned and other stakeholders, it then prepares its concluding observations and recommendations. The concluding observations and recommendations, inter alia, highlight the progress that the State Party has achieved in implementing the provisions of the Charter, the major issues of concern, and the Committee's suggestions and recommendations on what needs to be done in a better way.

The contents of the concluding observations and recommendations are aligned with what the State Parties are expected to include in their reports in accordance with the Committee's Guidelines on Periodic State Party Reports. Accordingly, the concluding observations and recommendations focus on the following major issues: General measures of implementation; Definition of the child; General principles; Civil rights and freedoms; Economic, social and cultural rights; Family environment and alternative care; Rights and protection of vulnerable children; Harmful practices and exploitation' Administration of juvenile justice; and Responsibilities of the child.

The State Party reporting mechanism gives the Committee an ample opportunity to play a valuable role in monitoring implementation of States' obligations to realize SRHR of adolescents as protected under the African Children's Charter. The Committee's role in this regard can be introduced at various stages of the State Party reporting procedure. Looking at Committee's Guidelines, one may learn that State Parties are under obligation to provide information on SRHR of adolescents as part of the following clusters of rights and obligations: General measures of implementation; General principles; Economic, social and cultural rights; Rights and protection of children in vulnerable situation; and Harmful practices.

The principle of non-discrimination is of particular significance in the area of SRHR of adolescents, where discrimination may be manifested through various instances in different forms. For instance, gender inequality and social norms may discriminate against and hinder fulfilment of the SRHR of adolescent girls in general and those in vulnerable situation in particular. Adolescents who belong to a particular group, such as lesbian, gay, transgender and bisexual, may also face stigma and discrimination in accessing SRH services which respond to their particular needs. Where adolescents age or gender is joined with another basis for discrimination, such as disability, race, or migration status, the discrimination they face in exercising their SRHR can be greatly exacerbated and also manifest in unique ways. Therefore, States should proactively take targeted measures to ensure that adolescents facing multiple forms of discrimination are able to exercise their sexual and reproductive rights on the basis of substantive equality. Particularly, due to the disproportionate impact this has on girls, guaranteeing all adolescents' right to make autonomous decisions about their sexual and reproductive health and rights is a critical component of the right to equality and non-discrimination. In line with this, treaty monitoring bodies, such as the CEDAW Committee, recognize that restrictive laws on sexual and reproductive health services, such as laws restricting the legality of specific services and requiring third-party authorization, violate the right to non-discrimination.

Similarly, the principle of the best interests of the child is of a particular relevance to realize the full implementation of the standards of SRHR of adolescents. For example, if the best interests of the child so require, States may justify intervention to order the medical treatment of a child even if a parent has refused consent. Similarly, in cases where the child's views and/or interests are distinct from those of parents, the best interests test can be used to legitimately respect the child's right to receive sexual and reproductive health services, including counseling and treatment, and override parental consent.

With regard to the principle of life, survival and development, as Sutherland, states 'it would be difficult to imagine anything more fundamental in the whole panoply of human rights than recognition of the right to life'.[28] In line with this, the United Nations Human Rights Committee (HRC) has described 'the right to life' as 'the supreme right from which no derogation is permitted even in time of public emergency which threatens the life of the nation'. Indeed, 'the right to life', as it applies to all human beings, seems to get a universal acceptance and had already been guaranteed to all people by various international and regional instruments. In addition to the right to life, by guaranteeing the right to survival and development, article 5 goes further and recognizes State Parties' obligation to take measures to ensure the survival, protection and development of the child. The right to survival and development is defined by treaty bodies, such as the CRC Committee, in its broadest sense as 'a holistic concept, embracing the child's physical, mental, spiritual, moral, psychological and social development'. Therefore, as part of their obligation, States Parties are under obligation to ensure a full and harmonious development of the child,

including at the spiritual, moral and social levels, where education, provision of health services, the provision of adequate information or knowledge on nutrition, hygiene and environmental sanitation play a great role.

Despite the far-reaching relevance of the right to education to matters of SRH of children, the Committee's Guidelines appears to be relatively limiting as it requires States to report only on the measures they have taken to address the challenges of girls who become pregnant while they are in schools.[29] Despite the limiting approach adopted by the Guidelines, it would then be paramount for the Committee to adopt a holistic approach to the right to education and require the reporting States to furnish more information regarding the measures it has undertaken in ensuring the implementation of SRHR of children through education. As mentioned above, the Charter prescribes that education must ensure the promotion and development of physical development of the child and foster human rights and fundamental freedoms in line with international and regional instruments. The information States should provide in this regard may include the measures they have undertaken to introduce a comprehensive reproductive and sexuality education for adolescent children.

Referring to the obligations under article 14 of the African Children's Charter, the Committee's Guidelines set one of the most directly applicable obligations of States concerning implementation of SRHR of children.[30] The Guidelines require, State Parties to provide relevant and updated information on the measures taken to ensure that every child enjoys the best attainable state of physical, mental and spiritual health. Particularly, States are required to report on the measures taken to reduce infant and child mortality; to ensure access to health and health services, which also includes SRH Services, to ensure appropriate health care for expectant and nursing mothers; and to prevent transmission of HIV from mother to child. Looking at the particulars that the Guidelines provide, it seems that, similar to the case of the right to education, the Committee's Reporting Guidelines chooses to follow a restrictive approach. The current article is of the view that ensuring every child's enjoyment of the best attainable state of physical, mental and spiritual health, requires a more comprehensive response, which definitely goes beyond what has been enumerated in the Committee's Reporting Guidelines.

State Parties have also the obligation to provide relevant and updated information on the nature, type and prevalence of harmful social and cultural practices within its jurisdiction. As part of their reports, States are expected to identify practices which could stem from deeply entrenched discriminatory views as they relate to SRHR. The role and position of girls in society, for instance, may legitimize and perpetuate various forms of violence against the SRHR of girls. In particular, States Parties need to provide information on the measures they have undertaken to address the adverse effects of such harmful practices on the SRHR of adolescents, such as such as child marriage, FGM, practices that prevent women from controlling their own fertility, son preference, female infanticide, early pregnancy and bride price.

From the above discussions, one may learn that the State Party reporting mechanism creates an ample opportunity for the Committee to address the

challenges that children in Africa are facing in relation SRHR. This would, however, require the Committee to better mainstream SRHR and attempt to call upon, particularly through the concluding observations and recommendations, African States to better address the challenges of adolescents in relation to their SRHR.

Looking at the current practice within the Committee, one may learn that the ACERWC's attempt to include issues of SRHR in its concluding observations and recommendations seems to be general and limited in nature and content. As it can be gathered from most of the concluding observations and recommendations, the Committee attempts to address SRHR of adolescents, mainly, as they relate to the right to health and health services. For instance, in its concluding observations and recommendations to the Governments of Eritrea,[31] Cameroon,[32] Ghana,[33] Tanzania,[34] Chad,[35] Comoros,[36] Niger,[37] and Sierra Leone,[38] the Committee recommends to the respective State Parties to ensure provision of health services which is appropriate to children's health needs and staffed with adequate and trained health personnel.[39] The Committee has also constantly urged State Parties to increase budgetary allocation to the health sector and ensure health services are easily accessible to all children in the respective country, including to those in rural areas and in vulnerable situations.[40]

While monitoring the implementation of article 14 on the right to health, it is only in limited cases that the Committee specifically refers to the SRHR challenges of adolescents. For instance, in its recommendations to the Government of Sierra Leone, the Committee notes that the State Party should work towards addressing the specific health needs of adolescents by providing age-appropriate information and sensitization about reproductive health and sexually transmitted diseases/infections.[41] Similarly, in its recommendations to the Government of Ghana, the Committee states that the Government should provide sufficient contraception especially to children to prevent unwanted pregnancies and STIs, and ensure that Family Planning Centres exist throughout its territory and are staffed with adequate and well-trained personnel to address the sexual and reproductive needs of children.[42] The Committee also addresses the challenges of HIV/AIDS by calling on State Parties to increase the number of health professionals trained on management of HIV/AIDS and the availability of ART to pregnant women and children who are living with the virus.[43]

Though the Committee takes an encouraging step towards addressing issues related to SRHR of adolescents, most of the Committee's observations and recommendations are general in nature and limited only to 'basic health and services', which is not in line with the comprehensive nature of the protection under Article 14 of the Charter. This limited approach to monitoring the right to health and health services can be inferred from the fact that in most of its observations and recommendations, the Committee contentiously refer only to implementation of national health policies, disparity in equal access to health care services, lack of trained health care

personnel and quality of service delivered in health centres, budget allocation for the health sector, and universal immunization. In addition to the protection under Article 14 of the Charter, the Committee has also used other clusters of rights to monitor State Parties obligations to implement SRHR of adolescents. The most commonly used clusters of rights in this regard relate to State Parties obligation under Article 27 of the Charter on sexual exploitation, and Article 21 on protection against harmful social and cultural practices.

4.2 The role of the communication and investigation procedures within the ACERWC

In line with article 44 of the ACERWC, which provides the *locus standi* and criteria for consideration of Communications, the ACERWC has adopted the Revised Guidelines for the Consideration of Communications. Among the Communications brought before the ACERWC, one is most relevant to matters of SRHR; i.e., *Institute for Human Right and Development in Africa and Finders Group Initiative on behalf of TFA (a minor) v. the Republic of Cameroon,*[44] a case particularly features rape at the center of its allegations Establishing violations of various articles of the Charter, the Committee pronounces that rape forms a gender based violence which amounts to gender based discrimination. The Committee reached at this conclusion considering the fact that rape disproportionately affects women and nullifies the enjoyment of several of their human rights. As discrimination is understood to be a differential treatment on a prohibited ground and that nullifies the enjoyment of rights. The Committee then recommends for the Government of Cameroon, among others, to enact and implement a legislation eliminating all forms of violence, including sexual violence against children; to train its police, prosecutors, and judiciary; establish a mechanism to support victims of sexual abuse, and to work towards the elimination of practices, custom, and stereotypes that legitimize abuse of children. The Decision and its recommendations, therefore, immensely contribute for implementation of SRHR of adolescents as violence against girls, such as rape, directly affects their reproductive rights and their right to sexual health.

In line with its mandate under article 45 (i) of the Charter, and the subsequent Guidelines that the Committee adopted, the ACERWC, in recent years, has conducted investigation missions to Countries such as South Sudan, Central African Republic (CAR) and Tanzania.[45] Though the main focuses of the investigations are not directly related to SRHR of adolescents, the Committee in its findings and recommendations indeed attempted to point out issues, though not adequately, relevant to therein. For instance, the Committee's reports on its investigative missions to South Sudan and CAR clearly cover various forms of violations that children in the respective countries are facing, sexual violence being one of them. In assessing the impact of conflict on children in South Sudan and CAR, the Committee concluded that the extent to

which these wars are being waged directly upon the children in the countries is apparent from the violent abduction of children, and the confirmed incidents of rape of both girls and boys.[46] In South Sudan, the Committee highlighted the particular SRHR challenges of adolescent girls, especially those living in the Protection of Civilian Centers (POCs).[47] Investigating the challenges of children in conflict settings, the Committee could have done more by referring to the obligations of the respective States to address maters such as increased exposure to coerced sex, early and forced marriage and childbearing, increased risk-taking associated with gender roles in family circles, and reduced availability of adolescent sexual and reproductive health services. Similarly, in its investigation mission to Tanzania, concerning the case of children with albinism,[48] the Committee has overlooked to address the SRHR challenges of adolescents with albinism. Using its wider mandate in investigations, the Committee should also strengthen its role in monitoring the full implementation of SRHR of adolescents, by initiating the procedure on its own motion, *suo motu*.

5 Conclusion

Taking the diverse range of barriers that adolescents are facing in relation to their right to sexual and reproductive health services, the current article attempts to explain the role that the ACERWC could play in monitoring the implementation of SRHR of adolescent children in Africa. While encouraging steps have been taken, particularly through State Party, Communications and Investigation procedures, it is noted that the ACERWC's response to the challenges of adolescent children in matters related to SRHR happens to be rather limited. Much remains to be done especially in Africa where laws, cultural practices, social norms that stigmatize adolescents' sexuality and limit access to information on sex and sexuality for adolescent children, are adversely impacting on their development and behaviour. The ACERWC should strategically engage countries with restrictive laws and policies which prohibit adolescents from accessing sexual and reproductive health services, and provide guidance on addressing the major barriers for the realization of SRHR rights of adolescent children in Africa. Such normative barriers may include laws and policies which deny adolescents the right to access sexual and reproductive health services, laws and policies which require parental or judicial notification or authorization. The Committee should also pronounce itself on special protection measures for adolescent children; including protection against violations of adolescents' reproductive rights, such as measures to control girls' sexuality and forced or coerced medical interventions.

Notes

1 International Conference on Population and Development, available at https://www.unfpa.org/icpd# (accessed 20 November 2020).
2 Fourth World Conference on Women, available at https://www.unfpa.org/events/fourth-world-conference-women (accessed 18 November 2020).

3 K Santhya & S Jejeebhoy 'Sexual and reproductive health and rights of adolescent girls: Evidence from low- and middle-income countries' (2015) 10 *Global Public Health* 191.
4 As above 203.
5 Center for Reproductive Rights 'Implementing adolescent reproductive rights through the convention on the rights of the child' Briefing Paper (2010) available at https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_bp_implementingadoles.pdf (accessed 10 November 2020).
6 IPPF 'Understanding young people's right to decide' (2012) available at https://www.ippf.org/sites/default/files/ippf_right_to_decide_02.pdf (accessed 15 December 2019).
7 ICPD para 7.6
8 For more discussion on these theories See L Mkandawire 'The balance between child autonomy and parental autonomy in Malawi; an analysis of the childcare, protection and justice act' (2017) unpublished Master thesis, University of Cape Town.
9 J Raz 'Legal rights' (1984) I *Oxford Journal Legal Studies* 13–14.
10 J Eekelaar 'The emergence of children's rights' (1986) *Oxford Journal of Legal Studies* 170.
11 As above 171.
12 As above 181.
13 IPPF (n 6 above).
14 As above.
15 G Kangaude & A Skelton '(De)criminalizing adolescent sex: A rights based assessment of age of consent laws in Eastern and Southern Africa' (2018) available at https://journals.sagepub.com/doi/full/10.1177/2158244018806036 (accessed 25 January 2019).
16 As above.
17 As above.
18 See article 6 of the Convention
19 See article 24 of the Convention and Committee on CRC General Comment 15 in this regard.
20 See for instance, Committee on CRC General Comment 3 on HIV/AIDS and General Comment 4 on Adolescent Health and Development para 28.
21 See Joint general comment of the African Commission on Human and Peoples' Rights (ACHPR) and the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) on ending child marriage adopted by the African Commission on Human and Peoples' Rights (ACHPR) and the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) 2017.
22 See General Comment 1 on article 14 (1) (d) and (e) of the Maputo Protocol adopted by the African Commission in 2012, see also, General Comment 3 on other provisions of article 14 of the Maputo Protocol
23 African Union Commission, the Maputo plan of action 2016-2030 for the operationalization of the continental policy framework for sexual and reproductive health and rights, (2015) available at https://www.au.int/web/sites/default/files/newsevents/workingdocuments/27513-wd-sa16952_e_original_mpoa.pdf (accessed 22 February 2019).
24 Six Member States are yet to ratify the Charter, these Countries are: DRC, South Sudan, Sahrawi Arab Democratic Republic, Somalia, Morocco and Tunisia.
25 T Kaime *The African Charter on the Rights and Welfare of the Chile: A socio-legal perspective* (2009) 130.
26 The General Comment refers to UN CESCR 'The right to the highest attainable standard of health General Comment No. 14: The right to the highest attainable standard of health (Art. 12)' General Comment No. 14 UN Doc. E/C.12/2000/4 (2000 para 1.
27 Between 2002 and 2019, the Committee has held 34 Ordinary Sessions and 18 pre-sessions.
28 E Sutherland 'The child's right to life, survival and development: Evolution and progress' (2015) available at https://www.researchgate.net/profile/Elaine_Sutherland2/publication/304784603_The_Child's_Right_to_Life_Survival_and_Development_Evolution_and_Progress/links/5bbced3a92851c7fde3748f2/The-Childs-Right-to-Life-Survival-and-Development-Evolution-and-Progress.pdf (accessed 30 December 2018).

29 ACERWC 'Guidelines on the Form and Content of Periodic State Party Reports to be Submitted Pursuant to Article 43(1)(b) of the African Charter on the Rights and Welfare of the Child' available at https://acerwc.africa/ (accessed 24 November 2018).
30 As above.
31 ACERWC 'Concluding observations and recommendations to the government of Eritrea' available at https://acerwc.africa/wp-content/uploads/2018/14/Concluding_%20Observations_%20Eritrea.pdf (accessed 15 February 2019).
32 ACERWC 'Concluding observations and recommendations to the government of Cameroon' available at https://acerwc.africa/wp-content/uploads/2018/14/Concluding_%20observations_%20Cameroon_ACERWC-2016.pdf (accessed 15 February 2019).
33 ACERWC 'Concluding observations and recommendations to the government of Ghana' available at https://acerwc.africa/wp-content/uploads/2018/14/Concluding_oberservation%20Ghana.pdf (accessed 15 February 2019).
34 ACERWC 'Concluding observations and ecommendations to the Government of Tanzania' available at https://acerwc.africa/wp-content/uploads/2018/14/CO_Tanzania_eng.pdf (accessed 15 February 2019).
35 ACERWC 'Concluding Observations and Recommendations to the Government of Chad' available at https://acerwc.africa/wp-content/uploads/2018/14/Concluding%20Observations%20Chad%20Fr.pdf (accessed 15 February 2019).
36 ACERWC 'Concluding Observations and Recommendations to the Government of Comoros' available at https://acerwc.africa/wp-content/uploads/2018/14/Concluding%20Observations%20Comoros%20Fr.pdf (accessed 15 February 2019).
37 ACERWC 'Concluding Observations and Recommendations to the Government of Niger' available at https://acerwc.africa/wp-content/uploads/2018/14/CO_Niger_French.pdf (accessed 15 February 2019).
38 ACERWC 'Concluding Observations and Recommendations to the Government of Sierra Leone' available at https://acerwc.africa/wp (accesed 15 March 2019)-content/uploads/2018/14/Sierra%20Leone_Concludig%20Observation%20final_English.pdf (accessed 15 February 2019).
39 ACERWC 'Concluding Observations and Recommendations' available at https://acerwc.africa/reporting-table/ (accessed 1 December 2019).
40 As above.
41 ACERWC 'Concluding Observations and Recommendations to the Government of Sierra Leone' (n. 38)
42 ACERWC 'Concluding Observations and Recommendations to the Government of Ghana' (n. 33).
43 ACERWC 'Concluding Observations and Recommendations, available at https://acerwc.africa/reporting-table/ (accessed on 01 December 2019)
44 ACERWC 'Communication No 006/Com/002/2015' *IHRDA and Finders Group Initiative v Cameroon* (2015) available at https://acerwc.africa/wp-content/uploads/2018/13/Cameron%20Rape%20Case.pdf.
45 ACERWC 'Missions and country visits by the ACERWC' (2014) available at https://www.acerwc.africa/missions-country-visits/ (accessed 15 January 2019).
46 ACERWC 'Missions reports' available at https://acerwc.africa/missions-country-visits/ (accessed 15 January 2019).
47 ACERWC 'Report on the advocacy mission to assess the situation of children in South Sudan' (2018) available at https://acerwc.africa/wp-content/uploads/2018/11/Advocacy_Mission_South_Sudan_English_PAGES-ilovepdf-compressed.pdf (accessed 15 January 2019).
48 ACERWC 'Report on investigation mission on the situation of children with albinism in temporary holding shelters in Tanzania' (2016) available at https://acerwc.africa/wp-content/uploads/2018/07/Investigative_Mission_on_the_Situation_of_Children_with_Albinism_A4.pdf (accessed 15 January 2019).

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