AAI SCORECARD
FOR WOMEN AND GIRLS
SRHR IN AFRICA

A Call for Accountability in the Context of the Sustainable Development Goals!

Bob Mwiinga Munyati
2017

AIDS Accountability International in Partnership with:
AIDS Accountability International’s vision is a world where strong and accountable leadership permeates all levels of society to ensure effective responses to health challenges.

We do this by increasing transparency, promoting dialogue and supporting action for an improved response.
# Table of Contents

Abbreviations ........................................................................................................................................................................ 5

Introduction ........................................................................................................................................................................... 6

Objective of this report ......................................................................................................................................................... 6

What does SRHR mean? ......................................................................................................................................................... 6

Focus countries ....................................................................................................................................................................... 6

Limitations of the research .................................................................................................................................................. 7

Thematic areas ....................................................................................................................................................................... 7

Case studies ........................................................................................................................................................................... 7

Contextual analysis ............................................................................................................................................................... 8

Global commitments to SRHR ........................................................................................................................................ 8

The Sustainable Development Goals .......................................................................................................................................... 8

African commitments to SRHR ........................................................................................................................................... 10

Ratification of the Maputo Protocol ...................................................................................................................................... 12

Demographic overview ........................................................................................................................................................ 13

AAI Scorecard methodology ............................................................................................................................................... 16

AAI Scorecard grades .......................................................................................................................................................... 16

Element 1: Strategic reproductive health indicators ........................................................................................................... 17

Indicator: Maternal mortality ratio ......................................................................................................................................... 17

Indicator: Unmet need for contraceptives .......................................................................................................................... 19

Indicator: Antenatal coverage (ANC) ................................................................................................................................... 21

Case Study: Malawi and maternal mortality ..................................................................................................................... 23

Element 2: Abortion ............................................................................................................................................................... 25

Indicator: Legality of abortions ............................................................................................................................................... 25

Indicator: Measures to improve access to safe abortion services ........................................................................................ 27

Case Study: Zambia's access to safe abortion under threat ................................................................................................ 28

Element 3: Violence against women ..................................................................................................................................... 31

Indicator: Prevalence of physical violence against women (%) ............................................................................................ 31

Indicator: Prevalence of sexual violence against women (%) ............................................................................................... 32

Indicator: FGM prevalence among girls (%) ........................................................................................................................ 33

Case Study: Liberia's female genital mutilation (FGM) challenge ......................................................................................... 35
Table of Contents

Element 4: Early and forced child marriage .................................................................................................................. 37
  Indicator: Policy on age of marital consent and ending child marriage ................................................................. 38
  Indicator: Law on child marriage .............................................................................................................................. 41
  Indicator: Percentage of women aged 20-24 who got married before age 18 ...................................................... 43
  Case Study: Ghana's fight against child marriage ..................................................................................................... 44
Element 5: Youth access to SRHR .................................................................................................................................. 46
  Indicator: Adolescent unwanted & unplanned pregnancy: percentage of women aged 20-24 who
gave birth before age 18 ........................................................................................................................................... 46
  Indicator: Policy provisions for comprehensive sexuality education ........................................................................ 48
  Indicator: National policy on comprehensive sexuality education ........................................................................... 49
  Indicator: Countries with programmes that ensure youth's access to contraception ........................................... 50
  Case Study: Tanzania's ban on teenage pregnancy a human rights abuse ............................................................ 51
Element 6: HIV and AIDS .................................................................................................................................................... 53
  Indicator: Number of new HIV infections per 1,000 uninfected population (15-49 years) .................................... 54
  Indicator: HIV prevalence .......................................................................................................................................... 55
  Case Study: South Africa’s adolescent HIV infection rates on the increase ........................................................ 56
Element 7: Budgeting ......................................................................................................................................................... 58
  Indicator: The percentage of national budget allocated to health ............................................................................... 58
  Indicator: Health spending per capita ...................................................................................................................... 59
  Case Study: Uganda’s steps toward accountable health budget allocation .......................................................... 60
Findings ........................................................................................................................................................................... 61
Recommendations .......................................................................................................................................................... 63
AAI’s Accountability Framework ..................................................................................................................................... 63
Acknowledgements ......................................................................................................................................................... 65
Copyright Notice/Creative Commons .......................................................................................................................... 65
Feedback ........................................................................................................................................................................ 65
Contact details .............................................................................................................................................................. 66
References ..................................................................................................................................................................... 67
## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>ART</td>
<td>Anti-Retroviral Therapy for HIV/AIDS</td>
</tr>
<tr>
<td>ARVs</td>
<td>Anti-Retroviral Drugs</td>
</tr>
<tr>
<td>ASRH</td>
<td>Adolescent Sexual and Reproductive Health</td>
</tr>
<tr>
<td>AU</td>
<td>African Union</td>
</tr>
<tr>
<td>AUC</td>
<td>African Union Commission</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil Society Organisations</td>
</tr>
<tr>
<td>EmONC</td>
<td>Emergency Obstetric and Newborn Care</td>
</tr>
<tr>
<td>FGM/C</td>
<td>Female Genital Mutilation/Cutting</td>
</tr>
<tr>
<td>GBV</td>
<td>Gender Based Violence</td>
</tr>
<tr>
<td>GNP</td>
<td>Gross National Product</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HPV</td>
<td>Human Papilloma Virus</td>
</tr>
<tr>
<td>HTPs</td>
<td>Harmful Traditional Practices</td>
</tr>
<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
</tr>
<tr>
<td>ICT</td>
<td>Information, Communication and Technology</td>
</tr>
<tr>
<td>ITNs</td>
<td>Insecticide Impregnated bed nets</td>
</tr>
<tr>
<td>M &amp; E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MPOA</td>
<td>Maputo Plan of Action</td>
</tr>
<tr>
<td>MCDSR</td>
<td>Maternal, Child Death Surveillance and Response</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MPoA</td>
<td>Maputo Plan of Action</td>
</tr>
<tr>
<td>PRSPs</td>
<td>Poverty Reduction Strategic Plans</td>
</tr>
<tr>
<td>RECs</td>
<td>Regional Economic Communities</td>
</tr>
<tr>
<td>RMNCAH</td>
<td>Reproductive, Sexual, Maternal, Neonatal, Child and Adolescent Health</td>
</tr>
<tr>
<td>SD</td>
<td>Standard Deviation</td>
</tr>
<tr>
<td>SDGs</td>
<td>Sustainable Development Goals</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
</tr>
<tr>
<td>SRH&amp;RR</td>
<td>Sexual and Reproductive Health and Reproductive Rights</td>
</tr>
<tr>
<td>SRHR</td>
<td>Sexual and Reproductive Health and Rights</td>
</tr>
<tr>
<td>STC-HPDC</td>
<td>Specialized Technical Committee on Health, Population and Drug Control</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Jointed United Nations Program on HIV/AIDS</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNGS</td>
<td>United Nations Global Strategy</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
**Introduction**

**Objective of this report**

The AAI Scorecard for Women and Girls SRHR in Africa is a research report using the AAI Scorecard methodology and an accountability lens to create transparency, stimulate dialogue and provoke action around the state of sexual and reproductive health and rights (SRHR) in Africa for women and girls. It hopes to make the existing data more available and transparent to all stakeholders. We also hope that it contributes to more urgent dialogue and inspires tangible action towards the promotion of universal access to sexual and reproductive health and rights in for all African women and girls.

To achieve this, the AAI Scorecard for Women and Girls SRHR in Africa deliberately focuses on the Sustainable Development Goals 3, 5 and 10 which aim for Good Health and Wellbeing, Gender Equality and Reduced Inequalities.

The report aims to highlight key issues that affect the full realization of sexual and reproductive health in Africa generally and specifically speaks to SRHR issues within seven African countries: Ghana, Liberia, Malawi, South Africa, Tanzania, Uganda and Zambia.

This scorecard provides a comparison of SRHR indicators among African countries using the AAI Scorecard Methodology explained in detail in this report.

**What does SRHR mean?**

Simply put, sexual and reproductive health is aimed at ensuring the “complete physical, mental and social well-being in all matters relating to the reproductive system.” (UNFPA, 2017). This definition falls within the World Health Organisation framework of health. However, it is important to note that sexual and reproductive health is not attainable and sustained without the attainment of sexual rights specifically and human rights in general (WHO, 2017). According to Amnesty International, “Sexual and reproductive health rights—including access to sexual and reproductive health care and information, as well as autonomy in sexual and reproductive decision-making are human rights; they are universal, indivisible, and undeniable.” (UNFPA, 2017) (Amnesty International, 2017).

**Focus countries**

We include data from across the entire continent with a focus on these seven countries: Ghana, Liberia, Malawi, South Africa, Tanzania, Uganda and Zambia. These countries were chosen because of the particular SRHR challenges
that they are experiencing. They serve as examples to highlight the status of sexual and reproductive health and rights from three regions on the continent: West Africa, East Africa and Southern Africa. And although the seven countries differ in cultural, economic, and health dynamics, they all face similar challenges in fully realizing sexual and reproductive health and rights.

Limitations of the research

It is important to note that this report does not focus on or provide analysis of LGBT issues. Although AAI is well known for always including LGBT data in all of our work, the data for this population in Africa is still unaccountably scarce. We instead continue to work with our partners to assist them in attaining LGBT-related data for advocacy reasons. We also have some of the data that we have previously collected with LGBT partners available on our website at www.aidsaccountability.org or contact phillipa@aidsaccountability.org.

This scorecard does in no way pretend to cover all of the issues facing women and girls in Africa in the arena of sexual and reproductive health and rights. We regret that we could not include issues of socio-economic equality, environment, inheritance and migration amongst many others have not been included here due to limitations in space. This in no ways means that these issues are not equally vital, urgent or need action.

Thematic areas

As we do in most of our scorecards, in the AAI Scorecard for Women and Girls SRHR in Africa we have chosen strategic issues to grade and discuss, led by the SDGs and based on what we as AAI consider strategic to include in this report.

Thus, the Elements are:

- **Element 1:** Strategic reproductive health indicators
- **Element 2:** Abortion
- **Element 3:** Violence against women
- **Element 4:** Early and forced child marriage
- **Element 5:** Youth access to SRHR
- **Element 6:** HIV and AIDS
- **Element 7:** Budgeting

Case studies

Each section also provides a country case study for each of our targeted countries: Ghana, Liberia, Malawi, South Africa, Tanzania, Uganda and Zambia. These case studies provide further insight into some important issues that are present as challenges and/or opportunities to advancing SRHR in Africa. Changing sexual and reproductive health outcomes of many African women, girls, young people and other marginalized populations would ensure progress being made towards achieving the SDGs. These health outcomes translate to reduced morbidity and mortality, which equally translates to economic development and improved social wellbeing.
Good access to sexual and reproductive health and rights (SRHR) serves as a key indicator of the health of a nation, as it is dependent upon various factors, including (but not limited to) socioeconomic status, quality of medical care, access and reach of health services, disease prevalence, cultural dynamics and the assurance of human rights (UNFPA, 2015).

Global commitments to SRHR

During the International Conference on Population and Development (ICPD); (held in Cairo in 1994 with representation from 179 countries that endorsed the commitment) world leaders agreed on a development framework that placed people at the centre by prioritizing several issues including the assurance of reproductive health and reproductive rights (UNFPA, 2015).

The ICPD programme of action “affirmed sexual and reproductive health as a fundamental human right and emphasized that empowering women and girls is key to ensuring the well-being of individuals, families, nations and our world” (United Nations, 2017). Both ICPD Beyond 2014 and the newly adopted Sustainable Development Goals (SDGs) recognise that sexual and reproductive health and rights are pivotal to achieving development generally. The inclusion of the Goal 3 (Goal 3: Good Health and Wellbeing) and Goal 5 (Gender Equality) point to this fact. (UNFPA, 2015) (United Nations, 2017).

The sustainable development goals

The AAI Scorecard for Women and Girls SRHR in Africa focuses on the several indicators related to sexual and reproductive health and rights as incorporated by Sustainable Development Goals 3, 5 and 10. This section provides a list of the goals that will be used to highlight the status of sexual and reproductive health on the African continent.
Goal 3: Good Health and Wellbeing

3.1 By 2030, reduce the global Maternal Mortality Ratio to less than 70 per 100,000 live births.

3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis and other communicable diseases.

3.7 By 2030, ensure universal access to SRH care services, including for family planning, information and education, and integration of reproductive health into national strategies and programmes.

3.8 By 2030, Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

Goal 5: Gender Equality

5.1 By 2030, End all forms of discrimination against all women and girls everywhere

5.2 By 2030, Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation

5.3 By 2030, Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation

5.6 By 2030, Ensure universal accesses to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.

Goal 10: Reduced Inequalities

10.2 By 2030, Empower and promote the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status.

10.3 By 2030, Ensure equal opportunity and reduce inequalities of outcome, including; by eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies and action in this regard.
Contextual Analysis

African commitments to SRHR

The figure shows the timeline of the SRHR related policies that have existed and been agreed upon by several African countries since 1994. These policies include the: The Maputo Plan of Action, the Continental Framework on Sexual and Reproductive Health and Rights; The International Conference on Population and Development and the Sustainable Development Goals. Further information on these policies is provided in the table.
Principal policy environment that guides SRHR implementation in Africa

<table>
<thead>
<tr>
<th>Policy</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maputo Protocol</td>
<td>The Maputo Protocol is the leading document that promotes and protects gender equality in Africa. It provides for women to have all rights and freedoms that men have and obliges all governments to act to provide these rights and freedoms to all women. Examples include non-discrimination, equal employment, right to peace and participation in political processes, as well as health and reproductive rights.</td>
</tr>
<tr>
<td>Maputo Plan of Action 2016-2030</td>
<td>The Continental Policy Framework on Sexual and Reproductive Health and Rights adopted by the 2nd Ordinary Session of the Conference of African Ministers of Health. It is judged to be more progressive in advancing women's rights than the SDGs and ICDP (Munyati, 2016)</td>
</tr>
<tr>
<td>International Conference on Population and Development Beyond 2014</td>
<td>The Programme of Action of the International Conference on Population and Development, was first adopted in 1994, with 179 Governments placing individuals at the centre of the development agenda. This programme of action placed human rights and dignity including that of women's access sexual and reproductive health and rights as a priority. 20 years on, the ICPD has been reviewed against its initial principles and objectives to assess progress made. This assessment coupled with identification of emerging challenges has allowed for the reaffirmation by African countries to the ICPD Beyond 2014 and the Addis Ababa Declaration on Population and Development (UNFPA, 2015) (African Union, United Nations Population Fund, United Nations Economic Commission for Africa, 2013)</td>
</tr>
<tr>
<td>Sustainable Development Goals (Agenda 2030)</td>
<td>The Sustainable Development Goals are set of 17 goals and 169 targets which detail the global development agenda. The SDGs aim at continuing the work started by the Millennium Development Goals and finishing what was not completed. “They seek to realize the human rights of all and to achieve gender equality and the empowerment of all women and girls.” The central pillars of achieving the SDGs are: the economic, social and environmental. (United Nations, 2017)</td>
</tr>
</tbody>
</table>
Contextual Analysis

Ratification of the Maputo Protocol

The African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, a declaration also known as the Maputo Protocol is a key document for women’s rights in Africa as it addresses several issues that pertain to women's sexual and reproductive health and rights as it addresses matters of: elimination of harmful tradition practices, right to dignity, right to education and reproductive health (African Union, 2003). The Maputo Protocol was adopted at the 2nd ordinary session of the Assembly of the Union in July 2003. The indicator shows the extent to which African countries have adopted the Maputo Protocol. Whether countries have ratified it remains a critical measure of their commitment to women.

It remains vital to hold governments accountable to the Maputo Protocol, especially when we see the recent retrogressive stances on the full realisation of universal access to sexual and reproductive health and rights, examples of which are denying women access to abortion, not providing the basics of maternal health and preventing girls from completing school if they get pregnant. We need to ensure accountability is to the Maputo Protocol is at the top of the agenda for all African leaders, because as per the Maputo Protocol, the provision of human rights remains paramount in guaranteeing women’s sexual and reproductive health (African Union, 2003).
It is important here to also remember that the African Commission on Human and Peoples’ Rights (ACHPR) through the “Resolution on Protection against Violence and other Human Rights Violations against Persons based on their Real or Imputed Sexual Orientation or Gender Identity” (also known as Resolution 275) affirmed the ACHPR’s commitment to the assurance of sexual and reproductive health and rights for all including lesbian, gay, bisexual, transgender, intersex, and queer and gender non-confirming people and any of the key populations that are currently being left behind because of stigma and discrimination (UNAIDS, 2016) (African Commission on Human and Peoples’ Rights, 2014).

Demographic overview

Prior to discussing the key sexual and reproductive health statistics of any population, it is vital to understand the key demographics of that group. Therefore this section provides the basic demographic statistics of the African continent in general and several other statistics as they refer to the seven countries of focus.

In 2015, it was estimated that 1.2 billion people were living in Africa, making up 16 percent of the global 7.3 billion (United Nations, 2015). Estimates are that more than half of the world’s population growth between 2015 and 2050 is anticipated to happen in Africa, which demonstrated growth rates of 2.55 percent annually in period between 2010 and 2015 (United Nations, 2015). Africa has a young population demonstrated by the fact that “children under age 15 accounted for 41 per cent of the population in 2015 and young persons aged 15 to 24 accounted for a further 19 per cent.” (United Nations, 2015).
Contextual Analysis

For the period between 2010 and 2015, the fertility rate in Africa stood at an average of 4.7 children per woman which is above the replacement fertility rate of 2.5 children per woman. In 2013, 1.5 million new HIV infections occurred in sub-Saharan Africa (UNAIDS, 2016). Furthermore, UNAIDS estimates that in sub-Saharan Africa, adolescent girls and young women made up for one in four of all new HIV infections (UNAIDS, 2016). Lastly, the African continent continues to have maternal mortality rates that remain extremely high despite several advances since the 1990s.

The seven focus countries are characterized by the following socio-economic factors:

- In 2012, 47.2 percent of the South Africans aged 25 or older had not completed upper secondary school, as compared to only 1.7 percent of the Ugandan population and 0.8 percent for Tanzania. (UNESCO, 2017).

- 60.5 percent of the Zambians lived below the national poverty line, as compared to only 63.8 percent of Liberians and 28.2 percent of the Tanzanians between 2007 and 2011 (The World Bank, 2017).

In addition to the provided socio-economic indicators, the map shows several indicators related to sexual and reproductive health outcomes as captured within national demographic health surveys of several countries. These indicators provide a glimpse at the challenges that the countries face in ensuring universal access to sexual and reproductive health and rights.

Good access to sexual and reproductive health and rights (SRHR) serves as a key indicator of the health of a nation, as it is dependent upon various factors, including (but not limited to) socioeconomic status, quality of medical care, access and reach of health services, disease prevalence, cultural dynamics and the assurance of human rights (UNFPA, 2015).

- **Ghana:** 87% of pregnant women had four or more antenatal care visits for the most recent live birth.
- **Uganda:** 25% of de jure children who have birth certificates.
- **Liberia:** 25% of de jure children who have birth certificate.
- **Tanzania:** 17.2 median age of its first sexual intercourse for women aged 25-49 years.
- **Zambia:** 60% births five years proceeding to 2013 assisted by skilled provider.
- **Malawi:** Total fertility Rate is 2.6 per women.
- **South Africa:** Total fertility Rate is 2.6 per women.

Source: Demographic Health Survey 2014 – 2015
AAI Scorecard Methodology

The AAI Scorecard Methodology and Accountability Framework were developed over 2 years with more than 100 global experts on HIV, epidemiology, communications, data and statistical analysis, advocacy, key populations and governance and accountability. For further information, please see our website at www.aidsaccountability.org

AAI Scorecard grades

The AAI Scorecard methodology places countries in five broad ‘grades’, from A to E. The grade is based on the percentage reported by the country per the following formula: A (81-100%); B (61-80%); C (41-60%); D (21-40%); E (0-20%) – from A (very good) to E (very poor). If a country has not reported on an element then the score will be marked as ND for No Data and because the value of knowing what the circumstance of your issue is paramount to informing and constructing your response, these indicators are given a numerical value of 0.

<table>
<thead>
<tr>
<th>Score</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>81-100%</td>
<td>A</td>
</tr>
<tr>
<td>61-80%</td>
<td>B</td>
</tr>
<tr>
<td>41-60%</td>
<td>C</td>
</tr>
<tr>
<td>21-40%</td>
<td>D</td>
</tr>
<tr>
<td>0-20%</td>
<td>E</td>
</tr>
<tr>
<td>No data submitted = 0%</td>
<td>ND</td>
</tr>
</tbody>
</table>

Conversely though sometimes the lower the percentage, the better the response is. For example, this kind of situation happens for example when we examine child marriage. We want lower percentages.

<table>
<thead>
<tr>
<th>Score</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5%</td>
<td>A</td>
</tr>
<tr>
<td>6-10%</td>
<td>B</td>
</tr>
<tr>
<td>11-15%</td>
<td>C</td>
</tr>
<tr>
<td>16-20%</td>
<td>D</td>
</tr>
<tr>
<td>&gt;20%</td>
<td>E</td>
</tr>
<tr>
<td>No data submitted = 0%</td>
<td>ND</td>
</tr>
</tbody>
</table>

Often AAI groups performance under quintiles, or five equal groups. By dividing countries into quintiles, we can see the best and worst performers, those that are near the top, and near the bottom, and those that are in the middle group.

<table>
<thead>
<tr>
<th>Score</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top quintile: Best performance</td>
<td>A</td>
</tr>
<tr>
<td>Upper middle quintile: Near to top performance</td>
<td>B</td>
</tr>
<tr>
<td>Middle quintile with middle level performance</td>
<td>C</td>
</tr>
<tr>
<td>Lower middle quintile with near to bottom performance</td>
<td>D</td>
</tr>
<tr>
<td>Bottom quintile: worst performance</td>
<td>E</td>
</tr>
<tr>
<td>No data submitted = 0%</td>
<td>ND</td>
</tr>
</tbody>
</table>
Element 1: Strategic Reproductive Health Indicators

Indicator: Maternal mortality ratio

Sub-Saharan Africa is identified to have one of the highest maternal mortality rates globally despite having been able to halve its rates since 1990. According to UNICEF, sub-Saharan Africa's maternal mortality ratio was estimated to be 546 deaths per 100,000 live births in 2015 (UNICEF, 2017). This needs to be addressed if we are ever to achieve the Sustainable Development Goals. One of the aims of the Agenda 2030 is: “By 2030, reduce global maternal mortality ratio to less than 70 per 100,000 live births” (World Health Organisation, 2017) (United Nations, 2017).

There are many factors that propel the high rate of maternal mortality in sub-Saharan Africa. Most of the reasons for high maternal mortality are preventable and/or treatable (WHO, 2017). Some of the reasons include (but not limited to):

1. Severe bleeding (mostly bleeding after childbirth)
2. Infections (usually after childbirth)
3. High blood pressure during pregnancy (pre-eclampsia and eclampsia)
4. Complications from delivery
5. Unsafe abortion

Source: (UNDESA, 2015)
Further to this high maternal mortality on the continent is an indicator of the levels of inequality that exist, particularly those that affect women’s access to sexual and reproductive health services.

The indicator highlights the maternal mortality rate of African countries per 100,000 women. According to the new adopted Sustainable Development Goals, maternal mortality remains as a vital goal of achieving Agenda 2030. It is targeted that by 2030 African government must at least two times the global target of 70 per 100,000 live births (United Nations, 2017).

Currently a few countries have managed to reach the SDGs target which include of below 70 per 100,000 live births: Egypt (33), Libya (9), Mauritius (53) and Tunisia (63). Conversely, a lot of countries have maternal mortality above 561 per 100,000 live births. These countries include Burundi (721), Cameroon (596), Cape Verde (596), Central African Republic (882), Chad (856), Côte d’Ivoire (645), Democratic Republic of the Congo (693), Gambia (706), Guinea (678), Liberia (725), Malawi (634), Mali (587) Mauritania (602), Nigeria (814), Sierra Leone (1360), Somalia (732), and South Sudan (789). The reasons for the high levels of maternal mortality include poor access to modern contraceptive methods, lack of skilled birth attendants, unsafe abortion, and/or the attempt by women to have children too often, too late or too early.

Despite the high rates of maternal mortality on the continent, several countries are making significant progress in the reduction of deaths. These countries have a MMR of between 141 and 280 deaths per 100,000 live births (Botswana (129), Morocco (121), South Africa (138), Benin (148), Nigeria (265), and Zambia (224).

Many African countries failed to meet the Millennium Development Goal that relates to maternal mortality. Despite reducing by 49 percent several countries still met challenges in fully reducing maternal mortality. Some reasons for this fail and current threat to the SDGs including: low antennal visits, lack of skilled birth attendants and poor access to sexual and reproductive health services (Maternal Worldwide, 2017).
Access to family planning or modern contraceptive methods remains vital in achieving the sustainable development goals as evidenced by the specific reference to family planning under Goal 3 (Target 3.7) (United Nations, 2017). This is because family planning allows people to plan their fertility which in turn affects their social and economic lives and bettering their ability to thrive. The World Health Organisation argues that “ensuring access to preferred contraceptive methods for women and couples is essential to securing the well-being and autonomy of women, while supporting the health and development of communities” (World Health Organisation, 2017).

Access to modern contraceptive allows for several benefits for including:

1. Prevention of health risks in women associated to their pregnancy. In turn, this allows for reduced rates of maternal mortality.
2. Prevention of sexually transmitted infections such as HIV using contraceptive methods such as condoms.
3. Prolonging women's access to education.
4. Reduces the incidence of adolescent pregnancies.

Indicator: Unmet need for contraceptives

(United Nations Department of Economic and Social Affairs, 2017)
Despite the obvious benefits of family planning/contraceptive access, there continues to be high rates of the unmet need for family planning in Africa. Before depicting the unmet need it is important to define unmet need as the desire to halt or postpone having children but not having access to any method of family planning (James Gribble and Joan Haffey, 2008). At the turn of the decade, Africa’s unmet need was at 23 percent compared to 8 percent and 9 percent in Asia and in Latin American (including Caribbean) respectively (Population Reference Bureau, 2014). Across the continent of Africa, countries remain significantly different in terms of the unmet need to family planning.

The indicator shows the percentage of women who want to space their birth or stop childbearing entirely but are not using contraception. This is also known as the unmet need for family planning.

The lowest unmet need for modern contraceptives is found in Mauritius is 4 percent. This is followed by Guinea-Bissau (6) and Tunisia (7). In addition to this set of countries, some countries including Egypt (12), Morocco (11), South Africa (14), Swaziland (13) and Zimbabwe (15) have unmet need of between 11 and 15 percent. Standing between 16 and 20 percent unmet need is Cape Verde (17), Congo (18), Madagascar (19), Niger (16) and Nigeria (19).

From the map it can be noticed that the majority of African countries a high unmet needs of family planning: Botswana (27), Burkina Faso (25), Burundi (32), Cameroon (24), Chad (28), Comoros (36), Democratic Republic of the Congo (24), Eritrea (29), Ethiopia (26), Gabon (27), Gambia (22), Ghana (37), Guinea (22), Lesotho (23), Liberia (36), Libya (27), Mali (28), Mauritania (32), Namibia (21), Sao Tome and Principe (38), Senegal (29), Sierra Leone (27), Sudan (29), Tanzania (25) and Zambia (27).

The high unmet need to family planning may be the leading cause to high rates of maternal health across the African continent. Furthermore, these high rates contribute to high rates of teenage pregnancy and unsafe abortions.
This indicator shows us the level of Antenatal Coverage (ANC) by women across the African continent. ANC is important in the attainment of sexual and reproductive health for women for several reasons. According to WHO, ANC is important as it is key for “identification and management of obstetric complications such as preeclampsia, tetanus toxoid immunisation, intermittent preventive treatment for malaria during pregnancy (IPTp), and identification and management of infections including HIV, syphilis and other sexually transmitted infections (STIs). (Ornella Lincetto, 2016)”

In addition, ANC is vital in the promotion of women using skilled health personal in their influence their behaviour toward “breastfeeding, early postnatal care, and planning for optimal pregnancy spacing” (Ibid).
According to the data, only Tunisia is reported to have the highest (over 85 percent) number of women that have attended more than 4 ANC visits. In polar contrast, seven countries have less than 20 percent of their populations attending at least four antenatal visits. These are Burkina Faso at 15.5 percent, Chad at 17.8 percent, Ethiopia at 9.2 percent, Niger at 15.3 percent, Rwanda at 9.7 percent, Somalia at 1.9 percent and South Sudan at 17.2 percent.

Most countries in Africa have between 41 and 60 percent of women having at least 4 ANC visits (Cameroon (58.1), Comoros (47.6), Côte d'Ivoire (42.8), Democratic Republic of the Congo (46.3), Egypt (42), Guinea (45.6), Kenya (48.6), Malawi (54.2), Mauritania (48.4), Mozambique (52.5), Nigeria (46.8), Sierra Leone (55.6), Sudan (47.2), Togo (54.9), and Tanzania (56.1).

Lastly, the following countries: Burundi (33.1), Central African Republic (38.1), Madagascar (35.9), Mali (29.1), Morocco (29.9), Senegal (39.9), and Uganda (39.7) have between 20 to 40 percent of women attending at least 4 ANC during their pregnancy.
Malawi and maternal mortality

Around the world postpartum haemorrhage (PPH) is the leading cause of maternal mortality.

In developing countries there is little activism around the issue due to the medically technical nature of the issue, as well as the fact that there is little understanding of the risk factors, prevention methods and treatment for post-partum haemorrhage. (Ononge, 2016). The World Health Organisation (WHO) guidelines for the management of postpartum haemorrhage and retained placenta follow the generally accepted definition of primary PPH as “blood loss greater than or equal to 500 ml within 24 hours after birth, while severe PPH is blood loss greater than or equal to 1000 ml within 24 hours.” Uterine atony is the single largest cause of PPH, some studies claiming 70 percent. (Carlos Montufar-Rueda, 2013) Uterine atony is the failure of the uterus to contract after birth. This contraction or shrinking also causes the blood vessels inside to compress and thus less blood to be lost. Two major drugs are available that can be used for uterine atony: Oxytocin and Misoprostol. A recent study in Uganda investigated the efficacy of the two drugs against each other, leading to the conclusion that Oxytocin was found to be more effective. Results showed that 29 percent of the misoprostol group experienced primary PPH, whereas only 17% in the oxytocin group. Severe PPH occurred in 3.6 percent of Misoprostol group and 2.7 percent of Oxytocin group (Atukunda EC, 2014). This would suggest that Oxytocin is more effective and should be the drug of choice. However, now consider that Oxytocin needs to be kept cool and that until recently only trained personnel were able to administer it (it’s best used as an injectable, and not very effective buccally, sublingually, nasally or orally (cheeks, below the tongue or nose spray or swallowed as a pill). Misoprostol, though less effective, can be self-administered as a pill and held under the tongue until it dissolves. The value of this is enormous in resource poor (both in terms of refrigeration and health care workers) countries like Malawi.

In 2015 WHO added Misoprostol to its list of essential medicines. (Gynuity Health Projects, 2017) yet too many African countries have not yet registered Misoprostol nationally and made it available for use by midwives and expectant mothers. Mothers could be given the drug at their first clinic visit and explained how to use it when the baby is born. The latest data available to the author (for 2014) shows that Misoprostol registration in Africa is slow: with only 211 of the 54 African countries having registered it (and then some only for gastric ulcer use only such as Democratic Rep of Congo, South Africa, Tunisia, Zimbabwe and then in Egypt for an obstetric intervention but not PPH). (Venture Strategies Innovations (VSI), 2017). Related to this is that WHO has recognised that anemia in pregnancy in developing countries exceeds 50% and evidence shows that the intersection of uterine atony and anaemia create a perfect storm for PPH (T.G. Sanghvi, 2010) and especially death from PPH, as much as 40-43% of maternal deaths in Africa and Asia. (Christian, 2008).

1 Angola, Burkina Faso, Burundi, Ethiopia, Ghana, Kenya, Madagascar, Malawi, Mali, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, Somalia, South Sudan, Sudan, Tanzania, Uganda, Zambia, Algeria, Benin, Botswana, Cameroon, Central African Republic, Chad, Cote d’Ivoire, DR Congo, Equatorial Guinea, Gabon, Gambia, Guinea-Bissau, Guinea, Liberia, Libya, Mauritania, Morocco, Namibia, Togo, and Western Sahara, seem not to have registered Misoprostol nationally.
Frass’s study in Egypt in resource poor settings shows that there is a link “between low hemoglobin levels at delivery and the potential risk of PPH which remains currently debated.”\(^2\) (Frass, 2015) Similarly a study from Pemba Island in Tanzania showed that anaemia was strongly associated with blood loss at delivery and the immediate postpartum period, even after adjusting for other factors such as duration of first stage of labour, weight of placenta, being given oxytocin and various other factors. (Kavle, 2008) An enormous piece of research on anaemia trends globally over more than a decade and published in 2013 found that anaemia prevalence decreased from 43% (39–47) to 38% (34–43) in pregnant women\(^3\) translating to approximately 32 million pregnant women, with figures being worst in south Asia and central and west Africa. (Stevens, 2013). Iron supplementation and misoprostol must become standard for pregnant women, and represent low cost, sustainable interventions that do not require refrigeration systems or mass upfront investment for African governments. Moving women\(^3\) to health care facilities is not the life-saving panacea that some may consider it to be.

This is reinforced by a study conducted in Malawi. This country has exceptionally high rates of maternal mortality and in December 2015, the Institute for Global Health, University College London, and PACHI Malawi (Parent and Child Health Initiative) conducted Maternal Death Audits in Malawi that were commissioned by MamaYe. The findings showed that:

1. Nearly half (44%) of MDAs analysed were for women who were stable on arrival at the health facility. This contradicts the assumption that pregnant women die because they arrive at a health facility critically ill.
2. Women who arrived in a stable condition experienced poorer quality of care compared to those who arrived critically ill:
   • Critically ill women were more than twice as likely to receive essential drugs compared to stable women.
   • Nearly half of stable women received incomplete initial assessments, compared to one-third for critically ill women.
   • Stable women were more than twice as likely to receive inadequate monitoring compared to women who were critically ill.

“There is an attitude among health workers to prioritise critical cases in order to save lives, for example, by preserving life-saving drugs for what are perceived to be critical cases.” (MamaYe, 2015)

There is an urgent need for postpartum haemorrhage (PPH) to be addressed as the leading cause of maternal mortality. Civil society needs to be more informed around the technical medical nature of the issue so we can advocate for better access to prevention methods and treatment.

\(^2\) Interestingly, Frass’s study also examined the impact of emergency hysterectomy and bears reading due to the conclusion: “Also we provide evidence of the association between severe anaemia and severe uterine atony requiring emergency hysterectomy.”

\(^3\) and from 47% (43–51) to 43% (38–47) in children!
Element 2: Abortion

Indicator: Legality of abortions

When attempting to understand whether women have access to safe abortions we can start by assessing the legality of abortions. For this indicator, we classify the legal status into four categories.

These categories include the following:

- Without restrictions, as to reason and/or socioeconomic reasons
- To prevent mental health (and all the reasons below)
- To preserve physical health (and to save a woman's life)
- To save the life of a woman
- Prohibited altogether, or no explicit legal expectation to save life of a woman
- No data

Source: (Guttmacher, 2016)
Element 2: Abortion

From the map we can see whether and how legal abortion is in the various African countries. Only five countries (Cape Verde, Mozambique, South Africa, Tunisia and Zambia) permit abortion without restriction, as to reason and/or socioeconomic reasons. In complete contrast, 12 countries in Africa completely prohibit abortion to the extent of not providing an explicit legal expectation to save life of a woman. These countries include: Angola, Central African Republic, Congo, Democratic Republic of the Congo, Egypt, Gabon, Guinea-Bissau, Madagascar, Mauritania, São Tomé and Príncipe and Senegal.

Furthermore, we can notice from the map that the number of have higher restrictions towards abortions are likely to be in central and western Africa. This include Tanzania, Uganda, Somalia, Ivory Coast, Mali and Nigeria that only provide an abortion to save the life of the woman.
Indicator: Measures to improve access to safe abortion services

The indicator shows countries’ attempt to improve access to safe abortion services. As can be noticed from the map, the majority of countries that has programmes in place aimed at improving access to safe abortion services are likely to be countries that have liberal abortion policies. This is evident in the case of Tunisia and Zambia. Despite countries like South Africa having a liberal policy towards abortion, there are no measures put in place to access safe abortions. Furthermore, it can be noticed that the majority of countries in East and parts of Northern Africa equally do not have measures in place to ensure improved access to abortions services. In the case of West Africa, most of countries have no data on the availability of services for abortion services in the country.

This indicator allows us to confirm that the adoption of policy is not sufficient to ensure that women's sexual and reproductive health and rights are realised. This should be followed by the provision of services/measures to ensure the successful implementation of policies.
Zambia’s Access to Safe Abortion Under Threat

Setting an early precedent for the Southern African region, Zambia legalized abortion in 1972 (Laws of Zambia, 1972). Despite this progressive legislation, abortion has remained a key cause of maternal mortality; in 2007, 30% of all maternal deaths in the country were attributed to unsafe abortions (CSO, 2007). This rate of abortion is remains high despite Zambian laws permitting access to abortion on social and economic grounds (Guttmacher, 2016).

The World Health Organization (WHO) defines unsafe abortion as “a procedure for terminating an unintended pregnancy that is carried out either by a person lacking the necessary skills or in an environment that does not conform to the minimal medical standards, or both” (WHO, 2004). Complications of unsafe abortions may result in severe haemorrhage, sepsis, chronic pelvic inflammatory disease, ectopic pregnancies, secondary infertility, or death (Koster-Oyekan, 1998).

Regionally, between the year 2003 and 2008, the number of induced abortions increased from 5.6 million to 6.4 million people in Africa. It is estimated that of all abortions in Africa, 97 percent were unsafe (Guttermacher, 2012). In Zambia, significant progress in reducing the numbers of women and girls who die because of unwanted pregnancy has been made. Today, Zambia’s maternal mortality rate stands at 398 maternal deaths per 100,000 live births, a figure that is still in distant feet from the newly adopted Sustainable Development Goal's global target of 70 deaths per 100,000 by 2030 (Central Statistical Office, 2014) (United Nations, 2017). The Ministry of Health in Zambia estimates that approximately 30 percent of all maternal deaths are because of unsafe abortions.
In 1972, the Termination of Pregnancy Act was enacted into the Zambia constitution and allowed an abortion only if three medical practitioners agreed that:

“(a) continuation of the pregnancy would involve risk to the life or of injury to the physical or mental health of the pregnant women, or injury to the physical or mental health of any existing children of the pregnant women, greater than if the pregnancy were terminated; or (b) that there is substantial risk that if the child should be born, it would suffer from such physical or mental abnormalities as to be severely handicapped.” (Laws of Zambia, 1972), 1972).

Despite the existence of Act 26 of 1972 which allows for termination of pregnancy on social and economic grounds, a recently failed referendum in August 2016 suggested the beginning of life to be at conception, thus attempting to make it a criminal offense to access an abortion. An action which was an attempted assault on women’s access to sexual and reproductive health and rights in Zambia (L Carmody, 2016).

Some of the reasons that contribute to the high abortion rates in Zambia include:

1. **Human resource crisis**: The law requires that an abortion be approved by three medical doctors. However, with a human resource crisis within the Zambian health system, it is expensive and difficult for a woman demanding an abortion to meet this threshold. This is due to a human resource for health crisis that exists in the country with 0.14 physicians per 1000 population, and 1.36 per 1000 population of nurses and midwives, which is less than a third of the doctor-patient ratio recommended by WHO (MOH, 2006) (Schatz, 2008) (SADC, 2014).

2. **Access to service providers**: Furthermore, the University Teaching Hospital (UTH), the biggest health facility found in the capital city Lusaka with 4 million inhabitants, is the only institution in the country that can legally provide abortions. The census results of 2000 showed that 60 percent of Zambia’s population are in rural areas thereby making it difficult for women to access abortion services (CSO, 2000). In addition, it is estimated that 60 percent of people in Zambia live below the poverty line, thus making it impossible for women to afford the cost of travel to UTH in Lusaka (CSO, 2010) (Central Statistical Office, 2014).

3. **Religion**: The role of the religion in Zambia can’t be overlooked. According to the international religious report, 87 percent of Zambians identify as Christians, of which a majority are Catholics or extreme-right evangelical. The Catholic Church’s official stance on the issue is: “Any direct attempt on an innocent life to an end—even to the end of saving another life is unlawful” (CAI, 2012). These religious groups have, in collaboration with other factors, increased stigma associated with safe access to abortions.
4. **Low contraceptive use:** Although a study by Marston has shown that increased contraceptive use may reduce the practice of unsafe abortions (Marton et al, 2003), Zambia suffers from a low rate of contraceptive use; as of 2007, 67 percent of sexually-active women within their reproductive age group reported ever using contraception. Of this percent, 56 percent used modern methods while 32 percent used traditional methods (CSO, 2007).

5. **Public and Service Provider Knowledge:** The lack of proper understanding of the laws on abortion by women has prevented them from accessing abortions. Additionally, many doctors lack general knowledge of the current laws on abortions (Guttmacher, 2009).

Historically, in 2001 George W. Bush reinstated the Global Gag Rule prohibiting organizations from providing abortion related services, including counselling and referrals, and/or lobbying on abortion issues. This adversely impacted gained momentum on reproductive health services delivered by organizations such as Planned Parenthood Association of Zambia (AD Report, 2006). The ripple effects of this policy lead to: (1.) fewer women accessing reproductive health information on safe abortions and (2.) reduced supply of contraceptives. Therefore, the impact of the Global Gag Rule was that it increased the number of unwanted pregnancies and promoted women accessing unsafe abortions (Ibid). Currently, this resurfacing of this policy through Donald Trump’s reinstatement of the Gag rule places women at risk of not accessing safe abortions (Starrs, 2017).

With the evidence of high unsafe abortions in Zambia, the following measures would help to reduce the rate of unsafe abortions: 1. Increasing the need for access to effective contraception through health education in both rural and urban areas. 2. Promote community sensitization programs that reduce stigma around seeking safe abortions. 3. Provide a comprehensive legal framework to increase access to abortions. 4. With the help of cooperating partners, increase information through media such as print, radio and television on how women can access post abortion care.
Element 3: Violence Against Women

Indicator: Prevalence of physical violence against women (%)

The map above provides evidence on prevalence of violence against women by all perpetrators. Physical violence is defined as an act that inflicts physical harm to the body of a woman (United Nations Statistics Division, 2017). An act that is a human rights violation and is a hindrance to achieving gender equality and women’s empowerment. The factors combined affect the attainment of the Sustainable Development Goals (UNWOMEN, 2017). Social norms and widespread impunity for perpetrators are key challenges in fuelling violence against women (Ibid, 2017).

As in the case of Africa, a majority violence against women remains high as can be seen from the following percentage of women that have experienced violence: Burkina Faso (19.8), Cabo Verde (21.5), Cameroon (54.6), Central African Republic (35.3), Comoros (14.0), Côte d’Ivoire (35.6), Democratic Republic of the Congo (63.7), Egypt (47.4), Equatorial Guinea (62.8), Gabon (52.4), Ghana (36.6), Kenya (38.5), Liberia (44.0), Malawi (28.2), Mali (38.3), Morocco (35.3), Mozambique (33.4), Nigeria (27.8), Rwanda (30.7), Rwanda (41.2), Sao Tome and Principe (33.4), Sierra Leone (55.5), Tunisia (31.7), Uganda (56.1), United Republic of Tanzania (38.7), Zambia (53.2) and Zimbabwe (29.9).

Despite not having data for every African country, it remains clear that violence against women remains a huge problem across the African continent. Therefore, the successful implementation of the Sustainable Development Goal 5 allows for countries to address violence against women.
Element 3: Violence Against Women

Indicator: Prevalence of sexual violence against women (%)

Globally, 1 in 5 women and girls aged 15-49 report experiencing physical and/or sexual violence by an intimate partner within the last 12 months. In the case of Africa, the above map provides a depiction of the prevalence of women that experience sexual violence at the hands of an intimate partner. Burkina Faso (1.5), Cabo Verde (3.6), Cameroon (20.3), Central African Republic (11.6), Comoros (1.8), Côte d’Ivoire (5.3), Democratic Republic of the Congo (35.3), Egypt (6.6), Equatorial Guinea (17.4), Ethiopia (58.6)⁴, Gabon (17.0), Ghana (8.2), Kenya (17.2), Liberia (10.8), Malawi (18.9), Mali (13.9), Mozambique (7.9), Namibia (16.5)⁵, Nigeria (4.8), Rwanda (17.5), Sao Tome and Principe (8.3), Sierra Leone (7.3), South Africa (4.4), Tunisia (14.2), Uganda (27.3), United Republic of Tanzania (17.2), Zambia (16.7) and Zimbabwe (26.0). The map and figure above show that majority of initiate partner violence occurs in Eastern and Southern Africa. Ethiopian province based data shows a prevalence rate of 58.6 percent compared only 1.5 percent in Burkina Faso. This data allows countries to effectively create programmes for addresses prevalence of gender based violence. Unfortunately, data on violence among women and girls is usually lacking particularly for women and girls with disabilities, older women and migrant workers (UNWOMEN, 2017). Therefore, increasing data collection on violence against women remains paramount for monitoring the problem across Africa and globally (Ibid, 2017).

⁴ Ethiopia data is provided at province level
⁵ Namibian data is provided at city level
Female Genital Mutilation (FGM) continues to be a significant problem in some parts of Africa. However, UNICEF reports that there has been “overall reduction in the prevalence of female genital mutilation (FGM) over the last three decades” (UNICEF, 2017). Over the years the percentage of girls 15 to 19 years who have undergone FGM has reduced from 51 percent in 1985 to 37 percent as of 2016. It because of this gradual decline that the United Nations General Assembly adopted a resolution in 2012 to finally bring the practice to an end globally. This resolution has since been reaffirmed by the adoption of the Sustainable Development Goals (SDG Goal 5) which aims at eliminating all forms of harmful traditional practices including early and forced child marriages and FGM by 2030. Historically, the African Union in 2003 also adopted a policy on the rights of women in Africa also known as the Maputo Protocol which clearly demands countries abolish FGM.
Element 3: Violence Against Women

As explained by UNICEF, FGM is violates fundamental human rights as it places girls and women at several health risks which can be life threatening. Specifically, FGM means that girls and woman are robbed of the right to attaining the highest standard of health and assurance of bodily integrity (UNICEF, 2005). This act thus means that women and girls do not fully realise their sexual and reproductive health and rights.

The highest rates of FGM have been recorded in the following countries: Djibouti (93.1), Egypt (87.2), Eritrea (83), Guinea (96.9), Mali (88.5), Sierra Leone (89.6), Somalia (97.9) and Sudan (87).

These countries each have a FGM prevalence among girls of over 80 percent. Conversely, the lowest rates (0 to 20 percent) have been record in Benin (9.2), Cameroon (1.4), Ghana (3.8), Niger (2), Tanzania (14.6), Togo (4.7) and Uganda (1.4).

Most of African countries do not provide date for FGM for various reasons including the (perhaps perceived) non-existence of the practice. Furthermore, it is important to note that the above map is based on count of FGM rather than type (as per World Health Organisation 4 type classification) (WHO, 2017).
Liberia's Female Genital Mutilation (FGM) challenge

United Nations Children Emergency Fund (UNICEF) reports that there has been “overall reduction in the prevalence of female gentile mutilation (FGM) over the last three decades” (UNICEF, Female Genital Mutilation, A Global Concern, 2016). Overtime, the percentage of girls 15 to 19 years who have undergone FGM has reduced from 51 percent in 1985 to 37 percent as of 2016. It because of this gradual decline that the United General Assembly adopted a resolution to bring an end of the practice globally in 2012. This resolution has since been reaffirmed by the adoption of the Sustainable Development Goals (SDG Goal 5) which aim at eliminating all forms of harmful traditional practices including early and force child marriages and FGM by 2030 (United Nations, 2017). Historically, the African Union in 2003 also adopted policy on the Rights of Women in Africa also known as the Maputo Protocol which clearly demands countries to abolish FGM (African Union, 2003).

Despite the existence of an ideal policy environment to combat FGM, the practice remains highly common in many parts of the Africa continent. Liberia, a country located in Western African is no exception to this practice. Evidence shows that during the period between 2004 to 2015, 50 percent of the girls and women aged 15 to 49 years had undergone FGM (UNICEF, 2016). This is despite 55 percent of girls and women aged 15 to 49 years who have heard about FGM/C and think the practice should end with the period of 2004 to 2015 (Ibid).

As explained by UNICEF, FGM is violates fundamental human rights as it places girls and women at several health risks which may at most be life threatening. Specifically, FGM means that girls and woman are robbed of the right to attaining the highest standard of health and assurance of bodily integrity (Ref). This act thus means that women and girls do not fully realise their sexual and reproductive health.

The World Health Organization cites that Type II FGM is widely prevalent in Liberia, a procedure that consists of “excision (removal) of clitoral hood with or without removal of all or part of the clitoris.” (WHO, 2017)

There are several reasons that have led to the practice of FGM stems including traditional practices. It is for this reason that rural areas where traditional practices are more pronounced have high rights of girls experiencing higher rights of FGM compared to their urban counterparts. Additionally, education also seems to contribute to protecting girls and women from the traditional practice. Despite evidence showing the role of education in protecting against FGM, several girls and women in Liberia are most disadvantaged when it comes to accessing education compared to their male counterparts (U.S. Department of State, 2017).
Additionally, most of the Liberian population continues to reside in rural settings thus perpetuating the practice for many generations. Historically, Liberia broke out in civil war in the late 1989, which dismantled social practices and norms including FGM. It is estimated that civil war could have reduced the practice of FGM especially in the western part of Liberia by approximately 10 percent due to the forced migration that was led people fleeing to other countries (WHO, 2017) (U.S. Department of State, 2017).

To date there is no existing law that explicitly deems that practice as illegal in Liberia. Section 242 of the Liberian Penal Code finds a person guilty of a felony and punishable offence with the possibility of serving a prison sentence of up to a maximum of five years should the person “maliciously and unlawfully injures another by cutting off or otherwise depriving him of any of the members of his body”. This close in Penal Code does not in any way accommodate for the practice of FGM (U.S. Department of State, 2017).

Considering the sustainable development goals, how then does FGM affect the attainment of sexual and reproductive health and rights? To begin with, FGM presents itself as a discrimination that is based on one’s sex. Discrimination against women is defined as “any distinction, exclusion or restriction made because of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field” (UNAIDS, 2017). This discrimination in turn takes away women’s ability to fully enjoy their sexuality (UNICEF, 2005). It could therefore be argued that FGM impedes the attainment of the sustainable development goal 5 (Achieve gender equality and empower all women and girls) (United Nations, 2017).

In addition, research shows there is an association between FGM and decision making by couples about one’s healthcare. Evidence shows that women involve their husbands or partners in the decision making around their sexual health. Often, women find themselves at the mercies of their partners decision. The husband’s decision-making powers are more pronounced in couples where the women have undergone FGM (U.S. Department of State, 2017). This lack of women’s self-interest and/or control further affects women’s access to attaining universal access to sexual and reproductive health and reproductive rights (SDGs 5.6) (United Nations, 2017).

In conclusion, FGM is undermines women and girls’ gender equality in society. Furthermore, it violates human rights generally and particularly as they relate to sexual and reproductive health and rights.
Another factor that influences sexual and reproductive health in Africa is the epidemic of early and forced child marriages. Several factors in sub-Saharan Africa cause girls to be married at an early age, including traditional practices, gender inequality and poverty. Child marriage halts a girl's ability to develop and hinders her socio-economic independence as she often suffers early pregnancies and/or termination of attendance of school (UNICEF, 2017). Child marriages remain a violation of a girl's basic human rights.

Child marriage continues to remain a huge problem across the continent of Africa. The continent makes up a significant proportion of the global rates of child marriage. UNICEF estimates that 15 and 39 percent of girls are married before the age of 15 and 19 years respectively. Africa accounts for 17 percent (125 million) of 700 million women alive currently that were married before their 18th birthday (UNICEF, 2017). It is estimated that by 2050, the number of children that are married before the age of 18 will double if nothing is done to halt this human rights abuse.

Child marriage affects girls and women's quality of life at several levels. These levels include the social and economic and vitally does not allow them to fully realise their sexual and reproductive health and rights. It is for this reason that several global and African regional policies condemn the practice. According to the UNFPA, child marriage forms a violation of a child's rights as provided within the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child (UNAIDS, 2017). Further, the United Nations Agenda 2030 for Sustainable Development also highlights the importance of ending child marriage (Goal 5 and target 5.3). Regionally, African Union members states have agreed to end child marriage through the several policy instruments as provided in the table.

African Policy instruments on ending early and forced child marriage

The African Youth Charter (article 8), 2006.
The Southern African Development Community (SADC) Protocol on Gender and Development (article 8), 2008.
The Maputo Plan of Action, the continental framework on sexual and reproductive health and rights, 2007
Agenda 2063
The Maputo Plan of Action (MPOA) 2016 – 2030

(Girls Not Brides, 2017)
The Agenda 2063 through aspiration 1: “A prosperous Africa based on inclusive growth and sustainable development” promotes that all Africans have a “high standard of living, and quality of life, sound health and well-being”. This must be achieved through the elimination of harmful social practices including female genite mutilation and child marriage. With this agenda that aligns itself with the global development agenda, it remains important for countries like Ghana to address early and forced child marriages. The failure to do so means that girl's human rights are violated (UNICEF, 2013). Child marriage is a gender inequality issue. Child marriage is a human rights issue. And oppressive social norms need to be changed with urgency to correct this.

Indicator: Policy on age of marital consent and ending child marriage

Based heavily on the work done in the AAI Child Marriage Scorecard, this indicator interrogates whether policy is in place to support the reduction of child marriage in a country. 3 types of policy are examined:

- National strategic plan on ending child marriage;
- Policies on age of marital consent and ending child marriage; and what they contain.
- Any other human rights commitments/policies/legislation as it relates to girls (example Female Genital Mutilation)

### A
Country has a national strategy to end child marriage; or explicit law against child marriage and 18 years old minimum no exceptions.

### B
The minimum age of consent to marriage for girls is 18 years or above, NO EXCEPTION

### C
The minimum age of consent to marriage for girls is 16 years or above, NO EXCEPTION

### D
Signed and ratified a relevant UN or African commitment but age of consent is below 16 years, even/usually as an exception.

### E
Law explicitly provides for marriage under 14 years of age.

According to the AUC 18 years of age is stated as minimum age for marriage, but many countries only have 18 years for males and not for females. These countries include Cameroon, Democratic Republic of Congo (DRC), Gabon, Niger, Seychelles, and Tanzania all have boys at 18 and girls 15 of which most of them have very high prevalence percentages. Countries such as Senegal and Swaziland boys are at 18 and girls at 16. Similarly, in Chad boys are at 18 and girls at 17 and in Burkina Faso boys are as high as 20 years and girls 17 years old. Other countries like Guinea Bissau have both at 16. Zambia has established 21 for both girls and boys but with parental consent at 16 years old.

Out of this data only two countries have truly set 18 years of age as the minimum for marriage consent, namely; Burundi and Cote d'Ivoire. The obvious exception to the rules are those where parental consent for a younger age than the stipulated minimum age can be provided and also in pluralistic legislative countries where certain matters can be debated under a cultural or religious law versus a civil law.

Sudan registers the lowest age of marital consent at 10 years old for both girls and boys.
Countries have policies, strategies or legislation in place that speak to consent of marriage, however, the contradiction exists when implementing these laws, policies and strategies. For example, a country of concern is Sudan that has marriage consent set at age 10 for both girls and boys, 33% prevalence percentage of child marriages, no minimum age of sexual consent is boys and 18 years for girls. All of these contradict each other. Sudan has no law in place to eradicate child marriages and therefore it is not illegal to have one, especially when it is supported by marriage consent age of 10 years. Hence, the prevalence percentage is high. However, it does have a law in place that prohibits sexual consent for a girl under the age of 18 and therefore any sexual activity the girl engages in is illegal. Clearly, the policy makers are not looking at cross-cutting issues in relations to laws being made in this country.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legislation or policies ending child marriages:</td>
<td></td>
</tr>
<tr>
<td>National strategy to end child marriage</td>
<td>Ghana, Mozambique, Zambia, Malawi, Mauritania,</td>
</tr>
<tr>
<td>Convention on Consent to Marriage, Minimum Age for Marriage and Registration of Marriages (1962)</td>
<td>Algeria</td>
</tr>
<tr>
<td>Human Rights inspired legislation or policies:</td>
<td></td>
</tr>
<tr>
<td>Sexual Offences, rape and violations</td>
<td>Kenya, Tanzania, Zimbabwe, Namibia</td>
</tr>
<tr>
<td>Female genital mutilation</td>
<td>Benin, Cameroon, Central African Republic (CAR), Cote d’Ivoire, Eritrea, Kenya, Mali, Nigeria, Togo, Uganda</td>
</tr>
<tr>
<td>Sexual exploitation</td>
<td>Algeria, Angola</td>
</tr>
<tr>
<td>Protection for women and children</td>
<td>Sierra Leone, Lesotho</td>
</tr>
<tr>
<td>Child rights and protection</td>
<td>Chad, Benin</td>
</tr>
</tbody>
</table>

Source: (Hattas & Tucker, 2016)

Again, the issue of difference in age for both boys and girls with regard to consent becomes apparent. The exceptions to this are Sudan, Malawi, Guinea Bissau, and Zambia.

In terms of criminalization of child marriage (Odala, 2013) found that three different type of approach exist in Africa:
1. Countries that criminalize the premature, early or child marriages (Botswana, Burkina Faso, Cameroon, Central African Republic, Chad, Congo Brazzaville, Democratic Republic of Congo, Egypt, Ethiopia, Gabon Ghana, Kenya, Liberia, Malawi, Mali, Mauritania, Nigeria, Rwanda, Senegal, Sierra Leone, South Sudan, Swaziland, Togo, Zambia and Zimbabwe),
2. Countries that ban or invalidate marriages below the minimum age (Angola, Burundi, Cape Verde, The Gambia, Mauritius, Mozambique, Namibia, Sao Tome and Principe, South Africa, Tanzania and Uganda), and
3. Countries that prescribe a minimum age of marriage without criminalizing or banning the practice (Algeria, Benin, Comoros, Cote d'Ivoire, Djibouti, Eritrea, Guinea, Guinea Bissau, Lesotho, Libya, Madagascar, Morocco, Niger, Seychelles and Tunisia).

However, some of the countries criminalizing child marriage have discriminatory minimum ages of marriage (different ages for boys and girls) and others have set the minimum age of marriage for both boys and girls below 18 years even though they have made claims to combating child marriage in other laws or with a National Strategy on Child Marriage. One good example of this is Zambia that has a strategy but has the age of consent to marry at 16 years, and even lower under exceptions. This contradictory legal and policy framework is easily abused and exploited by those wishing to violate the rights of children.
Indicator: Law on child marriage

In their paper “Minimum Marriage Age Laws and the Prevalence of Child Marriage and Adolescent Birth: Evidence from Sub-Saharan Africa” Maswikwa et al demonstrate that in an analysis of countries laws around age and consent, that the prevalence of child marriage was 40% lower in countries with consistent laws setting consent at 18 years and older. Additionally, “the prevalence of teenage childbearing was 25% lower in countries with consistent minimum marriage age laws than in countries without consistent laws.” (Maswikwa et al, 2015) The penalty for violating the law on child marriage varies widely among the countries from small fines and short imprisonment and up to 10 years’ imprisonment in Malawi.

This indicator must be read in conjunction with the data on policy on age of marital consent and ending child marriage above. It looks at the law on child marriage alone, not other surrounding policies. The different categories that show the legal approaches are:

- Countries which criminalise premature, early or child marriages
- Countries that ban or invalidate marriage below the legally prescribed minimum age
- Countries that merely prescribe a minimum age of marriage without expressly criminalizing or banning it
- No data
With reference to the map most African countries have favorable policies toward the abolishment of child marriage. Legally, most countries in Africa criminalize premature, early or child marriages. These countries include Botswana, Burkina Faso, Cameroon, Central African Republic, Chad, Congo Brazzaville, Democratic Republic of Congo, Egypt, Ethiopia, Gabon, Ghana, Kenya, Liberia, Malawi, Mali, Mauritania, Nigeria, Rwanda, Senegal, Sierra Leone, South Sudan, Swaziland, Togo, Zambia and Zimbabwe.

In contrast, several countries merely prescribe a minimum age but don’t in any way criminalise or ban them. These countries include Algeria, Benin, Comoros, Côte d’Ivoire, Djibouti, Eritrea, Guinea, Guinea Bissau, Lesotho, Libya, Madagascar, Morocco, Niger, Seychelles and Tunisia. Unfortunately, countries legal status towards child marriages does not always translate into the protection of children’s rights as the prevalence of child marriage continue to increase across the continent.

Despite the data provided in the map on legal approaches towards child marriage, there remains a huge range in the prescribed minimum age of marriage across the continent. The minimum age can be as low as 15 years and to as high as 21 (Girls not Brides, 2017).

It is therefore important to juxtaposition this map with that of the percentage of women aged 20-24 who got married before age 18 on the African continent. This allows us to assess the effectiveness of the laws on ending child marriage. In contrast to the maps that shows that legality and policy on child marriage in African countries. This map shows the percentage of women aged 20-24 who got married before age 18. This map provides a picture of the implementation of the policies on child marriage among African countries.

Most African countries have over 20 percent of their populations aged 20 – 24 having been married before the age of 18. These countries include Benin (31.9), Burkina Faso (51.6), Burundi (20.4), Cameroon (38.4), Central African Republic (67.9), Chad (68.1), Comoros (31.6), Congo (32.6), Côte d’Ivoire (33.2), Democratic Republic of the Congo (37.3), Equatorial Guinea (29.5), Eritrea (40.7), Ethiopia (41), Gabon (21.9), Gambia (30.4), Ghana (20.7), Guinea (51.7), Guinea-Bissau (22), Kenya (22.9), Liberia (35.9), Madagascar (41.2), Malawi (46.3), Mali (55), Mauritania (34.3), Mozambique (48.2), Niger (76.3), Nigeria (42.8), Sao Tome and Principe (34.4), Senegal (32.3), Sierra Leone (38.9), Somalia (45.3), South Sudan (51.5), Sudan (32.9), Togo (21.8), Uganda (39.7), Tanzania (36.9), Zambia (31.4) and Zimbabwe (33.5).

Nonetheless, some countries like Algeria (2.5), Tunisia (1.6) Namibia (6.9), Rwanda (8.1) and Swaziland (6.5) have lower Indicator: Percentage of women aged 20-24 who got married before age 18

Reducing the percentage of women that are married below the age of 18 ensures that women enter child birth when they are biologically able to bring a pregnancy to term. It also means that they are more likely to complete their education, and this ultimately reduces the cycle of poverty within their families (UNFPA, 2016). In some countries, reducing the rate of teenage pregnancy would also be a direct indication of the equal reductions in the occurrence of early and forced child marriages (Ibid).
Indicator: Percentage of women aged 20-24 who got married before age 18
In Ghana (like many other countries) child marriage affects girls more than boys. According to the Ghana Demographic Health Survey, “only 2 percent of men age 20-24 were married by age 18, as compared with 21 percent of women in the same age group” (Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF International, 2014). 20.7 percent of Ghanaian women aged 20-24 were married before the age of 18 (Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF International, 2014).

There are several reasons that have led to the problem of child marriage in Ghana. Some of these reasons include (but are not limited to) harmful traditional practices, gender inequality, poor education options, conflict, a lack of political engagement and poverty (Girls not Brides, 2017). The high adolescent and teenage pregnancy in Ghana are classified as both a cause and effect of child marriage. With teenage pregnancy standing at 14 percent within the age group 15-19, female sexuality and the concept of family “honor” have been used as reasons for marrying girls (UNFPA, 2016) (Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF International, 2014) (Girls not Brides, 2017). Furthermore, poverty as demonstrated by the higher rates of child marriage in poorer communities with 48 percent of families marrying their girls before the age of 18, compared to their wealthier counterparts with 11.5 percent, plays a role in keeping the practice in place (Ibid). The practice proves to be a problem to the attainment of sexual and reproductive health and rights of girls. It places girls at the risk of sexual and gender based violence, teenage pregnancy, maternal morbidity and mortality (UNFPA, 2016). The African Union Campaign to Eradicate Child Marriage says it best: “Child marriage has a devastating and long term effects (health, education, psychological, emotional and mental) on the life and future of girls”

Socially and economically, child marriage perpetuates the condition of poverty with girls that are married being unable to complete their education. Particularly for Ghana, 41.6 and 4.7 for women with no education and secondary education respectively being married before their 18th birthday (Girls not Brides, 2017).

In response to the problem of child marriage, Ghana has launched a national end child marriage campaign in February 2015. This initiative follows the African Union’s campaign that was launched in May 2014. The campaign focused “on accelerating change across the continent by encouraging AU member states to develop strategies to raise awareness of and address the harmful impact of child marriage” (Girls not brides, 2017). The Ghana national launched provided a detailed 10-year national strategy that aims at “ensuring the legal and policy frameworks related to ending child marriage are in place, effectively enforced and implemented” (Ibid). With this plan being implemented by the Ghanaian Ministry for Gender, Children and Social Protection will effectively reduce the harmful practice of child marriage (Girls not Brides, 2017).
The figure shows some of the drivers of child marriage as it relates to sexual and reproductive health outcomes such as teenage pregnancy and ultimately maternal mortality.
Element 5: Youth Access to SRHR

Indicator: Adolescent unwanted & unplanned pregnancy: percentage of women aged 20-24 who gave birth before age 18

The data shows the percentage of women aged 20-24 who give birth before age 18. Measuring teenage pregnancy allows to understand several socioeconomic factors that affect young girls and women's access to sexual and reproductive health and rights. Evidence suggests that there is an association between teenage pregnancy and access to sexual and reproductive health services such as modern contraceptive methods and/or comprehensive sexually education (UNFPA, 2016). In addition, teenage pregnancy can social norms such as early and forced child marriages. This teenage pregnancy ultimately contributes significantly to maternal mortality (UNFPA, 2016).

From the map we can see that the highest percentage (between 40 to 60 percent) of women aged 20 – 24 women who gave birth before age 18 were found in Central African Republic (45.3), Chad (47.4), Equatorial Guinea (42.3), Mali (46.3), and Niger (48.2). This is followed by Burkina Faso (28.2), Cameroon (27.5), Cape Verde (22.1), Congo (26), Côte d’Ivoire (31.1), Democratic Republic of the Congo (26.7), Ethiopia (22.2), Gabon (27.8), Guinea (40), Guinea-Bissau (28.3), Kenya (23.3), Liberia (37), Madagascar (35.8), Malawi (31.3), Mauritania (23.6), Nigeria (29.1), Sao Tome and Principe (27.3), Sierra Leone (36.4), South Sudan (27.9), Sudan (21.5), Uganda (33), Tanzania (28.3), Zambia (30.7) and Zimbabwe (22.4).
The lowest rates of women who gave birth before 18 were noticed in Algeria (0.8), Tunisia (0.5), Egypt (6.7) and Morocco (7.5). Six countries (Benin (19.5), Comoros (17.1), Eritrea (18.8), Gambia (19.4), Ghana (16.9), Senegal (18.4), and Swaziland (16.7)) have had women aged 20 – 24 years give birth before 18 years.

Adolescent pregnancy is a huge problem in Africa and we have the highest numbers globally. Having children while young makes it difficult for young girls to fully realise their full educational and employment potential, and being pregnant affects their socio-economic lives as they enter adulthood (UNFPA, 2016). WHO estimates that 11 percent of all births globally occur among women aged between 15 and 19 years old. About 16 million women 15–19 years old give birth each year. Sub-Saharan Africa makes up about 50 percent of all births among adolescents in contrast to China at 2 percent and Latin America at 18 percent (WHO, 2017). (For analysis sake: SSA has a population of 1,014 Billion in 2017; China has 1,379 billion in 2016 and Latin America had 639 million in 2014). These high levels of unwanted teenage pregnancies demonstrate a lack of accountability from governments to young women.

Biologically, most adolescent's reproductive system is not fully developed thus making obstetric fistula a potential health risk Plan International reports that Pregnancy and childbirth complications are the second highest cause of death for girls aged 15 to 19 years (Plan International, 2017). This is evident in the estimation that despite adolescents accounting for only 11 percent of global births, they make up 23 percent of overall burden of disease due to being pregnant and experiencing childbirth (Yeboah, 2017) (WHO, 2017).

Economically, adolescent pregnancy puts young women at risk of fully realizing their potential as it prevents them from completing their education, which is itself obviously a human right. Access to education for girls is well known to alleviate poverty and improves access to health. (UNFPA, 2016).

In conclusion, high rates of teenage pregnancy need to be addressed if we are ever to attain the Sustainable Development Goals especially, Goals 3, 4 and 5. Addressing teenage pregnancy remains key in achieving Agenda 2030 (United Nations, 2017).
This indicator investigates the implementation towards the provision of comprehensive sexuality at country level within the twenty-two African countries that have committed to the Eastern Southern African (ESA) Commitment on Comprehensive Sexuality Education (CSE). A commitment that was endorsed and affirmed by twenty ministers from the Ministry of Education and Health. The goal of this commitment is to increase comprehensive sexuality education. According to UNFPA, CSE “enables young people to protect their health, well-being and dignity. And because these programmes are based on human rights principles, they advance gender equality and the rights and empowerment of young people” (UNFPA, 2017). As part of this commitment countries targeted to reach the following landmarks: 15 out of 21 countries:

- Providing CSE/Life Skills in at least 40% of primary and secondary schools
- CSE training programmes for teachers
- Provision of youth-friendly SRH service training programmes for health and social workers
- Provision of the standard minimum package of adolescent and youth friendly SRH services” (UNESCO, 2016)

According to the UNESCO, there are only Lesotho, Namibia, South Africa, Swaziland, Mauritius, Seychelles, Tanzania, Zambia and Zimbabwe have reached the 4 of targets of the ESA commitment. Angola continues to be the least performed in the implementation of the CSE commitment with only addressing one target.
In comparison, Democratic Republic of Congo, South Sudan, Ethiopia, and Madagascar have only met two targets of the ESA CSE targets. Lastly, only three targets have been met by Botswana, Uganda, Burundi, Rwanda, Malawi and Mozambique.

It is important to note that countries outside the ESA commitment continue to implement provision of comprehensive sexuality education without an formalized commitment other than the provision stated in the Maputo Plan of Action, the continental framework on sexual and reproductive health and rights (African Union, 2016). Nonetheless, the continental framework on sexual and reproductive health and rights has a significant diversion from the Comprehensive Sexuality Education (CSE) as it refers it to Comprehensive Education on Sexual and Reproductive Health which may pose threats to the full realisation universal access to SRHR for young people (Munyati, 2016).

**Indicator: National policy on comprehensive sexuality education**

From the map it can be noticed that the majority of Sub-Saharan countries in Eastern, Central and Southern Africa have national policies in place on Comprehensive Sexuality Education.
Indicator: Countries with programmes that ensure youth’s access to contraception

The indicator provides evidence on countries’ performance on creating programmes that ensure youth access to conception. Most of countries in Africa have created programmes that ensure that youth have access to family planning services. Noticeable countries that do not provide services for young people include Algeria, Somalia, Sudan, South Sudan and Morocco. These countries could be influenced similar prevailing factors including perceptions on contraceptive services for young people and/or religion.
Tanzania’s ban on teenage pregnancy a human rights abuse

In late June 2017, President Magafuli of Tanzania reiterated his stance that “As long as I am president ... no pregnant student will be allowed to return to school.” The east African nation has one of the highest adolescent pregnancy and birth rates in the world and 21% of girls aged 15 to 19 have given birth, according to a 2015/16 survey conducted by the Tanzania Bureau of Statistics. (Reuters, 2017)

What President Magafuli is not aware of is that banning young girls from school is not only a violation of their basic right to an education, and later employment but is also counter to developing the entire social fabric of Tanzanian society. Research done by Tanzanian Salome Assey, A Critical Analysis Of The Expulsion Of Pregnant Girls From School: A Case Study Of Temeke District, Dar Es Salaam, Tanzania demonstrates that “The growing number of girls dropping out of school out is Tanzania’s single greatest problem in education.” (Assey, 2012) Assey’s research not only points out the government being in breach of several regional and international Human Rights Instruments, such as the African Charter on the Rights and Welfare of the Child and African (Banjul) Charter on Human and People’s Rights, to which Tanzania has bound itself but also shows through her research that the voluntary withdrawal or forced expulsion of young mothers from schools leaves them with few options. They are usually rejected by their family due to the stigma associated with early pregnancy, and struggle to find work, sometimes turning to sex work or marrying into abusive relationships to provide for themselves and their children.

Similarly, to his counterpart in South Africa, President Zuma, President Magafuli interestingly seems to blame young women especially for early pregnancy, failing to recognise many factors and the role of society and government in causing pregnancy. Gender-based violence, poor access to contraceptives and difficulties with using services for the termination of pregnancy, as well as the stigmatisation of young women’s sexuality, all contribute to high rates of teen pregnancy. (Tucker, 2015)

A more appropriate response would be that suggested by Tebogo Mothiba and Maria Maputle in their paper based on a study of a Limpopo district, in which they recommend effective, appropriate preventative measures to counter unwanted pregnancies, including providing information and contraceptive measures through youth-friendly clinics. (Mothiba, 2012) cited in (Tucker, 2015)

Adults should also talk about sex to their sons and daughters. Finally, programmes for males should be made available. “Boys and young men have information needs and anxieties about sex and relationships,” Mothiba and Maputle say. (Mothiba, 2012) cited in (Tucker, 2015)
The president’s comments place importance on education at a time when schools are failing our young people. Apart from going against his government’s own policy framework, the president’s comments are of deep concern to many for various reasons, not least of which is that he assumes all teenage pregnancies are unwanted. Many families change their minds during the pregnancy or after the baby is born, and such comments stigmatise both mother and child.

Assey goes on to state that “members of the government continue to enforce their harmful and discriminatory practices against these helpless girls based on outdated policies and misinterpreted and misapplied legislation incited by the judgmental spirit of a patriarchal society and culture; rather than their sharing blame for the problem (e.g., condoning parents’ preference for educating sons rather than daughters, encouraging early marriages for girls, failing to provide effective sex education at school, condoning parental collusion with male culprits and condoning police and judicial corruption which allows male culprits to escape punishment) and actively seeking ways of resolving it, they choose, at worst, to condemn these young girls to almost certain penury and possibly death or, at best, offer them paltry and little known forms of vocational assistance.” (Assey, 2012)

Assey’s solutions based on Malawi’s lead “which has, in compliance with its international human rights obligations, amended its policies and laws to outlaw its government’s similar illegal practices and to bring in laws which will assist young female victims without being seen to condone or encourage school pregnancies; actively and continually evaluating and monitoring the implementation of the new laws; establishing comprehensive and effective sex education at school; changing people’s attitudes to teenage pregnancy by educating them about the realities that cause it and working together to find ways of living with it and resolving it.” (Assey, 2012). Activists came out in full force to respond to Magafuli demanding that he apologise and retract his statement.

“That Magufuli, whom we thought pegged his campaign on a transformational streak, can wake up one day and re-victimise teenage girls who fall pregnant while in school is incredulous and utterly disgusting,” said executive director Dinah Musindarwezo of the African Woman’s Development Network (The Star Kenya, 2017). She noted the remarks were in “bad shape” especially after “all the work done to emancipate Africa’s girl-child from the shackles of discrimination and violation”. (The Star Kenya, 2017) Kavinya Makau, an African feminist lawyer and women’s rights defender, said it is a shame that Tanzania can take such a retrogressive path. “We are shocked and disgusted. It is a betrayal of the highest order. Magufuli now stands blacklisted in our course,” she said. She said Tanzania has obligations to the Maputo Protocol that ensures women are protected against discrimination, having ratified it in March 2007. (The Star Kenya, 2017)

http://www.pulse.ng/gist/tanzania-ban-on-pregnant-school-girls-raises-brow-id6905996.html
Element 6: HIV and AIDS

Despite major advances made towards the global elimination of HIV/AIDS, the epidemic remains a challenge in sub-Saharan Africa. It is estimated that 25.8 million people are currently living with HIV on the African continent. Furthermore, there is an additional 1.4 million new infections annually (UNAIDS, 2016). According to UNAIDS, “young women aged 15–24 years are at particularly high risk of HIV infection.” Evidence in sub-Saharan Africa points to the fact that “young women accounted for 25 percent of new HIV infections among adults and women accounted for 56 percent of new HIV infections among adults.” (UNAIDS, 2016).

The causes of this disproportionate transmission rate between men and women are attributed to gender inequalities, including gender-based violence. The UNAIDS suggests that these factors “exacerbate women's and girls’ physiological vulnerability to HIV and block their access to HIV services.” (UNAIDS, 2016).

In addition to women being at the centre of high infection rates, recent evidence suggests that there has been increased new infection rates among young people including adolescents in the region. This increase may be because of young people having limited or no access to quality “information and the freedom to make free and informed decisions about their sexual health”. (UNAIDS, 2016). This ultimately has resulted in them lacking the necessary life skills to protect them from HIV (UNAIDS, 2016).

Last, but not least, key populations including sex workers, prisons, transgender people, prisoners and gay men and other men who have sex with men have a higher risk of becoming HIV positive when compared to the general population. (UNAIDS, 2016). This is because of the fact that stigma and discrimination do not allow KPs equal access to health and human rights and thus they are disadvantaged in African health care settings.

The number of new HIV infections per 1,000 uninfected population (15-49 years) as an indicator provides a good

estimation of how well the response is toward HIV and AIDS in any population. The map shows that most African countries have low rates of new infections of persons within the age group 15 to 49 years. The following countries have HIV new infections rates below 5 percent: Algeria (0.02), Angola (1.86), Benin (0.69), Burkina Faso (0.45), Burundi (0.18), Côte d’Ivoire (1.88), Cabo Verde (0.6), Cameroon (3.57), Central African Republic (2.4), Chad (1.02), Democratic Republic of the Congo (0.34), Djibouti (1.09), Egypt (0.03), Equatorial Guinea (0.24), Eritrea (0.21), Gabon (1.39), Gambia (1.24), Ghana (0.77), Guinea (1.18), Kenya (3.52), Liberia (0.56), Madagascar (0.5), Malawi (3.82), Mali (1.05), Mauritania (0.28), Mauritius (0.42), Morocco (0.07), Niger (0.19), Rwanda (1.41), Senegal (0.14), Sierra Leone (0.69), Somalia (0.48), Togo (1.21), Tunisia (0.04) and Tanzania (2.11).

Inherently, several countries that have high HIV prevalence have moderately low new infections rates of between 6 to 10 percent. These countries include Botswana (9.37), Mozambique (7.07), Namibia (6.79), Zambia (8.55) and Zimbabwe (8.84). In addition, South Africa (14.4) has a slightly higher rate compared to it counterparts in the Southern African region. The highest rates for new infections continues to be in Lesotho (18.8) and Swaziland (23.6). As highlighted, this increased risk of new infections happening in Lesotho and Swaziland could be because of a poor coordinated response toward HIV (UNAIDS, 2016). Recent evidence from Swaziland shows that new infections have reduced by 44 percent. There are several possible explanations as to why there are higher rates of infection in the southern parts of the continent. These include: the neglect of marginalised populations such as adolescents, sex workers, men who have sex with men and injecting drug users (UNAIDS, 2016).

Over the years, HIV prevalence has been used to measure the extent to which the epidemic has spread through out...
Indicator: HIV prevalence

Most African countries have HIV prevalence below 5 percent. The following are the prevalence rates of countries across the continent: Algeria (0.1), Angola (2.2), Benin (1.1), Burkina Faso (0.8), Burundi (1), Cameroon (4.5), Cape Verde (1), Central African Republic (3.7), Chad (2), Côte d’Ivoire (3.2), Democratic Republic of the Congo (0.8), Djibouti (1.6), Egypt (0.1), Equatorial Guinea (4.9), Gabon (3.8), Gambia (1.8), Ghana (1.6), Guinea (1.6), Liberia (1.1), Madagascar (0.4), Mali (1.3), Mauritania (0.6), Mauritius (0.9), Morocco (0.1), Niger (0.5), Rwanda (2.9), Senegal (0.5), Sierra Leone (1.3), Somalia (0.5), South Sudan (2.5), Sudan (0.3), Togo (2.4), Tunisia (0.1), and Tanzania (4.7).

In addition, it can be noticed that the highest rates in Eastern Africa are in Kenya (5.9), and Uganda (7.1) except for Malawi (9.1) which make up the continent’s prevalence rate of between 6 – 10 percent. Standing at a rate between 11 -15 percent, Mozambique (10.5), Namibia (13.3), Zambia (12.9) and Zimbabwe (14.7) make up some of the highest rates in Southern Africa. The highest rates are in South Africa (19.2), Botswana (22.2), Lesotho (22.7) and Swaziland (28.8).
Public health evidence continues to advocate for the consideration of a life-course approach in dealing with sexual and reproductive health and rights. The failure to do so leaves individuals in a position where their various health needs across the span of their lifetime are not addressed. Importantly, many young people find themselves unable to access their full sexual and reproductive health and rights (Peter Sheehan, 2017). In Africa, adolescents remain marginalized from the general population for many reasons including the fact that the decision to realize their sexual and reproductive health is placed in the hands of their parents, community and the government (The Lancet Commission, 2016). Today, evidence shows that adolescents face several problems including the increasing rates of HIV infection and high rates of teenage pregnancy (UNAIDS, 2016) (UNFPA, 2016). In addition, adolescents lack the necessary information on sexual and reproductive health and rights which should usually be provided by comprehensive sexuality education (UNESCO, 2016).

Generally, these problems exist among adolescents across the continent, despite the fact that several countries (including South Africa) have been signatories to the Convention on the Rights of the Child (which makes governments a principle custodian of their transition through childhood to adulthood) (Edilberto Loaiza, 2013). This transition includes ensuring that they transition as healthy individuals. Therefore, failure to ensure this means that governments have failed to meet the goals and principles of the Convention on the Rights of the Child (Edilberto Loaiza, 2013). Unfortunately, girls face more challenges in realising their rights compared to their male counterparts and they are more vulnerable and at risk of lower health and social outcomes (UNFPA, 2016). This vulnerability of girls is explained and illustrated with examples of teenage pregnancies that affect many girls in Africa. According to the South African Demographic Health survey, the country’s “age-specific fertility rate for teenagers was 71 births per 1,000 women aged 15-19 years”, which makes up 16 percent of women aged 15-18 in South Africa (Statistics South Africa, 2017). Unfortunately, 16 percent as the number of child bearing women aged between 15-19 years has not changed since 1998 (Statistics South Africa, 2017).

Consequently, these high rates of teenage pregnancy don’t only have health implications but also socioeconomic that prevents girls from fully developing their future (Statistics South Africa, 2017). In the case of health and more specifically sexual and reproductive health, teenage pregnancy is not only a risk for the mother but also the child born. Evidence shows that small percent of children born from teenage mothers are unlikely to survive due the increased risk of sickness (Statistics South Africa, 2017). In the case of the mother, evidence shows that teenage pregnancy increases the risk of maternal mortality (UNFPA, 2016). Unwanted and unplanned teenage pregnancy prevents girls from completing their education. All too often there is a failure by governments to ensure school re-entry programmes. Globally, it is recorded that only 40 percent of countries have ensured “school completion programmes for pregnant girls”, a discrimination that does not only affect the mother but also the development outcomes of the child (UNFPA, 2016). This failure to ensure that girls return to school makes it difficult to achieve any of the national development
goals in any country or to achieve the Sustainable Development Goals (Goal 4 that aims at ensuring “inclusive and equitable quality education and promote lifelong learning opportunities for all” (United Nations, 2017). Another issue highlighted as a huge sexual and reproductive health outcome for adolescent is that of the increasing rates of HIV incidence among adolescents. Regionally, sub-Saharan Africa has a huge share of new infections with 450,000 000 (CI: 380,000 – 530,000) new infections in 2015 occurring among adolescent girls and young women within the age range of 15 to 24 years (UNAIDS, 2016). Reducing these high rates of HIV infections among adolescent is not only essential for achieving Sustainable Development Goal 3 (Target 3.3), but also HIV specific target of fewer than 100,000 new HIV infections within the above age group (United Nations, 2017) (UNFPA, 2015) (UNAIDS, 2016). Examining South Africa shows that the country continues to have one of the highest new infection rates among adolescents in comparison to any other country in the Southern and East African region (UNAIDS, 2016). Subsequently, this incidence is higher among young women aged between 15 and 24 years (Ibid). This is with much of infections happening in urban settlements. The impact of these new infections leads to WHO estimating that the likelihood of a girl from dying from AIDS is higher than that of dying from any other cause (UNFPA, 2016) (UNAIDS, 2016).

Views on the causes of the increasing adolescent rates range from behavioural, structural and biological factors.

<table>
<thead>
<tr>
<th>Factors that Influence the increased incidence of HIV among Adolescents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Behavioural</strong></td>
</tr>
<tr>
<td>1. Age-disparate sex</td>
</tr>
<tr>
<td>2. Multiple partnerships</td>
</tr>
<tr>
<td>3. Transactional sex</td>
</tr>
<tr>
<td>4. Early sexual debut</td>
</tr>
<tr>
<td>5. Sex work and sexually exploited adolescent girls</td>
</tr>
<tr>
<td>6. Gaps in knowledge and limited personalized risk</td>
</tr>
<tr>
<td><strong>Structural</strong></td>
</tr>
<tr>
<td>1. Harmful social and gender norms, gender inequality and unequal power dynamics</td>
</tr>
<tr>
<td>2. Low primary and secondary school attendance</td>
</tr>
<tr>
<td>3. Barriers to accessing sexual and reproductive health and HIV services</td>
</tr>
<tr>
<td>4. Gender-based violence</td>
</tr>
<tr>
<td>5. Child abuse</td>
</tr>
<tr>
<td><strong>Biological</strong></td>
</tr>
<tr>
<td>1. Biological susceptibility of women</td>
</tr>
<tr>
<td>2. Biological susceptibility of adolescent girls</td>
</tr>
<tr>
<td>3. High HIV viral load among male partners</td>
</tr>
<tr>
<td>4. Low prevalence of male circumcision</td>
</tr>
<tr>
<td>5. Harmful practices</td>
</tr>
</tbody>
</table>

Source: (UNAIDS, 2016)

As the evidence shows, several factors stand in the way of young people fully realizing their sexual and reproductive health and rights. In the case of girls, their right to privacy and bodily autonomy is deprived in many including their parents that would have to give consent to access sexual and reproductive health commodities including contraceptives (UNAIDS, 2016). Furthermore, the importance of comprehensive sexuality education has been overlooked coupled with the unavailability of youth friendly services at health facilities (UNFPA, 2016) (United Nations, 2017) (African Union, 2016). In conclusion, addressing the barriers that affect adolescents through the provision of comprehensive sexuality education and unrestricted access to sexual and reproductive health services would ensure that national goals to improving adolescent health and the goal development agenda is achieved (UNAIDS, 2016) (United Nations, 2017) (South African National AIDS Council, 2016).
From the figure we can see that only two countries across the continent of Africa have been able to allocate above the recommended 15 percent by Abuja Declaration. These two countries are Malawi (17 percent) and Swaziland (17 percent).

It can also be noticed that a majority of Southern and Eastern African countries allocate between 11 and 15 percent of their national budgets to health. A few West African countries also allocate similar amounts. The following are the countries allocating between 11 percent and 15 percent: Burkina Faso (11 percent), Burundi (13 percent), Cape Verde (11 percent), Central African Republic (14 percent), Djibouti (14 percent), Kenya (13 percent), Lesotho (13 percent), Liberia (12 percent), Namibia (14 percent), Sao Tome and Principe (12 percent), South Africa (14 percent), Sudan (12 percent), Tunisia (14 percent), Tanzania (12 percent), and Zambia (11 percent).
A majority of West African countries allocate less than 10 percent of their national budgets. These countries are Algeria (10 percent), Benin (10 percent), Botswana (9 percent), Chad (9 percent), Comoros (9 percent), Congo (9 percent), Côte d’Ivoire (7 percent), Equatorial Guinea (7 percent), Gabon (7 percent), Ghana (7 percent), Guinea (9 percent), Guinea-Bissau (8 percent), Mauritania (6 percent), Mauritius (10 percent), Mozambique (9 percent), Niger (8 percent), Nigeria (8 percent), Rwanda (10 percent), Senegal (8 percent), Togo (8 percent) and Zimbabwe (8 percent). Lastly, Angola (5 percent), Libya (5 percent) and Morocco (0) have allocated 5 percent or less. There is no data from Somalia and South Sudan.

Indicator: Health spending per capita

Uganda’s steps toward accountable health budget allocation

Uganda is a country that in 2015 reported life expectancy for both sexes at 54 years (African Health Observatory, 2016) and a country that continues to struggle with supplying the most basic health requirements required under the Millennium Development Goals. For example, Uganda struggled with MDG Target 7c, which aimed to half the proportion of people without sustainable access to safe drinking water and basic sanitation. The east African country reached the goal for the percentage of population using improving drinking water sources (moving from 40% in 1990 to 79% in 2015) but failed to meet the goal for the percentage of the population using improved sanitation (at 19% in 2015, up only marginally from 13% in 1990) (African Health Observatory, 2016).

It is in this context that budget allocation to development, budget allocation to health and to sexual and reproductive health and rights is important to this discussion. One tool for monitoring African countries’ commitments on domestic funding for development and health is the African Union Commission the Africa Scorecard on Domestic Financing for Health. It is a tool to monitor financial planning and health sector performance. The scorecard was adopted by the Member States Experts is recognised as a useful monitoring tool. (African Union Commission, 2016) According to various estimates, countries should spend between $75 and $100 per person on health, however in this AU Scorecard Uganda is spending $13 (African Union Commission, 2016). The AUC Scorecard also analyses sources of health expenditure by source, to determine who is paying for health in a country. In 2014 data Uganda reported that only 25% of all health costs were covered by the Ugandan government, with 36% coming from external resources and 41% coming from households themselves. (African Union Commission, 2016) Indeed, Uganda ranks 35 out of the 46 African countries for the percentage spending by households for healthcare (Musango, 2015). In June 2016 The Ugandan Finance Ministry presented a new budget to Parliament that had innovative changes to it such as an increased tax on luxuries such as sweets & confectionaries and personalised number plates, and a higher investment in electricity, oil and gas, ICT, education, health and agriculture appearing positive however, there were also poor absorption rates seen in the previous year, thus the Ministry announced a new system of penalisation of Ugandan Accounting Officers that failed to perform satisfactorily. The government reported reconstruction and equipping of nine regional referral hospitals as its capital investment. (Ugandan Parliamentary News, 2016).

However, all is not as well as the Ministry’s reports: The AUC Scorecard also measures countries performance of the 15% allocation to health as per the well-known Abuja commitment. Uganda reported 10.97% in 2014. Worryingly in June 2017, the Uganda Debt Network reports that in 2017/8 despite the overall budget increasing from 20 to 22 trillion Ugandan Shillings, that health will be cut by 953.24 billion Ugandan Shillings from 1827 to 1821 billion Ugandan Shillings. This means that health which previously represented 8.7% in the budget in the 2016/7 year will now be 5.7%, even further below the Abuja commitment of 15%. (Uganda Debt Network, 2017) (New Vision Daily, 2017).
Findings

When analysing performance on any development issue AAI uses the 4 steps we expect from government:

- Policy Development designed to improve access
- Programming to practically determine how to implement
- Implementation at community level that improves access
- Monitoring & Evaluation to measure impact

Steps Expected by Govt: AAI Accountability Literacy 2012 (developed by P. Tucker on behalf of AAI)

This is a simplified but effective way of measuring progress against any issue. It also allows us to analyse:

1. Where in the process a country is?
2. What approach a country is using?
   - Epidemiological Approach (we see data in the implementation and impact portions of the research;)
   - Human Rights Approach (we see progress only on law and policy & oftentimes no progress thereafter)
   - Ad Hoc/Low Hanging Fruit/Strategic Approach (we see progress across various steps)
Findings

One way to analyse the collection of data in this report is to understand how countries are performing on policy. Whether policy has been transformed into Programming and how and whether and how well this is being implemented. If good policy, is well programmed and implemented, we should see progress in the impact indicators.

POLICY

Generally, across the continent forward thinking policy and commitments have been put in place, and in some cases Africa actually has policies that are leading on the global stage (Munyati, 2017). This is evidenced by the Maputo Protocol, Maputo Plan of Action and Resolution 275. However major gaps in policy still exist: Policy of access to safe abortion remains limited, and only a few African countries provide limited provisions within their law for full access to safe abortion. This is with the example of South Africa, Mozambique, Tunisia and Zambia. In contrast, most of African countries prohibit abortions altogether making it difficult for women to fully realize their sexual and reproductive health and rights. One of the major reasons for these non-progressive stances in Africa on abortion are due to pre-colonial laws and the influence of religion. Policy on child marriage remains contradictory in many countries, allowing for loopholes which those wishing to marry children are able to use to commit these human rights crimes. Regarding CSE, most countries are making progress on policy in this regard.

PROGRAMMING & IMPLEMENTATION

Once policy has been agreed upon (whether at country, sub-regional (for example East Africa) or regional (Africa), national governments are expected to domesticate them by ratification and then move to step two which is to then ensuring that they develop programmes aimed at implementation. This usually takes the form of guidelines and programming efforts against the law itself. These programmes then need to be implemented at community level. Indicators like access to safe abortion, ante-natal coverage, unmet need for contraception, and youth access to contraception all reflect whether programming and implementation has been done, and done in a quality manner.

IMPACT

Once all investments are made in sexual and reproductive health and rights, the returns are translated with change in impact indicators such as: maternal mortality, child marriage prevalence, HIV prevalence and FGM prevalence. Africa is not performing well on most of the indicators that show impact. Although there is improvement over tie (not demonstrated in this report) the progress is too slow and the impact indicators how this.

CONCLUSION IN SUMMARY

Thus we can only conclude that forward thinking, inclusive and gender informed policy needs to be made, excellent programming and implementation with adequate budgeting then committed to and completed and only then will we see the necessary impact. Africa needs leadership that is fully accountable to women and children and this is currently lacking.
Using the AAI Accountability Framework, this section aims to systematically and strategically identify key necessary interventions that will be necessary to advance sexual and reproductive health and rights for women and girls in Africa. The Accountability Framework, developed by leaders in the field of accountability, entails three key steps: increasing transparency; promoting dialogue; and supporting action. (AIDS Accountability International, 2010).

**AAI’S ACCOUNTABILITY FRAMEWORK**

AAI use our 3 step Accountability Framework as a lens on all our work. The framework suggests a way to ensure that the principle of accountability is translated from rhetoric into action.

**INCREASING ACCOUNTABILITY**

AAI believes that strong and accountable leadership is necessary to ensure effective responses to health needs. We do this by increasing transparency, promoting dialogue and supporting action to improve the response.

**TRANSPARENCY**

Data, full, relevant, correct, accurate and unbiased data that is methodologically sound, periodically collected and collectively reported, discussed and reported as well as transparent about its failings and limitations is a vital starting point for any discussion on developing a response to health problems.

1. Roll out the collection, analysis and application of disaggregated data at sub-national levels, so at to allow stakeholders to unpack inequalities within countries, and respond in the most strategic way using the evidence.
2. Related to the above, prioritise disaggregated data for women and girls from key populations, especially for LGBT women and girls. Female sex workers are women. Lesbians are women. Trans women are women. Stigma and discrimination will not make these women disappear, and countries need to now begin to disaggregate their data in a way that they can know their health epidemic to know their response.
3. Ensure that adequate budgets are allocated on programmes that address these gaps in data.
4. Increase monitoring and evaluation of the efficiency, effectiveness, accessibility and satisfaction of targeted beneficiaries including women, girls, young people and other marginalised populations including LGBTI groups.
5. Increased transparency by gathering evidence that allows us to understand the gaps between sexual rights policies (where they exist) and related access to sexual health services.
6. Develop research to understand the emerging areas and challenges that for women and girls in Africa face on SRHR issues, for example the changing face of violence committed against women in the context of the emerging social-economic empowerment of women; or the impact of microbicides on women’s access to contraception and STI transmission prevention.
Recommendations

**DIALOGUE**

Dialogue should mean all relevant stakeholders can meaningfully and freely participate, without fear, in the discussions and debates on the delivery and performance of health by public servants, especially in relation to the commitments that they as governments and leaders have made.

1. Prioritise a participatory approach to policy development by ensuring partnerships among various stakeholders are developed to the fullest extent and that all stakeholders are empowered to come to the negotiation table as equals to debate and design SRHR responses for all in a country and at continental level.
2. Include vital concepts and lens such as intersectionalities, human rights, human dignity, decriminalisation, sexual rights and bodily autonomy in all dialogues to ensure inclusive, participatory and local dialogues lead to African-owned solutions.
3. For emphasis, this also means to ensure the full and meaningful participation of beneficiaries of the SRHR responses at all stages in the process: policy development, programme design, implementation at community level and in measuring impact and reviewing policy.
4. Linked to the above is that there is a need to increase utilisation of services by community and targeted populations through continuous feedback about the quality of the services provided.
5. Ensure that adequate budget and other resources are allocated for the implementation of sufficient opportunities for all stakeholders to be able to input throughout the process in order to strengthen the response.

**ACTION**

Action is necessary for public servants to improve their delivery of health, share their successes and learn from their failures making for quality, improved, sustainable and human rights based health access for all a reality. All leaders, not just governments, need to act to ensure transparency and dialogue are part of the health and social justice process.

1. Complete the ratification of pivotal SRHR policies and commitments such as the Maputo Protocol, and MPOA 2.
2. Support the emerging African Union Commission’s African Health Policy Instruments Accountability Framework to ensure it has sufficient resources of all kinds to be implemented in a quality, timely and widespread manner.
3. Continue to advocate for the achievement of the Abuja demand for 15% of national budget being allocated to health, without losing focus on the special needs of Key Populations and other marginalised groups. Quantitative goals cannot overtake qualitative.
4. Allocate adequate and dedicated budgets to ensure the implementation of quality programmes with quality of care in mind at all times.
5. Understand and incorporate into all responses the need for sustainable and resilient systems for health.
6. Ensure that intersectionalities are well understood at continental, national and sub-national levels and form a pivotal lens on all responses.
7. Increase utilization of the developed services based on identified gaps and dialogue.
8. Decrease poor reproductive health outcomes including unsafe abortions, child marriage and maternal mortality.
9. Create evidence based SRHR programming based on the available evidence, disaggregated at sub-national level.
Acknowledgements


COPYRIGHT NOTICE/CREATIVE COMMONS

AIDS Accountability International follows the recommendations provided by Creative Commons (creativecommons.org) to stimulate and facilitate the dissemination of the ratings and other tools we develop. Therefore, AIDS Accountability International under this license gives you the right to remix, tweak, and build upon our work non-commercially; as long as you credit us and that you license your new creations under the identical terms. Others can download and redistribute this work just like the by-nc-nd license, but they can also translate, make remixes, and produce new stories based on our work. All new work based on ours will carry the same license, so any derivatives will also be non-commercial in nature.

FEEDBACK

Bob Mwiinga Munyati, Senior Researcher at AIDS Accountability International is the principal author of this report, supported by Phillipa Tucker, Research and Communications Director at AAI and Amr Awad, Senior Researcher. Every attempt has been made to ensure the accuracy of this report, but any errors or omissions are our own. The author and AAI welcome any feedback, comments, and/or corrections on the content.
Contact Us

AIDS Accountability International

102 Greenmarket Place
54 Shortmarket Street
Cape Town 8000
South Africa

Tel: +27 (0)21 424 2057

4th Floor, Rue de l’Arbre Bénit 44
Ixelles 1050 Brussels
Belgium

Phillipa Tucker: phillipa@aidsaccountability.org
Bob Mwiinga Munyati: bob@aidsaccountability.org
Amr Awad: amr@aidsaccountability.org

Email: info@aidsaccountability.org
Twitter: @AAI_aidswatch
Facebook: /AIDSAccountabilityInternational

www.aidsaccountability.org
References


Statistical Tables. Geneva: UN.


References


SexualReproductiveRightsFactSheet.pdf


