KIT Royal Tropical Institute

FINAL REPORT

Regional Context Analysis of SRHR in Sub-Saharan Africa

Commissioned by: John Viner, Embassy of Sweden, Regional SRHR Team, Lusaka, Zambia
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KIT, Amsterdam
Mauritskade 64
1092 AD Amsterdam
Telefoon +31 (0)20 568 8711

www.kit.nl

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Abbreviations

ACHPR	African Commission on Human and People's Rights
AEC	African Economic Community
AIDS	Acquired Immune Deficiency Syndrome
APHRC	African Population and Health Research Center
APRM	African Peer Review Mechanism
ART	Antiretroviral Therapy
ARV	Antiretroviral
AU	African Union
AUC	African Union Commission
CEN-SAD	Community of Sahel-Saharan States
COMESA	Common Market for Eastern and Southern Africa
COWLHA	Coalition of Women Living with HIV/AIDS (Malawi)
CPA	Cotonou Partnership Agreement
CPF	Continental Policy Framework on Sexual and Reproductive Health and Rights
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organisation
CSW	Commission on the Status of Women
DFID	UK Department for International Development
DHS	Demographic Health Survey
DRC	Democratic Republic of Congo
EAC	East African Community
EACSOF	East African Civil Society Organisations Forum
EAHRC	East African Health Research Commission
ECCAS	Economic Community of Central African States
ECOWAS	Economic Community of West African States
EGDC	ECOWAS Gender Development Centre
eMTCT	Elimination of Mother-to-Child Transmission
ESA	Eastern and Southern Africa
EU	European Union
FEMNET	African Women's Development and Communications Network
FGM	Female Genital Mutilation
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GIPA	Greater Involvement of PLWHIV
GVAW	Gender-based Violence Against Women
HIV	Human Immunodeficiency Virus
ICCPR	International Covenant on Civil and Political Rights
ICPD	International Conference on Population and Development
ICT	Information and Communication Technology
IGAD	Intergovernmental Authority on Development
INGO	International Non-Governmental Organisation
IPPF AR	International Planned Parenthood Federation Africa Region
IPV	Intimate Partner Violence
JAES	Joint Africa EU Strategy
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
MERF	SADC Monitoring, Evaluation and Reporting Framework
MMR	Maternal Mortality Ratio
MoU	Memorandum of Understanding
MPoA	Maputo Plan of Action
MSM	Men Who Have Sex With Men
MTCT	Mother-to-Child Transmission

NAP	National Action Plan
NGO	Non-Governmental Organisation
NHIS	National Health Insurance Scheme (Ghana)
OHCHR	Office of the UN High Commissioner for Human Rights
PAC	Post-Abortion Care
PEP	Post-Exposure Prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLWHIV	People Living with HIV and AIDS
PMNCH	Partnership for Maternal, Newborn and Child Health
PMTCT	Prevention of Mother-to-Child Transmission
PoA	Programme of Action (ICPD)
PrEP	Pre-Exposure Prophylaxis
RCSF	Regional Civil Society Forum
REC	Regional Economic Community
RMNCAH	Reproductive, Maternal, Neonatal, Child and Adolescent Health
RMNCH	Reproductive, Maternal, New-Born and Child Health
SAC	Safe Abortion Care
SADC	Southern African Development Community
SADC-CNGO	SADC Congress of NGOs
SADC-PF	SADC Parliamentary Forum
SDG	Sustainable Development Goal
SOGIE	Sexual Orientation or Gender Identity or Expression
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
UDHR	Universal Declaration on Human Rights
UMA	Union du Maghreb Arabe (Arab Maghreb Union)
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNECA	United Nations Economic Commission for Africa
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UN-Habitat	United Nations Human Settlements Programme
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UNSCR	United Nations Security Council Resolution
USAID	United States Agency for International Development
VAW	Violence Against Women
VCAT	Value Clarification and Attitude Transformation
VCT	Voluntary Counselling and Testing
WAHO	West African Health Organisation
WCA	West and Central Africa
WHO	World Health Organization

Executive Summary

Sexual Reproductive Health and Rights (SRHR) is an important focus of the Swedish International Development Cooperation Agency (Sida) and is embedded in various policy frameworks and strategies, including the Regional Strategy for SRHR in sub-Sahara Africa (SSA) 2015–2021. As part of an in-depth review to reflect on the current strategy and for Sida to develop recommendations to the Swedish government on future regional development cooperation within the area of SRHR in Sub-Saharan Africa, this regional context analysis was conducted, based on the following approach: 1. Incorporate the Guttmacher-Lancet Commission definition of SRHR, 2. Analyse the regional context through the Theory of Change (2018) for the SRHR Strategy and identify possible gaps. The Theory of Change (annex 1) comprises of four result areas related to legal & policy environment, access to quality assured integrated SRHR services, changing social norms and increasing accountability, 3.Frame the context analysis in the Government of Sweden's five perspectives for development cooperation, being poverty, human rights, conflict, gender equality and environment or climate and 4. Identify new developments and challenges not captured in the previous context analysis from 2017/2018.

An extensive literature review was done, including peer reviewed and grey articles, and 14 key informants were interviewed. Limitations were mainly in the responsiveness of informants, quality of the interviews through phone and the limited timeframe not allowing for a re-iterative process. Data from literature was triangulated with insights from interviews.

The findings are presented in four chapters aligning with the outcome areas of the Theory of Change: Legal and policy environment (3.1), access to quality services (3.2), social norms (3.3) and accountability (3.4). Each chapter is divided in sub-chapters that are in line with Sida's discussed information needs and priorities. The chapters provide an overview of (1) the current *situation,* (2) the *gaps* and (3) *considerations for Sida*. The gaps analysis presented in each sub-chapter includes reflections on Sida's core perspectives of poverty, human rights and gender – and when relevant conflict and climate. This executive summary provides a synthesis of the findings from each chapter.

In the Summary chapter key findings are presented in a table where Sida's 5 core perspectives of poverty, human rights, gender equality, conflict and climate change are set out against the four outcome areas of the Theory of Change. The key-findings can be taken along in (re)considerations on Sida's strategy.

SRHR and Sida's five core perspectives for development cooperation

Poverty **-** Despite a global decline in poverty, poverty rates in Sub-Saharan Africa remain high and contribute to poor SRHR outcomes. Poverty reinforces poor SRHR, and poor SRHR reinforces poverty. The poorest women tend to have higher unmet need for SRH services, including modern contraceptives. In many countries fertility rate declines when prosperity and development increase.

Human rights **-** The human rights-based approach to health is translated into health services being available, accessible, acceptable and of good quality (3AQ) for all people, without discrimination of any kind. The momentum around Universal Health Coverage (UHC) is an opportunity to advance SRHR and there is growing consensus that UHC cannot be achieved without addressing SRHR.

Gender equality **-** Gender inequality and restrictive gender norms relate to differences in gendered health behaviours, access to care and gender-biased health systems, in turn reinforcing gender inequalities. The strong link requires gender-transformative programs and policies to achieve progress in SRHR.

Conflict- Rather than merely *conflict*, this context analysis adopted a definition of *humanitarian crisis* that may either be man-made (e.g. armed conflict) or a natural phenomenon (e.g. drought or floods). The need of people for services and protection increases while at the same time systems break down. Women, adolescents, people

with disabilities, ethnic minorities, and people with different Sexual Orientation, Gender Identity and Expression and Sex Characteristics (SOGIESC) are disproportionately affected by crisis and displacement.

Climate- Climate change threatens population health including adverse changes in air pollution, spreading of disease vectors, food insecurity and under-nutrition, displacement and mobility, and mental ill health and subsequently contribute to negative SRHR outcomes. The effects are disproportionately affecting populations and groups that are already struggling the most. Coping mechanisms for scarcity of resources and financial hardship tend to contribute to negative SRHR outcomes: such as migration, transactional sex and Child Marriage, and subsequently to teenage pregnancy. Studies show that met needs for contraception and SRH care are linked to reduced vulnerability and enhanced resilience for climate impacts.

Legal and policy environment

The African Union (AU) has a relatively strong regional normative framework on SRHR, that is challenged in its domestication and implementation and weak in its accountability. For the implementation of resolutions and recommendations in relation to SRHR, the African Commission on Human and People's Rights (ACHPR) depends on the political will of states, their regimes, their priority of human rights and their leadership on Women's rights issues. Low awareness on legal rights and charters such as the Maputo Protocol, further compounded by poverty and illiteracy, challenge domestication and highlight the need to address these issues. This requires advocacy and media coverage to enhance translation of the Maputo Protocol to domestic levels.

The eight Regional Economic Communities (RECs) vary in terms of roles, structures and progress in gender equality and SRHR. Five of the eight RECs (ECOWAS, EAC, IGAD, SADC and COMESA) have explicit normative frameworks in place that contain important commitments on gender equality and women and girls rights, such as gender mainstreaming and women's participation and elimination of discrimination. ECCAS, UMA and CEN-SAD are considered to have a lower level of activity, or at least very little information available. Commitments and frameworks relevant for SRHR were found for EAC (EAC SRHR bill), SADC (SADC SRHR strategy 2019-2030), ECOWAS (ECOWAS regional action plan of action for combatting obstetric fistula in West Africa and ECOWAS roadmap on prevention and response to child marriage) and IGAD (IGAD regional strategy implementation plan 2016-2020 Pillar 2 programme area 3). Apart from context-specific needs, REC's generally expressed the need for technical and financial support for regional accountability mechanisms, strengthening advocacy roles and availability of evidence and data.

Despite the relatively strong policy frameworks on SRHR and gender equality, the emphasis is largely on *reproductive* health & rights, while *sexual* health and rights are under addressed (and highly disputed). This shows the added value of Sida focusing on the 'sexual components' of the Guttmacher-Lancet SRHR definition. In addition, the poorest and most vulnerable populations are still left behind, there is a lack of strategies to achieve UHC and a risk for fragmentation of SRHR services, especially in fragile settings where restrictive policies and misinformation about existing policies prevent implementation of critical comprehensive SRHR services. This shows the need for ongoing attention for people living in poverty or in humanitarian crises.

Continental and sub-regional funding streams

In this sub-chapter a selection of funding streams for SRHR is described, focusing on EU funding, alignment and gaps in vertical funding from the 3 G's (Global Fund, Gavi and GFF) and domestic resource mobilization. Special attention is given to the financing of commodities.

With the launch of the Global Financing Facility (GFF) in 2015, another vertical funding program came into existence. To avoid overlap and mitigate the risks of inefficiency, the Global Fund, GFF and Gavi developed a paper to clarify mandates, common principles, and approaches, and propose concrete areas for intensified collaboration across the three organizations: Health Systems Strengthening, in country coordination, global coordination and governance, health financing strategies and public financial management, technical assistance and risk management.

Despite a positive trend in government ownership on how to spend donor money, the contentiousness of SRHR, both globally as in the EU, and complexity of co-management principles, leave little space for sexual rights components in funding. For example, few GFF Investment Cases respond to the unique needs of adolescents, such as youth-friendly services, and integration of comprehensive SRHR in negotiations on a post-Cotonou agreement (African-European partnership) is challenged by resistance from both EU as AU member states, contesting against SRHR concepts. The role of civil society in advocating and holding states and programs accountable for the integration of comprehensive SRHR, is challenged by the opacity around mechanism decision-making approaches and processes, lack of optimal inclusion of key stakeholders including CSOs, and the absence of sustainable financing mechanisms for CSOs. The tight procedures for financial reporting and NGOs' dependence on (Global Fund) funding have been argued to further contribute to redirecting accountability away from grass-roots constituencies and undermining or de-politicisation of the critical position of civil society on programme priorities.

Further linking to the global funding mechanisms, following the alignments and intensified collaboration and building alliances with like-wise donors, could create further opportunities to define the agenda, monitor the accountability mechanisms that are in place, including the involvement and support of civil society and young people when defining the investment cases and leverage on lessons learned cross-mechanism.

Domestic Resource Mobilization (DRM), a challenge and necessity for countries, is a generally integrated component in these programs. Even though, a recent in-depth comparative analysis on GFF processes in seven focus countries, showed there is little, if any, evidence, that this process has been able to unlock domestic resources for RMNCAH-N. The Abuja declaration target, being the commitment of states to allocate a minimum of 15% of their annual public budget to strengthen the health sector, comes with some limitations and the 2018 Africa Scorecard on domestic financing for health show that hardly any government met this target. Arguably, a more insightful target is to assess public spending on health in relation to GDP. Based on this measure significant variation can be observed from the Africa Scorecard between the most fragile, conflict-affected countries of the continent, with less than 1% of GDP being spent on health from public funds on the one hand to a number of Southern African countries spending between 4 and 5% of GDP on health from public funds.

Global and regional conservative forces contributed to a decrease in the contraceptive market of the public sector in the last years, risking an increase in unintended pregnancies, (unsafe) abortion and maternal morbidity and mortality. Due to deterring regulatory environment in many countries it remains challenging for pharmaceutical companies and other private sector initiatives to clear and register commodities and organizations. Harmonization among national medicines regulatory authorities (NMRAs) remains challenging and many countries struggle with their administrative and technical capacities to control medicines and quality. RECs could play a crucial role in the harmonization process. Secretariats of RECs have the necessary infrastructure to support harmonization. RECs can

bring member states together to identify similarities and differences, and work towards harmonized standards, guidelines and policies, or even a mutually recognized framework (making use of internationally recognized standards and best practices, such as good manufacturing practices, information management systems and quality management systems). Furthermore, joint assessments of regulatory systems could be supported by RECs to identify gaps and develop recommendations.

Access to quality services

While the overall contraceptive prevalence rate and coverage of MNCH services increased, the maternal and newborn mortality, child marriage, female genital mutilation/cutting (FGM/C) and HIV prevalence rates and AIDS related deaths declined and fewer women are dying from unsafe abortion, sub-Saharan Africa still accounts for the majority of global maternal deaths. In addition, sub-Saharan Africa has the highest unmet need for modern contraceptives, the highest adolescent birth rates, the highest child marriage rates, the highest burden of STIs including HIV in the world and a high total fertility rate. While over the last 20 years the increase in access to SRH services in several sub-Saharan African countries is considered substantial, the levels of inequality in the uptake of services remain high. The poorest populations, adolescents, people in countries facing humanitarian crisis, and women with specific health needs, people with disabilities and LGBTQI people have not yet shared equally in the developments, and substantial inequalities across and within countries in key indicators remain. Inequities in accessing SRH services are affected by income inequality, the quality and reach of health systems, laws and policies, education, social and cultural norms, and people's exposure to information and sexuality education.

The majority of adolescent women in need of contraception do not use a modern method and complications during pregnancy and childbirth are a leading cause of death among adolescent girls in sub-Saharan Africa. The majority of all abortions in sub-Saharan Africa is conducted unsafe. There is a great diversity of legal status of abortion among the different countries in sub-Saharan Africa varying from upon request, broad social and economic grounds, to preserve health, to save a woman's life and prohibited altogether. Restricting access to abortions does not reduce the number of abortions, but in those countries where abortion is illegal the likelihood of women undergoing *unsafe* induced abortion is significantly higher. Adolescents and young people are more susceptible for sexual transmitted infections: the prevalence rates of all STIs, except for HIV and chlamydia, have increased among adolescents. The gender divide in HIV transmission remained almost unchanged: women, and especially adolescent girls and young women, are more likely to acquire HIV than (young) men. Adolescent girls and young women account for one out of four HIV infections. While there is an increasing trend in cervical, breast and ovarian cancer observed in sub-Saharan African, there is limited awareness, and screening and treatment services available. One of the most commonly reported cause of infertility in sub-Saharan Africa is infection-related tube damage, due to STIs, post-partum infections, or infections after pregnancy loss, and primarily due to unsafe abortion. With infertility remaining invisible and highly tabooed, affordable and quality fertility care is nearly non-existent in sub-Saharan Africa. There is an increasing trend observed for intimate partner violence (IPV) at least among adolescent girls. Especially adolescent girls and young women, elderly women, women with disabilities, female sex workers and LBT women are more exposed and vulnerable for non-partner sexual violence. In addition women and girls in conflict or fragile states face specific threats and types of violence. Human trafficking mostly takes place within countries in Africa than across borders. FGM/C is prevalent in 27 African countries and an overall decline is observed. Being a violation of rights for both boys and girls, child marriage is

more common among girls than boys. While child marriage in sub-Saharan declined and the age at first marriage increased for both women and men, the levels of child marriage are still the highest in sub-Saharan Africa. Child marriage is related to early pregnancy, social isolation, school drop outs and increased risks of intimate partner violence. Sexual health, sexual rights and sexual pleasure are fundamental for people's health and wellbeing. There are serious gaps with regard to these aspects in SRHR policies, programming and research and these elements are mainly reviewed from a disease perspective. Addressing men's SRHR is essential to address both the SRHR and gender inequality agenda. Comprehensive sexuality education (CSE) in combination with the development of life skills is an evidence-based strategy that positively influences outcomes on all SRHR indicators and gender equality. The complementation of CSE with strengthened youth-friendly services, condom distribution and engaged key gatekeepers is essential also to reach marginalized young people. While many countries in sub-Saharan Africa realized the need for CSE for young people, a major gap remains between continental and regional policies and the actual implementation and monitoring of CSE on the ground.

Inequity in access: generally, access to SRH services is lowest among the poorest households and highest among the richest. Catastrophic health expenditures and impoverishment are described to be highly prevalent in sub-Saharan Africa. Catastrophic health expenditure is shown to be associated with adolescent pregnancy and GBV, and patients with HIV face the highest incidence of catastrophic expenditure due to their continued health expenses. While the private sector is reported to be the preferred source for obtaining modern contraceptives for (young) women in some countries, perceived as high quality, available, convenient, respecting privacy and confidentiality, and less provider stigma, the contribution of private providers to improve access to the very poor is limited in many countries in sub-Saharan Africa due to the associated costs and limited distribution of private health facilities in remote areas. Critical gaps in efforts to implement adolescent SRHR policies, programs and (quality youth-friendly) services are identified, which are impeded by extensive resistance to provide comprehensive SRHR information and services to adolescents due to legal restrictions, social and patriarchal norms and taboos around adolescents' sexuality. There are major setbacks in terms of human rights and LGBTQI. Same sex relationships are still criminalized in many countries in sub-Saharan Africa which can force people into hiding and prevent them from seeking or receiving the information and services they need. Competing priorities ensuring access to basic lifesaving services for displaced people, contribute to a lack of quality SRHR services. The focus predominantly goes towards safe motherhood interventions while programs to prevent and respond to SGBV, family planning and comprehensive contraception services and safe abortion care, as well as adolescent SRHR are under-prioritized. In the measurement of UHC and consequently SDG3, quality of care is hardly taken into account.

Social norms

Social norms continue to shape the discourse on gender equality, sexual orientation and gender identity (SOGI), safe abortion, and adolescents' access to SRHR across sub-Saharan Africa. Across sub-Saharan Africa, discriminatory social and cultural norms are translated into laws (e.g. parental or spousal consent, age-restrictive legal norms) that act as barriers to women and girls accessing SRH services, increasing their vulnerability to poor SRH outcomes.

Poverty is an overarching factor that exacerbates negative SRHR outcomes in sub-Saharan Africa and is further complicated by gender inequalities. Across sub-Saharan Africa, studies show poorer women

more likely to experience earlier sexual debut, to have multiple sexual partners and partners who are six or more years older and to report having had sex for material or financial support. Violence against women, including intimate partner violence and rape, is another consequence of gender inequality. RECs are working to address gender inequality by adopting national gender strategies and implementing legislative reforms, e.g. ECOWAS roadmap on prevention and response to child marriage, but legal loopholes and customary practices often weaken women's rights.

Violence and discrimination remain the most concerning legal, social issues facing LGBTIQ persons and communities. None of the East Africa countries have anti-discrimination legislation and hate crime laws to protect persons from bias or discrimination on the grounds of their SOGI, while legislation in West and Southern Africa is diverse. Evidence shows that governments of non-criminalizing countries have signalled support for Sexual Orientation and Gender Identities (SOGI) issues in several areas, including ending discrimination in education and supporting LGBTI asylum-seekers. Human rights abuses related to SOGI that occurs at the borders require that national governments train their border officials on these issues.

Abortion remains legally restrictive in most African countries, and efforts to repeal laws in order to reverse the situation attract strong opposition and controversy. Even in countries where abortion laws are less restrictive, access to abortion services is still a challenge because of the negative attitudes of healthcare providers. Expanding legal space for abortion ensure that women do not have to risk their health by resorting to clandestine abortion. Efforts for legal reforms should be complemented by strategies to address social norms at multiple levels, including providers, legal and political authorities. In highly restrictive settings improving the quality and coverage of post-abortion care remains crucial to saving lives and protecting women's health. Also, providing accurate information on how to safely use misoprostol should be widely conveyed to help make clandestine abortions safer, improve women's health and chances of survival, and reduce the heavy financial burden of providing post-abortion care, which poor African countries continue to struggle with budgetary allocation to health. Evidence shows that approaching LGBTIQ and abortion issues from a public health perspective allows people to come to the table. Child marriage, teenage pregnancy prevention and maternal mortality remain the best entering points to address abortion with national governments. ECOWAS and SADC strongly focus on Child Marriage. Opportunities can also be found in other sectors such as the education sector to achieve progress in the area of SRHR.

Education and keeping girls in school increase girls chances of becoming financially secure and independent, lower exposure to intimate partner violence, reduce the risk of HIV infection and expose girls to comprehensive sexuality education (CSE) – evidence shows CSE that explicitly focuses on gender rights and gender power dynamics is five times more effective than CSE programmes that do not, particularly in reducing unwanted pregnancies and new STIs infections. In some setting there are challenges to implement CSE at schools. Sometimes when it is brought under another label it is more accepted. The implementation of CSE policies across sub-Saharan Africa are faced by the challenge of labelling CSE to mean indoctrinating young people on LGBTIQ. Locally-generated, context-specific data to dispel these beliefs are urgently needed.

Transforming discriminatory social norms requires a solid understanding of the political economy and territorial realities. These efforts must be endogenous. Interventions are needed at regional, national, and grassroots levels and require the involvement of a wide range of stakeholders, including men and boys, to change attitudes on gender roles. For example, nationwide awareness-raising campaigns to

address social stigma, condemn victim shaming and support survivors of gender-based violence have proven efficient. Legal reforms to protect women's rights can also be backed by legal literacy programmes to help women, families and communities understand their legal rights to health and integrity. National and regional governments and research institutes need support to generate and manage data on sensitive SRHR topics and present it in a language that can convince policy makers on the need for paradigm shift in those topics. Advocacy remains crucial, with support to advocacy networks and civil society to mount advocacy efforts aimed at removing barriers like parental and spousal consent, which are critical for scaling up services and increasing access for adolescents.

Accountability

Accountability is fundamental for applying human rights to health and achieving universal access to comprehensive SRHR, in which inclusiveness and transparency are key. In the health sector, accountability can take many forms as described such as social, performance and political. To promote political accountability for the Sustainable Development Goals, which have specific targets and indicators to track progress, a 'follow-up and review framework' was agreed upon. The High Level Policy Forum (HLPF) has a central role in overseeing the follow-up and review; voluntary national reviews are presented at HLPF meetings as an indication of political ownership of national governments of the 2030 Agenda process. Since 2016, seventeen countries from sub-Saharan Africa have been reflecting upon their progress. As a result of intergovernmental negotiations about global accountability versus national sovereignty, there is no formal M&E or accountability system for the SDGs. The Agenda lacks enforceability as there are no sanctions nor consequences if governments fail to implement the SDGS – unless regional and binding commitments are aligned with the 2030 Agenda. The involvement of civil society and other key stakeholders in the HLPF remains limited, and there is no official status given to consolidated CSO alternative reports within the overall HLPF cycle.

In terms of political accountability for the Maputo Protocol, (which is binding for countries who ratified the protocol), the African Commission on Human and Peoples' Rights (ACHPR) reviews national level progress of implementation and provides guidance towards implementation. Cases of human right violations are prepared for submission to the African Court of Human and Peoples' rights (AfCHPR). There is a special rapporteur on rights of women monitoring specifically violations of women's rights. Again, there are no sanctions for failed implementation, but there are follow up mechanisms to promote implementation of the Commissions' recommendations; promotional visits by country rapporteurs and letters of appeal. CSOs also have opportunities to contribute to the review process by submitting shadow reports. Progress and implementation depend on the political will and leadership of States. Efforts towards weakening the accountability mechanisms are observed and the budget of the Commission is under pressure; retrogressive reviews of the protective mandate of the Commission and limitations of the civic space are proposed. The current technology trends provide an new window of opportunity: the power of social media is changing accountability opportunities.

The New Partnership for Africa's Development (NEPAD) is the strategic framework for socioeconomic development and is mainly implemented at the REC level. Within this framework the AU established the African Peer Review Mechanism (APRM). It is a tool where member countries go through a process of self-assessment and peer-review mission with broad consultations. Membership is voluntary and currently signed by 38 AU countries. A review of the process and reports emphasized the reliance on political will in a voluntary process; the lack of an M&E framework; and the need to deploy existing opportunities and synergies with key pan-African institutions. While strong continental and regional

SRHR policy frameworks, instruments and accountability mechanisms exist, there are gaps in implementation due to limited capacities and commitment of some member states. The most reported form of accountability is peer pressure between national governments during the regional reporting meetings, but not always towards SRHR progress.

Social accountability is described as actions by 'social actors' (such as citizens and civil society) to demand public officials and politicians to be accountable for their actions. Van Belle et al., described performance accountability as internal systems to support the functioning of health facilities and the objectives of health providers – for governments to demand health care service providers and systems to be accountable with Health facility committees serving as an extension of service providers and engage in community outreach, the co-management of health centre resources and the facilitation of repairs and fundraising. The review showed that in general when social and performance accountability are used within the SRHR sector it is mainly linked to the (quality of) maternal, neonatal and child health services, while legal and political accountability also addressed HIV, GBV and LGBTI concerns. Rights are at the centre of social accountability and citizens should be given the space and the authority to define their own needs and act upon them. Balance score cards, opinion boxes, audits, health reference groups, engaging communities are all seen as social accountability tools. The voices of the poorest and the most in need should be heard and services should be responsive to them. Transparency, space to act, incentives and relations between different actors are reported to be key, aimed at transforming citizen-state relationships in favour of the poor. A thorough understanding of local dynamics and incentives is needed, in order to build relationships based on trust. Besides space to act and financial constraints there are gaps in the knowledge how gender, power dynamics and other social hierarchies play out and influences realities as well as (social) accountability initiatives and processes. Social and performance accountability programs are mainly linked to maternal and reproductive health, leaving out sexual health and rights.

The meaningful participation of civil society actors in SRHR accountability matters depends highly on the general political space for expression and dissent, which varies enormously across sub-Saharan Africa. The democracy advocacy organization Freedom House claims that after much progress in the 1990s and early 2000s the sub-Saharan Africa region has seen a backsliding in recent years. At present it considers only 9 countries in the region to be 'free': Mauritius, South Africa, Botswana, Namibia, Benin, Ghana, Senegal, Sao Tome and Principe and Cape Verde. Central Africa and the Horn of Africa are dominated by repressive regimes. The political and civil space is closing in an increasing number of countries. Around 20 countries across the continent have attempted to introduce or are in the process of introducing legislation or policies that constrain non-governmental organisations (NGOs), particularly those working on human rights, including LGBTQI rights and governance issues. These restrictions violate global and regional human rights treaties.

1. Introduction to the report

This report presents a regional context analysis/update on Sexual and Reproductive Health and Rights (SRHR) in Sub-Saharan Africa. The purpose is to provide Sida with answers to the questions as set out in the terms of reference and further specified in an overview of Sida's information needs (see Annex 2). This report contains the background to the assignment, the purpose and scope, the methodology, the findings on the four key result areas of this analysis (policy and legal environment, access to quality SRH services, social norms and accountability), and concludes with the key findings and considerations.

1.1 Background

Sexual Reproductive Health and rights (SRHR) is an important focus of the Swedish International Development Cooperation Agency (Sida) and is embedded in various policy frameworks and strategies, including the Regional Strategy for SRHR in sub-Sahara Africa (SSA) which covers the period 2015–2021 and comprises a total of SEK 3.2 billion. This Regional Strategy aims to SRHR with a focus is on (i) Women's and children's health and SRHR, (ii) Health and SRHR of young women and men and LGBTI people, (iii) Strengthened health systems for greater access to SRHR and (iv) Strengthened democracy and gender equality, and greater respect for human rights with focus on the prevention of GBV and human rights for LGBTI people. Human rights are fundamental for sexuality and reproduction and inherently links the four fields of sexual health, sexual rights, reproductive health and reproductive rights[1].

SRHR is an integral part of the right to health, and the 2030 Agenda for the Sustainable Development Goals acknowledge SRH and reproductive rights. Since 2018, Sida uses the comprehensive definition of SRHR of the Guttmacher-Lancet Commission, resulting from the landmark paper 'Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission' by Starrs et al[2] (see textbox 1 on the next page).

In the area of development cooperation, poor people's perspectives on development and the rights perspective are fundamental and underlying stands for Sida. In addition to these two overarching perspectives, three thematic perspectives - conflict, gender equality and environmental and climate perspectives - are emphasized and reflected in Sida's definition of multidimensional poverty and its conceptual framework[3].

In 2018 a context analysis and a policy analysis were conducted which informed the recommendations that led to the two-year extension of Sida's SRHR strategy in sub-Saharan Africa. A mid-term review (MTR) of the strategy implementation concluded that the broad SRHR agenda, based on a rights perspective and focused on women and young people, regardless of sexual orientation or gender identity and expression, has served as a strong tool for a credible way of driving the SRHR agenda in

[1] Strategy for sexual and reproductive health and rights (SRHR) in Sub-Saharan Africa
[2] Starrs AM, Ezeh AC, Barker G et al., Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission, The Lancet, 2018 - https://www.thelancet.com/commissions/sexual-and-reproductive-health-and-rights
[3] Swedish development cooperation agency, Dimensions of Poverty Sida's Conceptual Framework, Sida, Stockholm 2017 - https://www.sida.se/contentassets/f3e30b6727e8450887950edb891c05af/22161.pdf

sub-Saharan Africa. The MTR resulted in recommendations including a Theory of Change (annex 1) outlining four result areas for which the overall impact is to contribute to SDG 3, 4, 5 and 16[4]:

1. Creating an enabling legal and policy environment for SRHR in sub-Saharan African
2. Expanding access to quality assured integrated SRHR services for women, men, adolescents and young people, and LGBTI
3. Changing social norms around gender equality, sexual orientation and gender identity, safe abortion and adolescents' access to SRHR
4. Increasing accountability for policy adoption and implementation, resource allocation, and quality of services

Textbox 1 Comprehensive definition of SRHR, Guttmacher–Lancet Commission 2018

Sexual and reproductive health is a state of physical, emotional, mental and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction or infirmity. Therefore, a positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust and communication in promoting self-esteem and overall well-being. All individuals have a right to make decisions governing their bodies and to access services that support that right . Achieving sexual and reproductive health relies on realising sexual and reproductive rights, which are based on the human rights of all individuals to:

- *have their bodily integrity, privacy and personal autonomy respected*
- *freely define their own sexuality, including sexual orientation and gender identity and expression*
- *decide whether and when to be sexually active*
- *choose their sexual partners*
- *have safe and pleasurable sexual experiences*
- *decide whether, when and whom to marry*
- *decide whether, when and by what means to have a child or children, and how many children to have*
- *have access over their lifetimes to the information, resources, services and support necessary to achieve all the above, free from discrimination, coercion, exploitation and violence."*

The Commission further outlines the following as elements of an essential package of sexual and reproductive health interventions:

- *Comprehensive sexuality education (CSE)*
- *Counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods*
- *Antenatal, childbirth and postnatal care, including emergency obstetric and new-born care*
- *Safe abortion services and treatment of complications of unsafe abortion*
- *Prevention and treatment of HIV and other STIs*
- *Prevention, detection, immediate services and referrals for cases of SGBV;*
- *Prevention, detection and management of reproductive cancers, especially cervical cancer Information, counselling and services for subfertility and infertility*
- *Information, counselling and services for sexual health and well-being*

In 2019 and 2020, an in-depth review is to be done by Sida to reflect upon the implementation of the current strategy as well as define who the most deprived are, and how their living conditions can be improved through Swedish development cooperation. The in-depth review will result in an in-depth strategy report early 2020. As part of this, an updated regional context analysis is needed. This report summarizes the main findings of the context analysis done by KIT royal tropical institute. Through this

[4] *Goal 3. Ensure healthy lives and promote well-being for all at all ages; Goal 4. Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all; Goal 5. Achieve gender equality and empower all women and girls; Goal 16. Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels.*

Sida will make recommendations to the government on future regional development cooperation within the area of SRHR in Sub-Saharan Africa.

1.2 Objectives and scope

The overall aim of the assignment was to conduct an (updated) regional context analysis guided by the Theory of Change that was developed in 2018. The context analysis has a regional focus of the SRHR context and challenges in sub-Saharan Africa, including regional communities such as SADC, EAC, ECOWAS. The assignment was conducted in the period 23 October 2019 – March 2020 with a focus on learning as input for management advice.

The following overall approach is described in the Terms of Reference and proposal:

1) Incorporate the Guttmacher-Lancet Commission definition of SRHR
2) Analyse the regional context through the Theory of Change (2018) for the SRHR Strategy and identify possible gaps
3) Frame the context analysis in the Government of Sweden's five perspectives for development cooperation
4) Identify new developments and challenges not captured in the previous context analysis from 2017/2018

2. Methodology

An overview of key information needs was designed jointly by the KIT team and Sida's regional team in Lusaka based on the expected result areas, and further developed and prioritized during online discussions and consultations. The information needs consisted of 14 elements with corresponding sets of questions within the 4 areas as formulated in the Terms of Reference and Sida's draft Theory of Change. An overview of the elements and key questions are outlined in Annex 2. It informed the topic guide used for the key informant interviews and literature search.

2.1 Literature and documentation review

The desk review encompassed peer reviewed and grey articles related to various elements of the Guttmacher-Lancet Commission's definition of SRHR, and the Swedish government's regional SRHR strategy with a focus on the key topics of the Theory of Change. In addition, previous Sida reports were included such as the 2018 Policy review, the 2018 context analysis, and others[5]. The overview of all reviewed literature and documents can be found in the footnotes.

Search strategy

Beside Google and google scholar search engine, several websites of key organizations, such as Guttmacher, UNFPA, UNICEF, UNAIDS, UNESCO, Worldbank, Family Planning 2020, and Country DHS's have been searched to get insight in (sub-)regional trends and context. To gain access to the latest evidence on the various aspects of SRHR and PUBMED data bases were searched for existing available peer-reviewed literature. The following search terms were used:

Table 1. Overview of search terms used to identify documents and literature

Regions	Africa OR "Southern Africa" OR "West* Africa" OR "Central Africa" OR "East* Africa" OR SADC OR ECOWAS OR EAC, AU/C
	[AND]
SRHR terms	SRHR OR "sexual health" OR "reproductive health" OR "sexual right*" OR sexuality OR gender OR lgbti OR SOGI OR "Comprehensive Sexuality Education" OR sexual health OR sexual pleasure or family planning or CSE OR contracept* OR "maternal health" OR antenatal OR childbirth OR postnatal OR EmONC OR abortion OR Termination of pregnancy or STI OR HIV OR AIDS OR "gender based violence" OR "intimate partner violence" "sexual violence" OR GBV OR "reproductive cancer" OR "cervical cancer" OR HPV OR subfertility OR infertility OR "female genital mutilation" OR "female genital cutting" OR "child marriage"
	[OR]/[AND]
Other terms	Law OR legal; policies OR policy; financ*; "Global Financing Facility" OR GFF; poverty; poor; vulnerable; "human rights" OR "civil rights"; democracy; gender; adolescents; "young people"; teenage; male OR men; migration; conflict; fragil*; humanitarian; environment; climate OR "climate change"; accountability; "civil society"; "service delivery"; "integrated services"; access; "social norms"; quality; discriminat*; "Gag rule" OR "Mexico City Policy" OR MCP OR "Protecting Life in Global Health Assistance" OR PLGHA; consequences OR implications OR effect; prioritiz*; Global Fund; GAVI; vaccine*; "Universal Health Coverage" OR UHC; misconceptions

[5] *Mid-term review Sida's contribution to DKT international; Mid-Term Review of the Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition (RMNCAH&N) Programme in Zambia; Mapping of CSO's working with young people's SRHR needs and social norms transformation in Zambia.*

2.2 Key informant interviews

Key informant interviews were held to gain insight in observations and perceptions of trends and achievements in SRHR & human rights, implications of neo-conservative influences, integration of poverty, human rights, gender equality, conflict, environmental and climate perspectives in the area of SRHR, barriers and opportunities and how to address these and additionally to discuss findings from the desk review.

For the in-depth interviews with key informants, a topic list (annex 3) was developed as a data collection tool based on the Terms of Reference and identified information needs. During the interviews, the issues in the topic list were adjusted to ensure suitability for each type of respondent based on their positions and backgrounds. The interviews, conducted as qualitative telephone interviews, lasted approximately one hour. The team identified key actors based on their knowledge of the field, input from Sida's regional team, internet search and snowballing. Purposive sampling assured all four Theory of Change result areas were covered. In total 25 key informants were approached of which 14 agreed to be interviewed. These included multilateral and network organizations, international NGO's, embassies, Regional Economic Communities (RECs) and private organizations.

2.3 Data processing and analysis

The interview notes taken were further developed. Data from the different types of interviews, as well as the desk review findings, were thereby triangulated and presented in a first draft report. Comments from discussions with Sida were thereafter incorporated. The different topics in the final report were presented on the current situation and then further analyzed on the gaps and considerations for Sida, taking in account the five perspectives for development cooperation of the Government of Sweden: *the perspectives of poor people, the rights perspective* (human rights and democracy), *conflict perspective* (peaceful and inclusiveness), *the gender perspective* (gender equality) and the *environmental and climate perspective* were integrated.

2.4 Limitations

This context-analysis had the following limitations.

- The result areas, elements and key questions identified and fine-tuned since the start of the assignment covered many complex SRHR, UHC, HSS and gender related issues. The time to interview all relevant stakeholders addressing the different result areas and all elements and key questions was therefore limited.
- The short timeframe did not allow for a re-iterative process where literature review and content of interviews iteratively informed each other.
- The key informants invited for the interviews had delays in responding and some did not respond at all or did not show up to appointments made.
- As interviews were conducted through Skype or phone the quality of the interview at times suffered from poor connections affecting the quality of the data.
- Data obtained from interviews is sometimes difficult to verify, although we tried to counteract this by using the principle of triangulation with literature there where possible.

3. Findings

The outline of the draft Theory of Change (see Annex 1) is used to present the findings from the literature review and interviews. The chapters are as follows: Legal and policy environment (3.1), access to quality services (3.2), social norms (3.3) and accountability (3.4). Each chapter is divided in sub-chapters that are in line with Sida's discussed information needs and priorities. The topics start with a short *introduction* followed by an overview of (1) the current *situation,* (2) the *gaps* and (3) *considerations for Sida*. The gaps analysis presented in each sub-chapter includes reflections on Sida's core areas of poverty, human rights and gender – and when relevant conflict and climate. Below a short introduction on the five perspectives related to SRHR are presented.

Perspectives of poor people and SRHR

Poverty has been declining in all regions of the world, except for sub Saharan Africa. According to the World Bank, the average poverty rate is 41 percent in sub Saharan Africa (World Bank, 2019[6]) and out of the 28 poorest countries in the world, 27 are in sub Saharan Africa. The total number of people living in extreme poverty in sub Saharan Africa increased from 278 million in 1990 to 413 million in 2015 (World Bank, 2018[7]). Poverty and SRHR are directly related as poverty reinforces poor SRHR, and poor SRHR reinforces poverty. Poverty is one of the known determinants of unintended pregnancy and unmet need for contraceptives (Rutgers, 2016[8]). Also, the Guttmacher Lancet report of 2018 presents that the poorest women tend to have higher unmet need for SRH services, including modern contraceptives. In many countries fertility rate declines when prosperity and development increase[9].

Core components of the right to health

Availability: refers to the existence and quantity of health facilities, goods, services and information. The commodities available should be based on the WHO Model List of Essential Medicines, including emergency contraception.

Accessibility: takes the cultural, physical and economic access to goods, services and information on a non-discriminatory basis into account.

Acceptability: refers to the facilities, goods, services and information being sensitive to medical ethics and culture of individuals, minorities, peoples and communities. The services and information should be provided in a respectful and ethical manner, sensitive to gender, life cycle requirements, and respecting confidentiality.

Quality: refers to the facilities, goods, services and information being scientifically and medically appropriate and of good quality, such as skilled medical personnel and scientifically and unexpired equipment, medicines and contraceptives.

[6] Beegle, Kathleen; Christiaensen, Luc. 2019. Accelerating Poverty Reduction in Africa. Washington, DC: World Bank. © World Bank. https://openknowledge.worldbank.org/handle/10986/32354 License: CC BY 3.0 IGO

[7] World Bank. 2018. Poverty and Shared Prosperity 2018: Piecing Together the Poverty Puzzle. Washington, DC: World Bank - https://openknowledge.worldbank.org/bitstream/handle/10986/30418/9781464813306.pdf

[8] Rutgers. 2016 Population dynamics and SRHR: What, why, and how to be addressed. Rutgers' position. Utrecht: Rutgers - https://www.rutgers.nl/sites/rutgersnl/files/PDF/Positionpaper_Population_oct_2016.pdf

[9] Jimoh Amzat, Oliver Razum. 2018 Towards a Sociology of Health Discourse in Africa (book).

Human Rights perspective in SRHR

The human rights-based approach to health is translated into health services being available, accessible, acceptable and of good quality (3AQ) for all people without discrimination of any kind based on race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status such as disability, age, marital and family status, sexual orientation and gender identity, health status, place of residence, economic and social situation (WHO, UNFPA, 2015; WHO, Human Rights and Health - Key Facts, 2017). The focus of section 3.2 will be on the accessibility and quality as presented in result area 2 of the draft Theory of Change of Sida.

The momentum around Universal Health Coverage and the adoption of the sustainable development goals has been fostering discussions on the potential synergies between the SRHR and the UHC agendas. Both agendas are aimed at improving access to quality health services and are grounded in principles of human rights, equity, dignity and non-discrimination. UHC as well as SRHR are linked to other developmental constraints, such as the gender inequality and are therefore is key achieve the 2030 agenda. UHC has been argued as an opportunity to advance SRHR. At the same time, there is growing consensus that UHC cannot be achieved without addressing SRHR. Reproduction and sex define unique and specific health needs throughout the life course of every person - specially girls and women that makes SRH services essential health services. Evidence shows that SRHR interventions are cost/effective for the focus on health promotion and prevention. According to Guttmacher (2017)[10] estimates, investing in both contraceptive and maternal and new-born services together, instead of only in maternal and new-born health care, would results in a net saving of 6.9 billion USD, as it would lead to a decline in unintended pregnancies, unplanned births, induced abortions and maternal and new-born death. Moreover, it has been argued that without setting SRHR as a key priority, health reforms aiming to move towards UHC will not advance in terms of equity of access, affordability or quality of health services[11] (Sen and Govender, 2015). The attractiveness of UHC in relation to SRHR relied in its affirmation of the right to health. This affirmation, explicit in the UHC2030 joint vision, links to the principle of universality and implies addressing key social determinants of health with multisector initiatives and adopting a rights approach.

Conflict perspective in SRHR

According to OCHA, 132 million people in 42 countries needed humanitarian assistance in 2019. Natural disasters and climate change contribute to the displacement of people (25 million people are displaced each year for a short-term period[12]). In 2017, 124 million people were additionally affected by the food insecurity crises. In 2019, more than 70 million people have been reported to be forcibly displaced: 41 million internally displaced people, 26 million refugees and 3.5 million asylum seekers[13]. Singh (2018)

[10] Guttmacher. 2017. Adding It Up: Investing in Contraception and Maternal and Newborn Health, 2017 – Factsheet. Guttmacher, New York

[11] Gita Sen and Veloshnee Govender. 2015 Sexual and reproductive health and rights in changing health systems, *Global Public Health*, 10:2, 228-242, DOI: 10.1080/17441692.2014.986161

[12] UNFPA State of World Population Report 2019: Unfinished Business: The Pursuit of Rights and Choices for All, UNFPA 2019 - https://asiapacific.unfpa.org/sites/default/files/pub-pdf/SWP19%20-%20EN%20report-web-%204%20April.pdf

[13] Bianca Tolboom, Anke van der Kwaak and Egbert Sondorp, 2019. Access to Quality Sexual and Reproductive Health for people affected by Crisis and Fragility – Narrative Review https://share-netinternational.org/wp-content/uploads/2019/12/narrative-review-acces-to-SRHR-quality-services.pdf

estimated that 26 million women and girls of reproductive age live in context of humanitarian crisis[14]. The definition of a humanitarian crisis as stated by Sign et al. in 2018 is as follows: *"a serious disruption of the functioning of a community or a society causing widespread human, material, economic or environmental losses that exceed the ability of the affected community or society to cope using its own resources, necessitating a request to the national or international level for external assistance. The crisis situation may either be man-made (e.g. armed conflict) or a natural phenomenon (e.g. drought)."* UNOCHA reported in 2019 that for sub-Saharan Africa new climatic and human-made shocks are to be expected [15]. Deep rooted poverty, economic inequality, political instability and climatic shocks contribute to the displacement of people. These shocks contribute to food insecurity, disease outbreaks and protection risks faced by mostly women and children. The need of people for services and protection increases while at the same time systems break down. Women, adolescents, people with disabilities, ethnic minorities, and people with different Sexual Orientation, Gender Identity and Expression and Sex Characteristics (SOGIESC) are disproportionately affected by crisis and displacement. They are in particular at increased risk of sexual violence, unintended pregnancy, STIs and HIV. Access to quality SRHR for people affected by fragility and crisis is an undeniably human right (United Nations, 1968). DHS data from several countries in sub-Saharan Africa show that women reported to have experienced sexual violence ranged from 16.3% in DRC (2007) to 23.1% in Burundi (2011). Irrespective of the context, the majority of the sexual violence was committed by the partner and survivors did not seek help (48% in DRC). Nine out of ten countries with the highest child marriage rates are considered either fragile or extremely fragile states[16] [17]. Over 500 women and girls affected by crises die each day during pregnancy or delivery due to a lack of available, appropriate, acceptable and accessible quality SRHR services such as skilled birth attendance, emergency obstetric care and safe abortions services[18]. While there is a lack of specific data or evidence, UNICEF reported that there is an additional burden of neonatal death in the first 28 days of life in crisis contexts[19].

Gender perspective in SRHR

A recent study conducted in 2019 looked into the relation between gender inequality, restrictive gender norms and health and wellbeing[20]. It showed how gender inequality and restrictive gender norms relate to health, amongst others the differences in gendered health behaviours, such as high risk sexual behaviour by men; the differences in access to care; and how gender-biased health systems and research in turn reinforce gender inequalities. Gender and SRHR are strongly interlinked, and progress in SRHR requires addressing gender inequality. Relational aspects and power dynamics are fundaments

[14] Singh NS, Aryasinghe S, Smith J, et al., 2018. A long way to go: a systematic review to assess the utilisation of sexual and reproductive health services during humanitarian crises. *BMJ Glob Health*; 3:e000682

[15] United Nations Office for the Coordination of Humanitarian Affairs, 2019. Global Humanitarian Overview 2019:United Nations coordinated support to people affected by disaster and conflict. UNOCHA- https://www.unocha.org/sites/unocha/files/GHO2019.pdf

[16] Janey Lawry-White, Katie Tong, 2017. UNFPA-UNICEF Global Programme to Accelerate Action to End Child Marriage Evaluability Assessment – Final Report.

[17] Girls not Brides, 2018. Child Marriage in Humanitarian Settings – Thematic brief. GnB 2018 - https://www.girlsnotbrides.org/wp-content/uploads/2016/05/Child-marriage-in-humanitarian-settings.pdf

[18] Bianca Tolboom, Anke van der Kwaak and Egbert Sondorp, 2019. Access to Quality Sexual and Reproductive Health for people affected by Crisis and Fragility – Narrative Review https://share-netinternational.org/wp-content/uploads/2019/12/narrative-review-acces-to-SRHR-quality-services.pdf

[19] United Nations Children's Fund, 2016. The State of the World's Children 2016: A fair chance for every child. UNICEF - https://www.unicef.org/media/50076/file/UNICEF_SOWC_2016-ENG.pdf

[20] Heise, L., Greene, M. E., Opper, N., Stavropoulou, M., Harper, C., Nascimento, M., Henry, S. , 2019. Gender inequality and restrictive gender norms: Framing the challenges to health. *The Lancet*, 393(10189), 2440-2454.

of SRHR, such as men's power over women in sexual decision- making[21]. Harmful gender norms impede SRHR as human rights principles. Forms of gender based violence include Female genital mutilation, child marriage, rape in marriage, wife inheritance and maltreatment of widows and son preference are all forms of gender based violence. Inequalities in adolescent sexual and reproductive health (ASRH) for women in sub-Saharan Africa are deeply rooted in social and cultural values and norms and economic perspectives affecting autonomy and decision-making power. Gender equality is essential for ASRH, especially for adolescent girls and young women to be able to realize their sexual and reproductive rights[22]. Green et al. (2019) therefore states that progress can be achieved in both the SRHR and the gender equality agenda through gender-transformative programs and policies.

Environmental and climate perspective in SRHR

Natural disasters and climate change affect 350 million people worldwide, displacing approximately 25 million people each year although the displacement is often short term[23]. The effects of climate change are affecting both natural and human systems in sub-Saharan Africa. "*There is no magic bullet or solution to resolving climate change quickly. It has become clear that nations will have to pursue many strategies in order to reduce emissions, build resilience, and adapt."* Jason Bremner (Population Reference Bureau, 2015). The direct effects of climate change include a warming trend, occurrence of extreme heat waves, increasing dryness, floods, storms and changes in rainfall (decline in southern Africa, increase in East Africa). Empirical evidence points to the indirect effects of climate change in sub-Saharan Africa, threatening population health including adverse changes in air pollution, spreading of disease vectors, food insecurity and under-nutrition, displacement and mobility, and mental ill health and subsequently contribute to negative SRHR outcomes. For example, the climate impacts such as a lack of food, water and sanitation and increased spread of infectious diseases affect maternal and newborn health[24]. In addition, storms and floods might directly constrain access to health care and social services, through damaged clinics and limited availability of products such as contraceptives. Key respondents all acknowledged the link between SRHR and climate change (when asked about their perspectives on SRHR and climate change in sub-Saharan Africa). The climate change catastrophes (drought, floods, cyclones etc) were reported to mostly and disproportionately affect populations and groups that are already struggling the most. Coping mechanisms for scarcity of resources and financial hardship tend to contribute to negative SRHR outcomes: such as migration, transactional sex and Child Marriage, and subsequently to teenage pregnancy[25]. "*Whatever their coping mechanism, it results in negative SRHR outcomes" [key respondent].* Studies show that met needs for contraception and SRH care are linked to reduced vulnerability and enhanced resilience for climate impacts[26]. Rain-fed

[21] Greene, M.E., Berger, B.O., Hakobyan, L., Stiefvater, E., and Levtov, R.G., 2019. Getting to Equal: Men, Gender Equality, and Sexual and Reproductive Health and Rights. Washington, DC: Promundo-US. https://promundoglobal.org/wp-content/uploads/2020/02/BLS19364_PRO_Men-and-SRH-report_018.1-WEB.pdf

[22] Melesse DY, Mutua MK, Choudhury A, et al., 2020. Adolescent sexual and reproductive health in sub-Saharan Africa: who is left behind?. *BMJ Global Health* 2020;5:e002231https://gh.bmj.com/content/5/1/e002231

[23] UNFPA State of World Population Report 2019: Unfinished Business: The Pursuit of Rights and Choices for All, UNFPA 2019 - https://asiapacific.unfpa.org/sites/default/files/pub-pdf/SWP19%20-%20EN%20report-web-%204%20April.pdf

[24] Rylander, C., Odland, J. Ø., & Sandanger, T. M., 2013. Climate change and the potential effects on maternal and pregnancy outcomes: an assessment of the most vulnerable--the mother, fetus, and newborn child. *Global health action*, 6, 19538 - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3595418/

[25] Asian-Pacific Resource & Research Centre for Women, 2014. Identifying Opportunities for Action on Climate Change and Sexual and Reproductive Health and Rights in Bangladesh, Indonesia and the Philippines. ARROW, 2014 - https://arrow.org.my/wp-content/uploads/2015/04/Climate-Change-and-SRHR-Scoping-Study_Working-Paper_2014.pdf

[26] Kristen P Patterso, KathleenMogelgaard, CharlesKabiswa Raymond Ruyoka, 2019 Building resilience through family planning and climate adaptation finance: systematic review and opportunity analysis. *The Lancet Planetary Health* Vol 3, Suppl 1, Sept 2019, Page S12 https://www.sciencedirect.com/science/article/pii/S254251961930155X

agricultural systems are vulnerable to climate change and agricultural livelihoods become more precarious leading to displacement, mobility and migration of people (environmental migrants). The figure 1 below presents direct and indirect effects of climate change and health and wellbeing, and complex interactions between causes and effects[27].

In the following sub-chapters specific reflections on SRHR and climate are presented in the gap analysis.

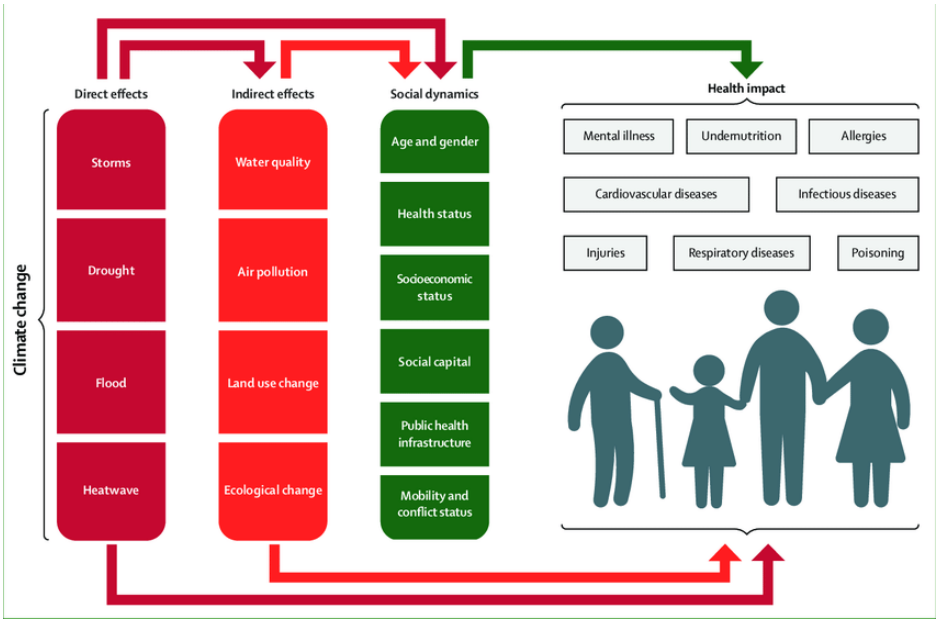


Figure 1 direct and indirect effects of climate change and health and wellbeing

3.1 Legal and policy environment

INTRODUCTION

This chapter reflects on the first outcome area of the Theory of Change and builds on the 'SRHR policy mapping and strategic engagement report' that was conducted by Sida in 2018[28]. A key conclusion of that report was that the regional normative framework is relatively strong 'with progressive continental and regional SRHR policy instruments, from legally binding agreements such as the Maputo protocol, to African Union (AU) strategies and declarations, action plans and targets', but there is a need to focus on performance and accountability for domestication, implementation and reporting on commitments.

For elaborative explanation on the content of the SRHR frameworks we refer to the respective policy report. In addition we recommend the 'State of African Women Report' that provides a comprehensive

[27] Watts, N. & Adger, W. & Agnolucci, Paolo & Blackstock, J. & Byass, P. & Cai, Wenjia & Chaytor, Sarah & Colbourn, Tim & Collins, M. & Cooper, A. & Cox, Peter & Depledge, J. & Drummond, Paul & Ekins, P. & Galaz, Victor & Grace, Delia & Graham, H. & Grubb, M. & Haines, Andy & Costello, Anthony, 2015. Health and climate change - Political strategies for the protection of public health. 20. 167-169. https://www.researchgate.net/publication/284736607_Health_and_climate_change_-_Political_strategies_for_the_protection_of_public_health

[28] Caya Lewis Atkins, 2018. SRHR policy mapping an strategic engagement report: summary of findings. Global DC Strategies. December 2018.

overview of the African continental normative and institutional frameworks for SRHR[29]. A figure on the timeline of key frameworks is presented in Annex 4.

This chapter will give an updated overview of the existing SRHR frameworks at the level of the African Union and Regional Economic Communities (REC's), as well as other regional commitments and partnerships. Furthermore it will provide insight on continental financing mechanisms. The related accountability mechanisms will be described in chapter 3.4.

3.1.1 Policy arenas and SRHR frameworks

WHAT IS THE SITUATION?

African Union

The African Union (AU), officially launched in 2002 as a successor to the Organisation of African Unity (OAU, 1963-1999), is a continental body consisting of the 55 member states of the African continent. Its main objectives are supposed to be fulfilled through a number of decision-making organs in addition to organs that handle judicial and legal matters, including human rights issues (see textbox 2). Furthermore the AU is working towards the establishment of three financial institutions, namely the African Investment Bank[30], African Central Bank[31] and African Monetary Fund[32]. The AU's African Peer Review Mechanism (APRM) is described in chapter 3.4.

Textbox 2 The African Union[33]

Objectives

- To promote the unity and solidarity of the African States;
- To coordinate and intensify their cooperation and efforts to achieve a better life for the peoples of Africa;
- To defend their sovereignty, their territorial integrity and independence;
- To eradicate all forms of colonialism from Africa; and
- To promote international cooperation, having due regard to the Charter of the United Nations and the Universal Declaration of Human Rights.

Decision making organs	*Judicial organs*
• The assembly of Heads of State and Government • The Executive Council • The Permanent Representatives Committee • Specialised Technical Committees • Peace and Security Council • African Union Commission • Pan-African Parliament • Economic, Social and Cultural Council	• African Commission on Human and People's Rights (ACHPR) • African Court on Human and Peoples' Rights • AU Commission on International Law • AU Advisory Board on Corruption • African Committee of Experts on the Rights and Welfare of the Child

Throughout the years the AU established a number of policy frameworks and commitments that link to SRHR. These are outlined in table 1 of Annex 4.

[29] van Eerdewijk A, Kamunyu M, Nyirinkindi L, Sow R, Visser M, Lodenstein E. The State of African Women report. 2018. Available through: https://rightbyher.org/wp-content/uploads/2018/08/SOAW-Report-FULL.pdf
[30] AU website: Protocol on the African investment bank https://au.int/sites/default/files/treaties/36414-treaty-0038_-_protocol_on_the_african_investment_bank_e.pdf
[31] AU website press release https://au.int/sites/default/files/pressreleases/33879-pr-pr_031-_african_central_bank_pr-_dea.pdf
[32] AU website: Protocol on the establishment of the African monetary fund https://au.int/sites/default/files/treaties/36417-treaty-0046_-_protocol_on_the_establishment_of_the_african_monetary_fund_e.pdf
[33] AU website: about the African Union https://au.int/en/overview

The African Commission of Human and People's Rights (ACHPR) has a number of resolutions that should protect the reproductive and sexual rights of people, the Maputo protocol being the ground-breaking continental protocol on women and girls' human rights, and a number of resolutions reinforcing and supporting the Maputo protocol and other international human rights declarations.

- **The Maputo protocol (2003):** the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, also referred to as 'the Maputo Protocol', is a continental policy framework on SRHR, and has strong provisions regarding gender-based violence against women, harmful practices, female genital mutilation, child marriage, reproductive rights and SRH, access to safe abortion, and HIV and AIDS. The African Commission on Human and People's Rights (ACHPR) developed General Comments as well as Guidelines on specific topics, to guide states on the provisions and responses of the Maputo Protocol. The Maputo Protocol is currently signed by 49 countries (out of 55 countries) and ratified by 42 countries - meaning the Maputo protocol becomes legally binding. Most recent ratifications are from Ethiopia in July 2018, Tunisia in August 2018 and Sao Tome & Principe in April 2019. Botswana, Egypt and Morocco are the only three countries that have neither signed nor ratified the treaty[34]. Eight countries have made reservations on certain articles or declarations of the protocol– mostly related to marriage or access to safe abortion (Annex 4). For accountability mechanisms in relation to the Maputo protocol see chapter 3.4.
- **Resolution 111** (2007) recalls the Maputo Protocol and the right to a remedy and reparation for women and girls victims of sexual violence[35].
- **Resolution 275** (2014) clarifies the meaning of the African Charter in the context of the increasing violence against persons based on their real or imputed sexual orientation or gender identity, and committed by both state and non-state actors[36].
- **Resolution 283** (2014) addressing violence against women and children in conflict and post-conflict situations.

For the accountability function of the ACHPR see chapter 3.4

Regional Economic Communities

There are eight Regional Economic Communities (RECs) recognized by the African Union, which vary in terms of roles, structures and progress in gender equality and SRHR:

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

[34] A regular updated list on the status of the Maputo Protocol can be accessed via: https://au.int/en/treaties/1170
[35] African Commission on Human and People's Rights Resolutions https://www.achpr.org/sessions/resolutions?id=163
[36] African Commission on Human and People's Rights Resolutions https://www.achpr.org/sessions/resolutions?id=322

Annex 5 outlines to what REC's countries in the western, eastern, central and southern region belong and where there is overlap.
Five of the eight RECs (ECOWAS, EAC, IGAD, SADC and COMESA) have explicit normative frameworks in place that contain important commitments on gender equality and women and girls rights, such as gender mainstreaming and women's participation and elimination of discrimination. These commitments are legally binding for ECOWAS (Supplementary Act of 2015), SADC (Protocol on Gender and Development, updated in 2016), COMESA (Revised Gender Policy of 2016) and EAC (Gender Equality Bill). The Gender Policy Framework of IGAD is not binding.[37]

ECCAS, UMA and CEN-SAD are considered to have a lower level of activity, or at least very little information available. ECCAS has made some declarations on gender equality and women and girls' rights and has a gender unit, but there is no framework, protocol or strategy. CEN-SAD is not highly active as REC and as a result there is no normative or institutional frameworks around gender equality or SRHR.[id]

In addition to the gender normative frameworks described above, RECs have commitments and frameworks relevant to SRHR, such as HIV & AIDS and sexual and gender-based violence. Table 2 in annex 4 provides an overview of relevant sub-regional frameworks and commitments related to SRHR. Chapter 4 of the State of African Women report provides comprehensive tables on key documents and institutional infrastructure for each REC, as well as an overview of strengths, opportunities and challenges.

Other regional commitments and partnerships

Additionally to the frameworks from the AU and the RECs, other regional frameworks are in place towards gender equality and women and girls' rights. An overview is provided in table 3 of annex 4.

WHAT ARE THE GAPS?

Limited attention for sexual rights and UHC

As earlier indicated by Sida in their policy review, Sub-Saharan Africa has quite strong SRHR and gender equality policy frameworks. However, when reviewing the existing policy frameworks against the Lancet-Guttmacher definition of SRHR, as well as against the five Sida perspectives, it comes to light that the emphasis is largely on *reproductive* health & rights, while *sexual* health and rights are under addressed (and highly disputed as will become evident in the rest of the report). Another gap in the policy frameworks is a focus on the poorest and most vulnerable populations and a strategy to achieve universal health coverage.

Gaps in implementation and in awareness of legal rights

Furthermore there are gaps in implementation. For example, even when ratified, challenges in the implementation of the Maputo Protocol remain. The ACHPR depends on the political will of states to implement the recommendations, as also expressed by one of our key informants. This often depends on the regime, their priority of human rights issues and their leadership on Women's rights issues. A

[37] van Eerdewijk A, Kamunyu M, Nyirinkindi L, Sow R, Visser M, Lodenstein E. The State of African Women report. 2018. Available through: https://rightbyher.org/wp-content/uploads/2018/08/SOAW-Report-FULL.pdf

book published by the Centre for Human Right of the University of Pretoria on *The Impact of the African Charter and the Maputo Protocol in Selected African States* concluded that the African Charter and Maputo Protocol have had 'modest yet significant impact' in each of the 17 studied countries[38], but the level of effect differed based on contextual and conditional factors. It showed that awareness on the charters is crucial, but low among legal actors and CSOs. In addition a lack of political will, lack of human rights culture, political instability and widespread poverty and illiteracy were observed as key challenges, as well as a need to intensify media coverage to enhance translation of the Maputo Protocol to domestic levels[39].

Fragmentation of SRHR services in fragile settings and divide between the humanitarian and development nexus

Absence of policy frameworks can hamper development and implementation of national health policies in fragile settings [40] . Restrictive policies and misinformation about existing policies prevent implementation of critical comprehensive SRHR services[41] and allows for cherry picking in the delivery of SRHR services, which in turn leads to fragmentation, particular for contraceptive and abortion services[42]. There is a lingering divide (and lack of synergy) between humanitarian and development actors[43].

CONSIDERATIONS FOR SIDA'S STRATEGY

- With the growing conservatism and limited attention for sexual health and rights, Sida's added value, in complement to others, is really on the 'sexual components' of the Guttmacher-Lancet SRHR definition. With respect to universal health coverage and 'leaving no one behind' ongoing attention for poor people's perspective is needed as well as increased attention for integration of comprehensive SRHR in those settings where it easily falls off from the agenda. Not only conflict, but also the effects of climate change and pandemic outbreaks show the fragility of systems. Thus, comprehensive SRHR, including the S and second R, and an emphasis for people living in poverty or humanitarian crises. To address the lingering divide (and lack of synergy) between humanitarian and development actors, Sida could consider to link up to the Inter-Agency Working Group on Reproductive Health in crises (IAWG).
- There is a need to support the implementation of existing policy frameworks through legal and political awareness creation. This requires support for advocacy, including media attention and translation of policies and charters to domestic levels, and a multi-sectoral approach that links to the other chapters on social norms and accountability.
- **Entry points with REC's:**

[38] Burkina Faso, Cameroon, Côte d'Ivoire, Ethiopia, The Gambia, Ghana, Kenya, Lesotho, Malawi, Mauritius, Nigeria, Sierra Leone, South Africa, Swaziland, Tanzania, Uganda and Zimbabwe.
[39] University of Pretoria, centre for human rights (2012). The impact of the African Charter and Women's Protocol in selected African states. http://www.pulp.up.ac.za/edited-collections/the-impact-of-the-african-charter-and-women-s-protocol-in-selected-african-states
[40] Chi et al. (2015) A qualitative study exploring the determinants of maternal health service uptake in postconflict Burundi and Northern Uganda. BMC Pregnancy and Childbirth. 15 (18).
[41] Chynoweth SK (2015) Advancing reproductive health on the humanitarian agenda: the 2012-2014 global review. Conflict and Health. 9(1):I1.
[42] WHO (World Health Organization) (2017) Minutes technical consultation on research on sexual and reproductive health and rights in humanitarian setting
[43] Tolboom et al. (2019). Access to quality an reproductive health for people affected by crisis and fragility. Narrative review. Share-Net International https://share-netinternational.org/wp-content/uploads/2019/12/narrative-review-acces-to-SRHR-quality-services.pdf

For this context analysis we got the chance to speak to ECOWAS, IGAD, SADC secretariat and SADC parliamentary forum.

In general REC's expressed the need for:

1. technical and financial support for regional accountability mechanisms,
2. strengthening advocacy roles,
3. availability of evidence and data.

More specifically, the following focus areas and needs were identified with the REC's that were interviewed:

- IGAD: focuses on SRHR for moving and cross-border populations and expressed a need for a stronger analysis on what is happening on this aspect; digitalization and linking ICT health systems across borders (including the development of data sharing policies); access to quality medicines regulations and harmonization.
  IGAD has been the only REC who explicitly expressed a policy on SRHR for cross-border and mobile populations, especially people living around the borders of Kenya and Uganda. Examples of successful initiatives are the establishment of cross-border health committees to ensure the continuum of care at both sides and WhatsApp groups of health workers in border regions. They have worked on digitalized immunization services by linking ICT systems across border; with the 'IGAD visa card' a woman can present with her child at both sides of the border carrying the information on what vaccinations have been received. There are ambitions to scale this system up to family planning services and work is conducted on a data sharing policy.[44]
- ECOWAS: currently main focus on child marriage with a new roadmap on the prevention and response to child marriage; they expressed the need to translate policy into implementation.
- SADC: there is currently no formal relationships between SADC PF and SADC secretariat and it is not clear how these speak to each other. The secretariat expressed capacity constraints for coordination and M&E, including the need for real-time data systems and access to HMIS of member states (instead of waiting for questionnaires). Need for technical assistance on HSS at country level.

3.1.2 Continental and sub-regional funding streams for SRHR

This section starts with a description on the current status of selected continental and sub-regional funding streams. The description is not exhaustive, but provides an overview, In line with interest and focus as discussed with Sida, to serve the gap analysis. Special attention is given to the financing of commodities. The description of the situation is followed by an analysis of the gaps and considerations for Sida's strategy.

WHAT IS THE SITUATION?

European Union (EU) funding mechanisms

SRHR support from the EU to SSA comes through several EU external financing instruments (EFIs) of the current Multiannual Financial Framework (MFF) 2014-2020, such as the European Development

[44] Information from interview with IGAD senior regional program coordinator RMNCAH-N.

Fund (EDF), the Development Cooperation Instrument (DCI), the European Instrument for Democracy and Human Rights (EIDHR) and the Humanitarian Aid Instrument (HAI). [45]
European EFIs also fund global initiatives including Global Alliance Vaccine Initiative (GAVI), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the United Nations Population Fund (UNFPA) Supplies programme and the EU-UN Spotlight Initiative on gender-based violence.

Global funding streams

The Global Financing Facility (GFF), launched in 2015, supports countries to identify an evidence-based set of priority investments to help "bend the curve" to accelerate progress on RMNCAH-N and to get on a trajectory toward achieving the SDGs (the Investment Case). It has been estimated that the GFF could mobilise US$50-75 billion of additional funds for expanding delivery of life-saving health and nutrition interventions to reach coverage of at least 70% for most interventions by 2030 and thereby avert 34.7 million deaths-including preventable deaths of mothers, newborns, children and stillbirths[46]. African countries (26) that are currently GFF supported are Burkina Faso, Cameroon, Central African Republic, Chad, Cote d'Ivoire, DRC, Ethiopia, Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Mauritania, Mali, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, Somalia, Tanzania, Uganda, Zambia and Zimbabwe.

With the launch of the GFF another vertical funding program came into existence. The Global Fund, GFF and Gavi collectively developed a paper to clarify mandates, common principles, and approaches, and propose concrete areas for intensified collaboration across the three organizations[47]: "The three organizations have been working together both at leadership and operational levels to demonstrate their complementarity, harmonize approaches and strengthen collaboration. Both Gavi and Global Fund are members of the GFF Investors Group, and Gavi and Global Fund have longstanding mutual bilateral collaboration, including at the Board level. Following lessons learned from the GFF partnership process, and in response to country demand, the Gavi, the GFF and the Global Fund are working to improve the efficiency and effectiveness to better serve the needs of countries and actively seek to enhance areas for intensified collaboration in particular at the country level." Identified areas for intensified collaboration are in Health Systems Strengthening (including community engagement and responses, data systems for health, supply chain systems, human resources for health), in country coordination (including process for developing and implementing the GFF Investment Cases to ensure that all investments related to RMNCAH are included, streamline coordination structures within in-country institutional partners, better harmonize financing support from WHO, UNICEF, multilaterals, the Islamic Development Bank and large humanitarian actors through clearer articulation of the priorities in order to increase the likelihood that gaps are recognized and closed), global coordination and governance, health financing strategies and public financial management (support catalytic health financing to drive sufficient increases in domestic and private financing in order to close a large financing gap), technical assistance (e.g. implementation guidance) and risk management.

[45] Thijssen S, Bossuyt J, Desmidt S. Sexual and reproductive health and rights: opportunities in eu external action beyond 2020. 2019. https://euagenda.eu/upload/publications/sexual-and-reproductive-health-and-rights-opportunities-in-eu-external-action-beyond-2020.pdf
[46] Chou VB, Bubb-Humfryes O, Sanders R, Walker N, Stover J, Cochrane T, et al. Pushing the envelope through the Global Financing Facility: Potential impact of mobilising additional support to scale-up life-saving interventions for women, children and adolescents in 50 high-burden countries. BMJ Glob Heal 2018;3. doi:10.1136/bmjgh-2018-001126.
[47] https://www.csogffhub.org/wp-content/uploads/2019/09/Global-Health-Architecture_Gavi-GFF-GF.pdf

Domestic resource mobilisation

In 2001 AU heads of states committed in the Abuja declaration to allocate a minimum of 15% of their annual public budget to strengthen the health sector, and particularly the fight against communicable diseases[48].

Domestic resource mobilization (DRM) is a challenge and necessity for countries around the world to meet the Sustainable Development Goals, which is why particularly the World Bank and International Monetary Fund dedicate general programmes to it, regardless of which sector the domestic resources will be spent on. They estimate that many lower-income countries have the potential to raise their revenue collection by 2-4% without sacrificing equity or economic growth, reaching the minimum target of 15% tax to GDP ratio to fund a minimum of basic state functions[49]. The GFF supports governments in mobilizing domestic resources for RMNCAH-N through: i) identifying potential additional sources of sustainable resources for health; (ii) increasing the prioritization of health in the budget (i.e. increasing the share of health in the government budget) and; (iii) increasing health-specific revenues, mainly from sin taxes. In support of this agenda, the GFF Secretariat aims to work with different partners to intensify collaboration[50].

The Addis Ababa Action Agenda, formulated in 2015 at the Third International Conference on Financing for Development emphasized the importance of DRM. The Agenda gave rise to the Addis Tax Initiative, initiated by the governments of Germany, the UK, the Netherlands and the United States, which aims at enhancing DRM in partner countries, of which 16 are in Sub-Saharan Africa. It publishes annual monitoring reports on the state of DRM in signatory partner countries and technical assistance to these countries by donors. The 2017 monitoring report shows a slight increase in tax to GDP ratio[51] between 2015 and 2017.

Financing commodities

Government support for contraceptive information and services increased over the years, as is the number of people accessing these services. Almost all countries make contraceptive information and services available either through public health clinics or through NGOs. The 6% of governments who provided no support for family planning in 2015, allowed the private sector to provide these services[52]. Also the international donor community contributed to the expansion of the availability of multiple contraceptive methods. However, as reported by key informants conservative forces contributed to a decrease in the contraceptive market of the public sector in the last years. This was also presented at the FP2020 in Rwanda and reported in December 2018 by the Reproductive Health Supplies Coalition[53] (value decrease reported from a total of 277 million USD in 2011 to 186 million USD in 2017 in the 69 FP2020 countries – market share of SSA is 65% in 2017). The report of the Reproductive Supplies Coalition showed that while an increase in shipments of implants and emergency contraceptives was

[48] https://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf
[49] "Junquera-Varela, Raul Felix; Verhoeven, Marijn; Shukla, Gangadhar P.; Haven, Bernard; Awasthi, Rajul; Moreno-Dodson, Blanca. 2017. Strengthening Domestic Resource Mobilization : Moving from Theory to Practice in Low- and Middle-Income Countries. Directions in Development—Public Sector Governance;. Washington, DC: World Bank. © World Bank. *https://openknowledge.worldbank.org/handle/10986/27265*
[50] GFF factsheet: The GFF 's Contribution to Domestic Resource Mobilization for health and nutrition. https://www.csogffhub.org/resources/the-gffs-contribution-to-domestic-resource-mobilization-for-health-and-nutrition/
[51] ATI monitoring report 2017: https://www.addistaxinitiative.net/resource/ati-monitoring-report-2017
[52] Reproductive Health Policies 2017 data booklet https://www.un.org/en/development/desa/population/publications/pdf/policy/reproductive_health_policies_2017_data_booklet.pdf
[53] Reproductive Health Supplies Coalition and Clinton Health Access Initiative (2019) Family Planning Market Report. https://www.rhsupplies.org/uploads/tx_rhscpublications/Family-Planning-Market-Report.pdf

observed over a period of 6 years (2011 – 2017), the decline is mostly due to an overall decrease in the shipments of injectables and oral contraceptives (combined and progestin). The report does not provide a reason for the shift in type of contraceptives, but it is well known that the use of contraceptives implants is rising rapidly in Sub-Saharan Africa[54].

USAID and UNFPA are the two largest institutional procurers of commodities (excluding male and female condoms). The value of commodities procured by UNFPA decreased by 2 percent annually but increased by 25 percent in 2017 compared to 2016, however did not reach the levels of 2012 - 2015. Between 2012 – 2015 the annual value of all contraceptives shipped by USAID remained at 77 million USD, while the decrease between 2015-2016 was 37% and another 25% reduction between 2016-2017. The total value procured by USAID in 2017 (34 million USD) is lower than any other years since 2011 (77 million USD).

The Protecting Life in Global Health Assistance or the Mexico City Policy is a US policy which excludes US foreign assistance to any organization performing or providing counselling on abortion. The policy was reinstated by US President Donald Trump on 3 January 2017. The Policy does not only apply to funding to earmarked organizations that focus on reproductive health (as was the case when George W. Bush reinstated the Policy) but affected all global health assistance of an estimated total amount of 9.5 billion USD[55]. The policy has an impact on organizations providing modern contraceptives. Marie Stopes International estimated that due to the loss of funding as a result of the PLGHA 6.5 million unintended pregnancies, 2.1 unsafe abortions and 21.700 maternal deaths could not be prevented by 2020. A study published in 2019 by Stanford University showed that the unintended result of the Policy over the years is an increase of abortion rates[56]. This study looked at patterns of modern contraceptive use, pregnancies and abortion among women in 26 SSA countries in response to the Policy being in place or not across three presidential administrations (Clinton, George W Bush, and Obama), and compared high and low exposed countries. The study showed that when the Policy was in place the abortion rates increased with almost 5 abortions per 10000 women years in countries highly exposed by the policy: which represents a rise of approximately 40%. This finding was accompanied by a decline in modern contraceptive use and increase in pregnancies[56]. In response to the reinstatement of the Policy, the She Decides initiative lead by former Dutch Minister Lilianne Ploumen was launched early 2017 as a fundraising platform to maintain access to SRHR. In March 2017, a conference hosted by The Netherlands, Belgium, Sweden and Denmark mobilised commitments for almost 200 million USD. By the end of 2017, the She Decides campaign includes more than 40.000 Friends, 36 global champions including Ministers, youth leaders, and others and mobilized 450 million USD (mostly from EU member states, Canada and the Bill and Melinda Gates Foundation)[57],[58].

[54] Roy Jacobstein (2018) The Blossoming of Contraceptive Implant Use in Africa. Global Health: Science and Practice. https://doi.org/10.9745/GHSP-D-17-00396
[55] Sarah Pugh, Sapna Desai, Laura Ferguson, Heidi Stöckl & Shirin Heidari (2017) Not without a fight: standing up against the Global Gag Rule, Reproductive Health Matters, 25:49, 14-16, DOI: 10.1080/09688080.2017.1303250
[56] Brooks, Nina et al. USA aid policy and induced abortion in sub-Saharan Africa: an analysis of the Mexico City Policy. The Lancet Global Health, Volume 7, Issue 8, e1046 - e1053. https://www.thelancet.com/action/showPdf?pii=S2214-109X%2819%2930267-0
[57] She Decides. The journey so far. Website, accessed December 2019 - https://www.shedecides.com/timeline/
[58] Thijssen S, Bossuyt J, Desmidt S. Sexual and reproductive health and rights: opportunities in eu external action beyond 2020. 2019. https://euagenda.eu/upload/publications/sexual-and-reproductive-health-and-rights-opportunities-in-eu-external-action-beyond-2020.pdf

According to the UNFPA Supplies Annual Report of 2017[59], new donor commitments could improve the availability of financing for commodities in 2018. Also the ICPD+25 in Nairobi showed again increased commitments for family planning[60], also by European donors and the Global Fund which might result in some improvements in the contraceptive market of the public sector in the next years. However, the 2018 RHSC Global Contraceptive Commodity Gap Analysis showed increasing funding gaps up to 2020 which could – if remained unaddressed – result in ceasing the growth or decreasing modern contraceptive uptake.

WHAT ARE THE GAPS?

Little space for more contentious aspects of sexual rights in global funding streams

Despite the positive trend of increasing voice for governments in how to spend donor money (e.g. structured funding dialogues of UNFPA[61], GFF investment cases), it comes with the risk of leaving little space for more contentious aspects within 'sexual rights' programs. For example contributions of the GFF, as a government-led process, depend on the priorities and investment case of the respective government, e.g. for countries in favour or dependent of US policies the focus will lie not so much on SRHR and more on maternal health[62]. Equally, few Investment Cases respond to the unique needs of adolescents, such as youth-friendly services, nor do they include multi-sector investments to address social and gender determinants of adolescent health across education, water and sanitation, and social protection.[63]

Also under the African (as well as the Caribbean and Pacific)-EU partnership decisions on how to spend EU funding is based on a co-management principle. The inclusion of a comprehensive regional approach to SRHR in the current negotiations on a post-Cotonou agreement[64] and the new MFF 2021-2027, is challenged by both internal EU resistance through several member states, as well as political contestation from the AU. The launch of the EU-UN Spotlight Initiative on GBV was complicated by a statement from the AU commission expressing reservations as the language of the document was "not consistent with negotiated language on Sexual and Reproductive Health and Rights and Sexual Orientation, that has been negotiated in the key policy documents of the African Union" and as the commission "was not involved in the conceptualization, design, and development of the Spotlight Initiative, of the project document titled Africa Regional Programme document, within which there are multiple references to Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI)" [65].

[59] United Nations Population Fund, 2018. The UNFPA Supplies Annual Report 2017. UNFPA, New York 2018 - https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_Supplies_Annual_Report_2017_FINAL.pdf

[60] United Nations Population Fund, 2019. Press release – website accessed December 2019 - https://www.unfpa.org/press/nairobi-summit-icpd25-ends-clear-path-forward-transform-world-women-and-girls

[61] Within the strategic plan 2018-2021 UNFPA has enhanced dialogues with members states on how to fund development results through the Structured Funding Dialogues (https://www.unfpa.org/sites/default/files/event-pdf/STRUCTURED_FUNDING_DIALOGUES_2019_-_DOCUMENT_For_member_states_-_Final.pdf).

[62] See also KIT's helpdesk report for Sida on the Global Financing Facility (2018).

[63] Meaningful Adolescent and Youth Engagement in the Global Financing Facility: Analysis and Recommendations https://www.csogffhub.org/wp-content/uploads/2019/10/MAYE-in-the-GFF_April-2019_FINAL.pdf

[64] I.e. renewal of the ACP-EU Partnership Agreement beyond 2020 https://ec.europa.eu/europeaid/policies/european-development-policy/acp-eu-partnership-after-2020_en

[65] Thijssen S, Bossuyt J, Desmidt S. Sexual and reproductive health and rights: opportunities in eu external action beyond 2020. 2019. https://ecdpm.org/wp-content/uploads/Sexual-and-reproductive-health-and-rights-DP-254-Thijssen-Bossuyt-Desmidt-ECDPM-June-2019.pdf

Opaque mechanisms in GFF participating countries and lack of inclusion of key stakeholders, including CSOs

An in-depth comparative analysis on GFF processes in seven focus countries (Cote d'Ivoire, Guatemala, Kenya, Malawi, Nigeria, Sierra Leone and Uganda) found that while the mechanism is expected to unlock domestic resources for reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N), there is little, if any, evidence that this is achieved. Opacity around the mechanism's decision-making approaches and processes, lack of optimal inclusion of key stakeholders including CSOs, misunderstanding of what the mechanism is by stakeholders, and the absence of sustainable financing mechanisms for CSOs constitute other key challenges facing the mechanism.[66] On the contrary, a 2009 study[67] concluded that global health initiatives such as the Global Fund have enabled wider stakeholder participation, including civil society, in decision-making and service delivery, although, particularly in the early years this came at the detriment of systems-strengthening, effective coordination and accountability towards the wider public. The latter is the result of a proliferation of NGOs without clear support bases, quality control or accountability towards communities. The tight procedures for financial reporting and NGOs' dependence on Global Fund funding have been argued to further contribute to redirecting accountability away from grass-roots constituencies and undermining or de-politicisation of the critical position of civil society on programme priorities[68].

Limitations in the Abuja target of 15%

Although now used as a regional benchmark against which countries' performance is measured, the Abuja declaration target remains ambiguous in its use and applicability[69]. For a start, it is unclear how the target of 15% was chosen and its translation into absolute spending is highly contingent on the size of the public budget (as share of GDP: fiscal space), as well as the execution of the budget into actual expenditure. In the National Health Accounts (WHO), the corresponding indicator is Domestic General Government Health Expenditures as part of General Government Expenditure. That means that External funds passing through government, apart from general budget support, are not comprised in the Abuja calculation. In practice this may be unclear in specific country accounts. User fees are accounted as out-of-pocket and are not included in the calculation of the Abuja target; social insurance premium (but not voluntary ones, including both private health insurance and voluntary community based health insurance) are public and are part of the Abuja commitment calculations.

Despite these limitations the Abuja target remains one of the few health financing targets on the basis of which governments can be held to account. The 2018 Africa Scorecard on domestic financing for health is a tool that illustrates the degree to which governments live up to this target. It shows that in 2015 only Madagascar and Sudan met this target, although a number of Southern African countries approach it[70]. Arguably, a more insightful target is to assess public spending on health in relation to GDP[71]. Based on this measure significant variation can be observed from the Africa Scorecard between

[66] E&K consulting policy brief (2019). Comparative analysis of the Global Financing Facility. https://www.csogffhub.org/wp-content/uploads/2019/12/Comparative-Analysis-of-the-Global-Financing-Facility-Enhancing-inclusivity-transparency-and-accountability-2019.pdf

[67] Biesma, R. G., Brugha, R., Harmer, A., Walsh, A., Spicer, N., & Walt, G. (2009). The effects of global health initiatives on country health systems: a review of the evidence from HIV/AIDS control. *Health policy and planning*, *24*(4), 239-252.

[68] Kapilashrami, A., & O'Brien, O. (2012). The Global Fund and the re-configuration and re-emergence of 'civil society': Widening or closing the democratic deficit?. *Global Public Health*, *7*(5), 437-451.

[69] Witter, S., Jones, A., & Ensor, T. (2013). How to (or not to)… measure performance against the Abuja target for public health expenditure. *Health policy and planning*, *29*(4), 450-455.

[70] Scorecard and data on government expenditure on health per capita, as % of GDP and as % of Govt budget available at: http://www.aidswatchafrica.net/index.php/africa-scorecard-on-domestic-financing-for-health

[71] Data on National Health Accounts can be found in the Global Health Expenditure database of WHO: http://apps.who.int/nha/database/ViewData/Indicators/en

the most fragile, conflict-affected countries of the continent, with less than 1% of GDP being spent on health from public funds on the one hand to a number of Southern African countries spending between 4 and 5% of GDP on health from public funds.

Lack of commodity regulatory harmonization

According to key informant interviews, the deterring regulatory environment in many countries in sub-Saharan countries are complicated, not efficient and regulatory barriers hinder the clearance and registration of commodities and organisations. Both the registration process to establish an organization in a country and the time for product approval on the contraceptive market are very intensive. For these reasons, it remains very challenging for pharmaceutical companies to invest in these processes (limited margins: limited return of investment). As social marketing organisations receive donor funding to support their regulatory processes, they can make these investments. These findings from the key informants are also supported by the synthesis report of the VNRs (2019) which mentioned that a more favourable business environment should be created to enhance private sector engagement.

While it is widely acknowledged that pharmaceutical production and distribution of contraceptive commodities have become globalized, and that regulatory authorities should not work isolation, harmonization remains challenging and especially for commodities. In addition, there is urgency felt by national governments for harmonization and creating a more favourable business environment as donors funding might end. According to one of the key informants, the limited capacity at national levels to change the registration process (how do you get a product registered, what if deviations are observed, how to test and sample) or the tender process (how to establish, implement and handle tender processes around commodities and ensure quality?) is a major struggle. Also according to WHO (2014), the medicines regulatory authorities in many countries struggle with their administrative and technical capacities to control medicines and quality. WHO, requested in 2008 to support harmonization approaches among national medicines regulatory authorities (NMRAs), identified that states having their own laws and regulations as a major challenge in this process[72].

CONSIDERATIONS FOR SIDA'S STRATEGY

- Follow alignment and intensified collaboration across the major global funding organisations. In order to leverage Health Systems Strengthening, in-country coordination, global coordination & governance, financial management (including domestic resource mobilization), technical assistance and risk management. Also possibility to link up to these mechanisms in order to define the agenda, monitor the accountability mechanisms that are in place, including the involvement of civil society and young people when defining the investment cases, leverage on lessons learned in other financing mechanisms such as the Global Fund to improve on the GFF.
- Consider building alliances with like-wise donors and invest in advocacy to ensure that sexual rights issues and contentious topics, such as access for adolescents, are addressed. The role of civil society in advocating and holding states and programs accountable for the integration of comprehensive SRHR, should be further supported.
- Explore joining The African Medicines Registration Harmonization initiative to support WHO in getting registration processes harmonized. According to WHO, RECs already have to some extent commitments for medicines regulatory harmonization. One of the key informants mentioned that

[72] WHO drug information (2014) WHO support for medicines regulatory harmonization in Africa: focus on East African Community https://apps.who.int/medicinedocs/documents/s21399en/s21399en.pdf

while in West Africa regulations for commodity regulatory harmonization remains difficult, this has been on the agenda of ECOWAS for several years. RECs can play a crucial role in the harmonization process. Secretariats of RECs have the necessary infrastructure to support harmonization. RECs can bring member states together to identify similarities and differences, and work towards harmonized standards, guidelines and policies, or even a mutually recognized framework (making use of internationally recognized standards and best practices, such as good manufacturing practices, information management systems and quality management systems). Furthermore, joint assessments of regulatory systems could be supported by RECs to identify gaps and develop recommendations. WHO developed a data collection tool for the assessments of NMRAs, which was used to assess NMRAs in 5 EAC countries in 2010. In addition to the RECs, the African Union can also play an important role in harmonization of regulatory processes around commodities – and according to one of the key informants they are getting involved.

3.2 Access to quality SRHR services

INTRODUCTION

The concept of "access" is multidimensional, and goes beyond making reproductive health services and commodities available. Access is affected by multiple levels: individual, community, provider and service-delivery points. It includes social, economic and other elements, such as the geographic proximity to service-delivery points[73]. Quality is a crucial facet of access to SRHR services and the importance of quality of care has recently been highlighted in a number of publications: the Lancet Global Health Commission on High-quality health systems in the Sustainable Development Goals era[74] summarized the evidence on the precarious state of quality of service delivery.

WHAT IS THE SITUATION?

In this chapter the access to the different elements of the essential package of services for SRHR as outlined by the Guttmacher-Lancet Commission will be reviewed and analysed. Under *what is the situation*? the current status of the following elements will shortly be reviewed: Comprehensive sexuality education; modern contraceptives; Antenatal, childbirth and postnatal care; Abortion; HIV prevention, treatment and integrated services; Sexual and Gender-based Violence; Reproductive cancers; Subfertility and infertility; Sexual health and well-being. Specific attention is given to the SRHR elements of adolescent girls and young women in sub-Saharan Africa as a major public health concern in terms of unintended pregnancies and STIs including HIV specifically[75].

Modern Contraceptives

At the London Summit on Family Planning, Saifuddin Ahmed presented study findings on the *progress and trends in modern contraceptive prevalence rates* among women 15 – 49 years since the 2012 London Summit on Family Planning in 8 sub-Saharan African countries using data from 45 rounds of

[73] Yakubu, I., Salisu, W.J., 2018. Determinants of adolescent pregnancy in sub-Saharan Africa: a systematic review. *Reprod Health* 15, 15 (2018). https://doi.org/10.1186/s12978-018-0460-4 https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-018-0460-4

[74] Kruk ME, Gage AD, Arsenault C, et al., 2018. High-quality health systems in the Sustainable Development Goals era: time for a revolution. *Lancet Glob Health*. 2018; 6: e1196-e1252 - https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(18)30529-1/fulltext

[75] Melesse DY, Mutua MK, Choudhury A, et al., 2020. Adolescent sexual and reproductive health in sub-Saharan Africa: who is left behind?. *BMJ Global Health* 2020;5:e002231 - https://gh.bmj.com/content/5/1/e002231

Performance Monitoring and Accountability 2020 surveys (Burkina Faso, Democratic Republic of Congo, Ethiopia, Ghana, Kenya, Niger, Nigeria, and Uganda). An increased contraceptive prevalence was achieved in Burkina Faso, Ghana, Kaduna (Nigeria), Kinshasa (DR Congo) and Uganda. However, the findings from Ethiopia, Kenya, Lagos (Nigeria), or Niamey (Niger) showed non-significant changes of less than 1 percentage point[76]. The major reason for the found rise in modern contraceptive prevalence rates in the assessed settings as presented by Saifuddin Ahmed was linked to the increase of contraceptive implants use and other initiatives such as the levonorgestrel-intrauterine device. Contraceptive implants are restricted to more open societies as it cannot be hidden from a partner and require available health services, adequate facilities and trained healthcare providers for placement and removals, and to follow-up women.

Overall, Africa has the highest unmet need for modern contraceptives: proportion of women of reproductive age (15 – 49 years) who are sexually active and want to avoid pregnancy but are not using contraception (24%)[77]. Many sub-Saharan African countries still show a high total fertility rate of 4.3 children per women and a low contraceptive prevalence rate[78]. The percentage of married women or women in an union between 15 – 49 years using a method of modern contraception is much lower for sub-Saharan Africa (31%) than for other parts of the world (58%). Central Africa (24%) and West Africa (22%) have the lowest percentages. The low levels of contraceptive use are accompanied by an unmet need for modern contraceptives which is actually likely to be higher, as these figures do not include unmarried women[77].

While the majority of adolescent girls and young women (15 – 24 years old) in need of contraception do not use a modern method[79], the contraceptive prevalence rate among single adolescent girls and young women (15 – 24 years) in sub-Saharan Africa did increase from 23% in 2000 to 33% in 2015[75]. Adolescent birth rates are highest in sub-Saharan Africa: 1 out of 9 adolescent girls compared to the global adolescent birth rate of 1 out of 23 adolescent girls. The adolescent fertility rate decreased from 126 per 1000 live births (2000 – 2005) to 103 (2015 – 2020) as shown by Melesse et al. The adolescent birth rates is highest in Central Africa: 131/1000 adolescent girls age 15 – 19 years, followed by West Africa with 118/1000. These figures are only slightly lower for East (86/1000) and Southern Africa (107/1000). It should be considered that there are great variations even within each region, for example: in the Central African Republic, more than one in five adolescent girls had given birth in the past five years compared to 1 in 11 in Gabon. The incidence of adolescent pregnancy is strongly related to child marriages. Countries such as Niger (76%), CAR (68%), Chad (67%), Mali (52%), South Sudan (52%) and Mozambique (48%) report the highest numbers of pregnancies before the age of 18 in the region in 2017[80]. The majority of adolescent women in need of contraception do not use a modern

[76] Bahamondes L, Peloggia A., 2019. Modern contraceptives in sub-Saharan African countries. *The Lancet. Global Health*. 2019 Jul;7(7):e819-e820. DOI: 10.1016/s2214-109x(19)30199-8 - https://www.thelancet.com/action/showPdf?pii=S2214-109X%2819%2930199-8

[77] van Eerdewijk A, Kamunyu M, Nyirinkindi L, Sow R, Visser M, Lodenstein E. , 2018. The State of African Women report. 2018. Available through: https://rightbyher.org/wp-content/uploads/2018/08/SOAW-Report-FULL.pdf

[78] World Health Organisation, 2018. Family planning/contraception. WHO, 2018. https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception

Brown W, Druce N, Bunting J, et al. Developing the 120 by 20 goal for the Global FP2020 Initiative. Stud Fam Plann 2014; 45: 73–84.

Cleland J, Bernstein S, Ezeh A, Faundes A, Glasier A, Innis J. Family planning: the unfinished agenda. Lancet 2006; 368: 1810–27.

Osotimehin B. Family planning as a critical component of sustainable global development. Glob Health Action 2015; 8: 29978

[79] Singh S, Darroch JE and Ashford LS, Adding It Up: The Costs and Benefits of Investing in Sexual and Reproductive Health 2014, New York: Guttmacher Institute, 2014.- https://www.guttmacher.org/sites/default/files/report_pdf/addingitup2014.pdf

[80] United Nations Population Fund, 2019. State of World Population Report 2019: Unfinished Business: The Pursuit of Rights and Choices for All, UNFPA 2019 - https://asiapacific.unfpa.org/sites/default/files/pub-pdf/SWP19%20-%20EN%20report-web-%204%20April.pdf

method (60% globally). In addition, women younger than 25 years showed higher rates of contraceptive failure during the first year of use for all methods than women older than 25 years (Guttmacher, 2014).

Antenatal, childbirth and postnatal care, including emergency obstetric and new-born care

While there is overall decline observed in maternal and newborn mortality and an increased coverage of services in Sub-Saharan Africa, maternal and newborn mortality remains high[77,,81]: with strong variation between countries and across regions, approximately 66% of all maternal deaths occur in sub-Saharan Africa according to estimates by WHO, UNICEF, UNFPA, World Bank Group and the UNDP in 2015[82] Sub-Saharan Africa accounts for 546 maternal deaths per 100.000 live births.

In general, the decline is reflected in a lower proportion of deaths from direct obstetric causes (e.g. post-partum haemorrhage, hypertensive disorders in pregnancy, obstructed labour), but has shifted to a proportionate increase in indirect mortality. This phenomenon, called obstetric transition[83], is induced by shifts in the environment, such as increasing urbanization, increased wealth (contributing to the global obesity crisis), as well as changes in the demographics of pregnant women themselves (e.g. increased age at first pregnancy). Control programmes have reduced the incidence of malaria, but climate change and globalisation are probably driving the spread of other infectious diseases across the world, such as dengue (and Zika, currently less a problem for Sub-Saharan Africa but a threat for the future[84]). While a large proportion of maternal deaths and most neonatal deaths occur in the first weeks after delivery, the provision and quality of postnatal care as part of the continuum of care is still far from universal[85].

Increased risks of pregnancy related complications and maternal deaths can be found among adolescents girls and young women giving birth at a very young age. Complications during pregnancy and childbirth are a leading cause of death among adolescent girls in sub-Saharan Africa. Also the post-partum health risk such as obstetric fistula is a major source of morbidity in sub-Saharan Africa[77]. In addition, the firstborn children of adolescent mothers are faced with increased health related risks such as neonatal mortality, pre-term birth and infant mortality, as well as stunting and anaemia than those with older mothers (Guttmacher-Lancet, 2018). Another review[86] showed that stillbirths and deaths of babies born from adolescent and young mothers younger than 20 years are 50% higher compared to mothers aged 20 to 29 years. The same study showed that still a significant pregnant adolescents in sub-Saharan Africa do not access maternity services.

[81] Starrs AM, Ezeh AC, Barker G et al., 2018. Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission, The Lancet, 2018. https://www.thelancet.com/commissions/sexual-and-reproductive-health-and-rights

[82] World Health Organisation, 2015. Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva: WHO 2015 - https://apps.who.int/iris/bitstream/handle/10665/194254/9789241565141_eng.pdf;jsessionid=1442A7D1AA7B6328F5591FE8377EE9AA?sequence=1

[83] Souza JP, TuncßalpO, Vogel JP, Bohren M, Widmer M, Oladapo OT, Say L, Gulmezoglu AM, Temmerman M., 2014. Obstetric transition: the pathway towards ending preventable maternal deaths. *BJOG* 2014; 121 (Suppl. 1): 1–4 - https://obgyn.onlinelibrary.wiley.com/doi/pdf/10.1111/1471-0528.12735

[84] Baraka, Vito, and Eliningaya J Kweka, 2016. "The Threat of Zika Virus in Sub-Saharan Africa - The Need to Remain Vigilant." *Frontiers in public health* 2016, doi:10.3389/fpubh.2016.00110. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4885858/

[85] Benova L, Owolabi O, Radovich E, Wong KLM, Macleod D, Langlois EV, et al., 2019. Provision of postpartum care to women giving birth in health facilities in sub-Saharan Africa: A cross-sectional study using Demographic and Health Survey data from 33 countries. *PLoS Med* 16(10): e1002943. https://doi.org/10.1371/journal.pmed.1002943- https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002943

[86] Mekonnen, T., Dune, T. & Perz, J., 2019. Maternal health service utilisation of adolescent women in sub-Saharan Africa: a systematic scoping review. *BMC Pregnancy Childbirth* 19, 366 (2019). https://doi.org/10.1186/s12884-019-2501-6- https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-019-2501-6

Abortion

In recent years, overall access to health care improved and more governments prioritize implementing World Health Organization (WHO) guidelines, including access to quality post-abortion care. This trend in combination with safer procedures, including use of pharmaceutical drugs (such as combined misoprostol-mifepristone) and training of professionals, resulted in fewer women dying from unsafe abortion. A study conducted in 2016 by Sedgh et al. showed that in 2014 approximately 44% of all pregnancies in sub-Saharan Africa are unintended: with great variations between the regions, varying from 28% of all pregnancies being unintended in West Africa to 65% in Southern Africa. The percentage of all pregnancies ending in an induced abortion is 16% in sub-Saharan Africa, where the proportions for Eastern, Central and Western Africa (14, 13, 12% respectively) are comparable, while 1 in 4 pregnancies ends in abortion annually in Southern Africa[87], [88]. Worldwide (and in most sub regions in the world), the estimated annual abortion rates for women age 15 – 44 years are higher among married women (36%) than among unmarried women (25%) between 2010 - 2014. However, in sub-Saharan Africa unmarried women have higher annual abortion (36%) rates than married women (26%)[89].

There is a great diversity of legal status of abortion among the different countries in the sub-regions in sub-Saharan Africa. Five different categories have been identified by the Center for Reproductive Rights[90]:

1. Upon request, with the most common gestational limit of 12 weeks. South Africa, Mozambique and Guinea-Bissau fall in this category.
2. Broad social and economic grounds: to permit abortion under a broad range of circumstances. For example, in Rwanda and Ethiopia abortion is permitted in cases of rape, incest and fetal impairment and additional grounds. In Zambia abortion is allowed in cases of fetal impairment.
3. To preserve health: to permit abortion on the basis of (mental) health or therapeutic grounds. The following countries can be categorized here: Liberia, Ghana, Eritrea, Chad, DRC, Mauritius, Eswatini, Namibia, Botswana which specifically make reference to mental health. Furthermore, Lesotho, Zimbabwe, Burundi, Kenya, Cameroon, CAR, Niger, Benin, Togo, Burkina Faso, Guinea. Finally also Equatorial Guinea fits this category but parental and spouse consent is required.
4. To save a woman's life: to permit abortion when the woman's life is at risk. Countries in sub-Saharan Africa within this category are: Malawi, Tanzania, Gabon, Uganda and Somalia, South Sudan, Sudan, Nigeria, Cote d'Ivoir and Mali.
5. Prohibited altogether: abortion is not permitted under any circumstances, also not when the woman's life or health is at risk. Countries in sub-Saharan Africa in this category are Madagascar, Angola, Congo, Sierra Leone, Senegal and Mauritania.

According to the Guttmacher Institute, abortion rates are not significantly affected by the legal status of abortion: abortion rates in countries with a restrictive legal environment are approximately the same as abortion rates in countries with a liberal legal environment: 37 and 34 per 1,000 women, respectively.[80] These findings underline that restricting access to abortions does not reduce the number

[87] Guttmacher Institute, 2017. 'Abortion Worldwide: Uneven Progress and Unequal Access'. Washington, DC: Guttmacher Institute - https://www.guttmacher.org/sites/default/files/report_pdf/abortion-worldwide-2017.pdf

[88] Ganatra, B., Gerdts, C., Rossier, C. et al., 2017. 'Global, Regional, and Subregional Classification of Abortions by Safety: Estimates from a Bayesian Hierarchical Mode'. *The Lancet* 390: 2373–81

[89] Sedgh, G., Bearak, J., Singh, S. et al., 2016. 'Abortion Incidence between 1990 and 2014: Global, Regional, and Subregional Levels and Trends'. *Lancet* 388(10041): 258–67 -https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5498988/

[90] Center for Reproductive Rights, website The World's Abortion Laws: The definitive record of the legal status of abortion in countries across the globe, updated in real time (accessed Mar 2020) - https://reproductiverights.org/worldabortionlaws

of abortions. However, in those countries where abortion is illegal, the likelihood of women undergoing *unsafe* induced abortion is significantly higher: ranging from <1% in the least restrictive countries to 31% in the most restrictive countries[87].

Of all abortions in sub-Saharan Africa, only 31.1% are safely conducted by a trained provider using a recommended method. Specifically, in Western and Central Africa sub-regions these percentages are lowest; 15.3%, 11.8% respectively. Southern Africa stands out because many of the conducted abortions are classified as safe. Each year, approximately 36.000 women and girls in sub-Saharan Africa die from the complications of unsafe abortions[91].

***Safe abortions**: refer to abortions provided by an appropriately trained provider and using a recommended (by WHO) method.*
***Unsafe abortions** - can be split in two categories: Less safe abortions: are conducted by trained providers using non-recommended methods or using a safe method but without adequate information or support from trained individuals. Least safe abortions: refer to a procedure for terminating a pregnancy performed by persons lacking the necessary skills and without a recommended method (Guttmacher, 2017)*

HIV and other STIs

The Guttmacher-Lancet identified 8 sexual transmitted infections (STIs) that are well-known of which 4 are curable STIs (syphilis, gonorrhoea, chlamydia, and trichomoniasis) and 4 are incurable viral infections (HIV, hepatitis B, herpes simplex virus, and human papillomavirus (HPV). Though the symptoms of these latter four viral infections can be managed, and HPV can be cleared from the human body on its own. In sub-Saharan Africa is the burden of STIs the highest in the world with 241 per 1000 adults (15 – 49 years) infected, with HIV being the most fatal STI.

Between 2010 – 2018, new HIV infections showed a declining trend of 23.5% in sub-Saharan Africa. In 2018, 1.088.930 people got newly infected and 470.400 people died because of AIDS[92]. Strong declines of new HIV infections were observed in Burkina Faso, Burundi, Rwanda, South Africa and Uganda, while increases were shown in Mali, Nigeria, Angola, Madagascar and South Sudan. The highest number of new HIV infections can be found in Southern Africa where AIDS related deaths, the number of PLHIV and the prevalence rates are the highest. Interesting, the lowest total number of new HIV infections, the lowest AIDS related deaths and total number of PLHIV can be found in Central Africa which represents the region with lowest number of countries but with the second highest prevalence rate. Between 2010 - 2018, the AIDS related deaths decreased with 39% in sub-Saharan Africa. In Kenya, Malawi, South Africa, Uganda and Zimbabwe the decline was even more than 50%. The HIV prevalence rate in sub-Saharan Africa is 4.8% which also declined since 2010 (5.3%). However, ten countries mostly in eastern and southern Africa with available data (37 out of 46) showed an HIV prevalence rate of more than 40 % among sex workers – with Uganda showing alarming figures of 85% prevalence among sex workers. The HIV prevalence rate among people injecting drugs is more than 20% in 3 countries (out of 6 with data available), and between 12 – 20% in 7 countries (out of 12 with data) among men having sex with men.

[91] Singh S, Maddow-Zimet I., 2016. Facility-based treatment for medical complications resulting from unsafe pregnancy termination in the developing world, 2012: a review of evidence from 26 countries. *BJOG* 2016;123:1489–1498. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4767687/pdf/BJO-123-1489.pdf
[92] Joint United Nations Programme on HIV/AIDS, 2019. UNAIDS Data 2019. Geneva, Switzerland. UNAIDS - https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf

Both UNAIDS[93] and the Guttmacher-Lancet Commission reported that (young) women are more likely to acquire HIV than men: women (15 years and older) in sub-Saharan Africa represent 59% of new HIV infections. Adolescent girls and young women in sub-Saharan Africa are 2.4 times more likely to get HIV infected than adolescent boys and young men (UNAIDS,2020). This gender divide in HIV transmission remained almost unchanged between 1995 – 2018 and is caused by biological, behavioural and structural factors (UNAIDS, 2020; Melesse et al., 2020). In 2017, adolescent girls and young women between 15 – 24 years in sub-Saharan Africa accounted for 10% of the total population and for 1 in 4 HIV infections (UNAIDS, 2018). Gender, social and cultural norms also underpin condom use for HIV and STI prevention, driven by the ability to communicate and negotiate condom use. The reported condom use at last high risk sex among adolescents is higher in Eastern and Southern Africa than in West and Central Africa and adolescent girls report lower condom use than adolescent boys (UNAIDS, 2019): in Eastern and Southern Africa 43.2% adolescent girls and 58% for adolescent boys reported condom use at last high risk sex, while in West and Central Africa 31.8% of girls and 46.2% of boys reported condom use.

In addition to HIV, other STIs contribute significantly to the SRH disease burden especially among young people who are more susceptible for infections. Chlamydia and gonorrhoea lead to pelvic inflammatory disease and infertility in women, while some types of HPV can cause cervical cancer and other cancers of the reproductive tract, such as anal, vaginal, vulvar and penile cancer. Herpes, syphilis, and gonorrhoea can increase the risk of HIV infection. Surveillance data on other STIs than HIV is much weaker, but the populations at highest risk for STIs are shown to overlap with those at risk of HIV (Liang et al., 2019). Both HIV and syphilis can be transmitted from mother to child, the latter leading to stillbirths, neonatal deaths, and pneumonia amongst others. Torrone et al., 2018[94] showed a higher prevalence of STIs among younger women (15–24 years) than older (25–49 years) women in Southern and Eastern Africa. Since 1994, the prevalence rates of all STIs, except for chlamydia, have increased also among adolescents (Liang et al., 2019). The emergency and rapid spread of the resistant Neisseria gonorrhoeae to commonly available antibacterial agents hinders infection control of untreatable gonorrhoea in sub-Saharan Africa[95].

Reproductive cancers

Reproductive cancers relate to cancers in the reproductive organs, both in men and women: breast, cervix, uterus, vulva, endometrium, ovaries, prostate, testicles and penis. Especially cervical cancers are highlighted by the Guttmacher-Lancet Commission[81] as a growing concern to cause many preventable and increasing number of deaths. There is a growing body of evidence supporting that the human papillomavirus infection (HPV) is the main cause of invasive cervical cancer. The prevalence of cervical cancer in sub-Saharan Africa is between 43.3/100.000 to 69.8/100.000 women[96]. UNAIDS (2019)

[93] Joint United Nations Programme on HIV/AIDS, 2020. 'We've got the power: Women, Adolescent girls and the HIV Response'. Geneva, Switzerland. UNAIDS, 2020 - https://www.unaids.org/sites/default/files/media_asset/2020_women-adolescent-girls-and-hiv_en.pdf

[94] Torrone EA, Morrison CS, Chen P-L, Kwok C, Francis SC, Hayes RJ, et al., 2018. Correction: Prevalence of sexually transmitted infections and bacterial vaginosis among women in sub-Saharan Africa: An individual participant data meta-analysis of 18 HIV prevention studies. *PLoS Med* 15(6):e1002608.https://doi.org/10.1371/journal.pmed.1002608

[95] Kariuki, Samuel, and Gordon Dougan, 2014. "Antibacterial resistance in sub-Saharan Africa: an underestimated emergency." Annals of the New York Academy of Sciences vol. 1323,1 (2014): 43-55. doi:10.1111/nyas.12380 ncbi.nlm.nih.gov/pmc/articles/PMC4159419/

[96] Viviano M, DeBeaudrap P, Tebeu PM, Fouogue JT, Vassilakos P, Petignat P., 2017. A review of screening strategies for cervical cancer in human immunodeficiency virus-positive women in sub-Saharan Africa. *Int J Womens Health*. 2017 doi:10.2147/IJWH.S103868 - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5298303/#!po=0.833333

reported the link between HIV and cervical cancer: the likelihood for women living with HIV to develop invasive cervical cancer is 5 times higher than for women not living with HIV. On the other hand, the overall risk for women who have (had) a HPV infection to acquire HIV infection is doubled. The review article on The State of Adolescent Sexual and Reproductive Health (2019) also highlights the increase in reproductive cancers, specifically mentioning breast and ovarian cancers among adolescents 15 – 19 years[97]. The increasing trends in cervical, breast and ovarian cancer are also observed in sub-Saharan African[98]. Several studies report limited reproductive cancer awareness, and screening and treatment services available in the sub-Saharan Africa[99], for example only 10% of girls access the HPV vaccine, compared to 90% in high income countries and only 19% of women living with HIV (between 30 – 49 years) in Malawi have ever been screened for cervical cancer[100].

Subfertility and infertility

The Guttmacher-Lancet Commission reported that approximately 186 million couples worldwide suffer from infertility and involuntary childlessness[75]. There are many effects related to infertility, including psychological distress, intimate partner violence, economic hardship, stigma and exclusion[75]. There are commonly two main categories of infertility: one related with anatomical, genetic, endocrinological and immunological problems, the other category is related to preventive problems such as reproductive tract infections (STIs), risky healthcare practices and exposure to toxic substances (diet or environment related). WHO distinguishes between primary infertility, the inability to bear a child, and secondary infertility, the inability to bear a child after an earlier birth. Secondary infertility is largely preventable or treatable through access to SRHR services (for example, safe abortion care, STI treatment) and information. While both sub-categories affect couples worldwide and in sub-Saharan Africa, secondary infertility is most common[81,101]. One of the most commonly reported cause of infertility in sub-Saharan Africa is infection-related tube damage[101], due to STIs, post-partum infections, or infections after pregnancy loss, and primarily due to unsafe abortion. With infertility remaining invisible and highly tabooed, affordable and quality fertility care is nearly non-existent in sub-Saharan Africa.

Sexual and Gender-based Violence, including harmful practices

Gender-based violence (GBV) is a manifestation and a perpetuation of gender inequalities and unequal power relations, closely linked to the subordination of women and girls, in families, communities and states. It includes multiple types of violence - physical violence, sexual violence, psychological abuse and violence, and economic abuse and exploitation – and occurs in different public and private settings, including in the family, community, workplace and educational institutions, formal and state institutions, and in situations of armed conflict and insecurity. Due to persistent gender norms, beliefs and practices several forms of gender-based violence are accepted and/or justified, for example

[97] Mengjia Liang, Sandile Simelane, Guillem Fortuny Fillo, Satvika Chalasani, Katherine Weny, Pablo Salazar Canelos, Lorna Jenkins, Ann-Beth Moller, Venkatraman Chandra-Mouli, Lale Say, et al., 2019. The State of Adolescent Sexual and Reproductive Health. *J Adolesc Health*. 2019 Dec; 65(6S): S3–S15. doi: 10.1016/j.jadohealth.2019.09.015 - https://www.sciencedirect.com/science/article/pii/S1054139X19304732

[98] Global Health Data Exchange. Website (accessed December 2019) - http://ghdx.healthdata.org/gbd-results-tool

[99] Azubuike, S.O., Muirhead, C., Hayes, L. et al., 2018. Rising global burden of breast cancer: the case of sub-Saharan Africa (with emphasis on Nigeria) and implications for regional development: a review. World J Surg Onc 16, 63 (2018). https://doi.org/10.1186/s12957-018-1345-2 -https://wjso.biomedcentral.com/articles/10.1186/s12957-018-1345-2

[100] Joint United Nations Programme on HIV/AIDS, 2016. 'HPV, HIV and cervical cancer: leveraging synergies to save women's lives'. Geneva, Switzerland. UNAIDS, 2016 - https://www.unaids.org/sites/default/files/media_asset/JC2851_HPV-HIV-cervicalcancer_en.pdf

[101] Tanywe, Asahngwa; Matchawe, Chelea; Fernandez, Ritin; Lapkin, Samue, 2018. Experiences of women living with infertility in Africa a qualitative systematic review protocol. *JBI Database System* Rev Implement Rep. 2018 Sep;16(9):1772-1778. doi: 10.11124/JBISRIR-2017-003625.https://journals.lww.com/jbisrir/Fulltext/2018/09000/Experiences_of_women_living_with_infertility_in.5.aspx

attitudes tolerating wife-beating are found in all countries albeit with considerable variations between countries and across regions. In sub-Saharan Africa more than half of the adolescent girls say wife-beating can be justified under certain circumstances[102].

There is an increasing trend observed for intimate partner violence (IPV) between 2000 – 2010 and 2012 - 2018, at least among adolescent girls[97]. In total 22% of women and girls (15 - 49 years) have been subjected to physical and/or sexual violence by a current or former intimate partner in the previous 12 months in sub-Saharan Africa (United Nations, 2019), 36.6% at least once in their lives, varying between countries from 5% to 57%[103]. Almost 15 % of women and girls in sub-Saharan Africa experienced non-partner sexual violence: with higher percentages in Central (21%) and Southern (17.4%), compared to Eastern (11.5%) and Western Africa (9.2%) (State of the African Women Report, 2018). Especially adolescent girls and young women, but also elderly women, women with disabilities, female sex workers and LBT women are more exposed and vulnerable for violence. In addition women and girls in conflict or fragile states face specific threats and types of violence, including sexual violence as a weapon of war which also affects men and boys (State of the African Women, 2018). Human trafficking mostly takes place within countries in Africa (83%) than across borders and 25% of the detected cases concern adolescent girls and young women[77]. However, collection of data on GBV is challenging and its reliability is uncertain, owing to underreporting and the sensitivity of the issue. The comparability of data is weakened because different organisations use different ways of measuring GBV. Also, most data is on IPV or non-partner violence, with less available on other forms of violence (in particular trafficking of women and girls and GBV in contexts of armed conflict and war[77].

The State of the African Women report reviewed legal and policy reforms of gender-based violence against women based on 5 indicators at national levels: Legislation on domestic violence, Criminalisation of marital rape, Legislation on sexual harassment, Law on human trafficking and National Action Plan on UNSCR 1325 (NAP1325). The report published significant variations between countries and across regions: all countries (except South Sudan) have at least one law that prohibits a form of gender-based violence against women, and half of the countries have 2 or 3 indicators covered by their laws and policies. Six countries have legislations in place for all indicators (Burkina Faso, The Gambia, Ghana, Kenya, Rwanda and Sierra Leone) and 10 countries have 4 out of 5 indicators in place (Benin, Burundi, Cape Verde, CAR, Guinea, Namibia, São Tomé and Príncipe, Senegal, South Africa and Zimbabwe). However, 7 countries only have 1 of these indicators covered: Congo Republic, Eritrea, Equatorial Guinea, Somalia, South Sudan, Sudan and Swaziland. In the Western region the main gap in legislation relate to domestic violence, marital rape and/or sexual harassment. In the Eastern region, the countries in the Horn of Africa have limited legislation on all indicators, while in the Central region lack the criminalisation of martial rape with Angola, Congo and DRC having the weakest legal and policy frameworks. In the Southern region, the legislation of prohibiting marital rape is lacking. Legal provisions regarding domestic violence (specific laws) are provided by two thirds of African countries, with 10 countries having a Penal Code. However, 3 out of 10 countries still lack a legal framework. Furthermore, 75% of African countries have legal provisions on sexual harassment with 31 countries have specific legislation and 12 address sexual harassment in work-place or education-related

[102] United Nations Children's Fund, 2014. A Statistical Snapshot of Violence against Adolescent Girls, UNICEF, New York, 2014. https://www.unicef.org/publications/files/A_Statistical_Snapshot_of_Violence_Against_Adolescent_Girls.pdf
[103] UN Women United Nations Entity for Gender Equality and the Empowerment of Women. (n.d.) 'Global Database on Violence against Women'. UN Women - http://evaw-global-database.unwomen.org/en

legislation such as the Labour Code. However, marital rape is not criminalized in 3 out of 5 countries – only in 14 countries (Benin, Burkina Faso, Cape Verde, Comoros, The Gambia, Ghana, Kenya, Lesotho, Namibia, Rwanda, São Tomé and Príncipe, Sierra Leone, South Africa and Zimbabwe) legislation can be found. Most countries have a law addressing human trafficking (except for Comoros, Congo Republic, Equatorial Guinea, Somalia, South Sudan and Sudan) but do not meet the minimum standards on the elimination of trafficking in persons (prohibition and prosecution). Approximately 50% of the countries have a NAP1325 in place, mostly in Western region (13 out of 15 countries) and limited in the Southern region (1 out of 16 countries).

The Guttmacher-Lancet commission includes harmful practices such as child marriage, sex trafficking, honour killings, sex-selective abortion, female genital mutilation and sexual harassment and abuse in the definition of gender-based violence. Female Genital Mutilation is prevalent in 27 African countries with prevalence rates of higher than 80% in Djibouti, Eritrea, Mali, Sierra Leone, Sudan, Guinea (97%) and Somalia (98%). Prevalence rates and the average age of girls being cut (before 5ht birthday, between 5 – 9 years or between 10 – 14 years) might vary between ethnic groups and across regions in countries. The report of the Secretary General on SDG progress 2019[104] presented an overall decline in the prevalence of female genital mutilation, which is also confirmed by the review article of the State of Adolescent Sexual and Reproductive Health[97] who reported that female genital mutilation declined from 35% in 2003 to 25% in 2018 in sub- Saharan Africa.

Being a violation of rights for both boys and girls, child marriage is more common among girls than boys: median ages of 33 countries in sub-Saharan Africa is for women 19.4, while 24.9 years for men[75]. While evidence showed that between 2004 – 2015 child marriage in sub-Saharan declined: the age at first marriage increased with 0.7 years for both women and men[75], the levels of child marriage are still the highest in sub-Saharan Africa with almost 4 in 10 young women married before the age of 18 (UNICEF, 2019[105]). In addition, the decline in child marriage is not uniform: in some countries there is no reported decline such as in Chad, CAR and Niger where more than 60% of all girls are married before the age of 18 years[75, 106], UNICEF, 2017). Child marriage is related to early pregnancy, social isolation and school drop outs (UNICEF, 2019). In addition, adolescent girls and young women who marry at a young age have increased risks of intimate partner violence compared to women who marry at the age of 18 or older (Guttmacher-Lancet, 2018).

Sexual Health and Well-being

Several studies show that sexual health, sexual rights and sexual pleasure are fundamental for people's health and wellbeing[107]. The Guttmacher-Lancet Commission defines Sexual Health holistically, including sexual function, satisfaction and pleasure. Access to information, counseling and services for sexual health and well-being should be part of the essential package of SRHR. The Lancet-Guttmacher

[104] United Nations, 2019. Report of the Secretary-General on SDG Progress 2019, Special Edition. United Nations, New York, 2019. https://sustainabledevelopment.un.org/content/documents/24978Report_of_the_SG_on_SDG_Progress_2019.pdf
[105] United Nations Child's Fund, 2019. UNICEF Data: Monitoring the situation of children and women. UNICEF, 2019 - https://data.unicef.org/topic/child-protection/child-marriage/
[106] Girls not Brides. Website accessed Jan 2020. Child Marriage prevalence rates - https://www.girlsnotbrides.org/where-does-it-happen/atlas/
[107] Jessie V. Ford, Esther Corona Vargas, Itor Finotelli Jr., J. Dennis Fortenberry, Eszter Kismödi, Anne Philpott, Eusebio Rubio-Aurioles & Eli Coleman (2019): Why Pleasure Matters: Its Global Relevance for Sexual Health, Sexual Rights and Wellbeing, International Journal of Sexual Health, DOI: 10.1080/19317611.2019.1654587

report flags serious global gaps with regard to these aspects in SRHR programming and research[81]. Conversations revealed that the issue of sexual health was underexposed in the recent ICPD conference and that, for that aspect, the field seems to move backwards compared to 25 years ago. Within our literature review for sub-Saharan Africa sexual health and behavior was mainly reviewed from a disease perspective[108] addressing harmful consequences such as STIs/HIV, unintended pregnancy and sexual violence. While these elements are important to address to enhance sexual health, achieving fulfilling sexual lives and elements of sexual pleasure are also important aspects of sexual health and wellbeing. There are studies found describing the relation of HIV infection and the sexual health and wellbeing of sub-Saharan African migrant women[109]. Ford et al. argued in 2019 that while sexual pleasure drives sexual behavior, is an element of overall wellbeing and linked to sexual rights, it is currently insufficiently integrated into health education and promotion[107].

The harmful consequences are well known and described for women's health and well-being, while this is more limited for men. Addressing men's SRHR is essential to address both the SRHR and gender inequality agenda[110]. Part of (young) men's SRHR is learning about sexuality and feelings, their attitudes and respect for others, and caring for their own bodies. Comprehensive sexuality education has the potential to contribute to an inclusive approach to sexual health for young people. When there is no access to comprehensive sexuality education, other sources of information are explored amongst others pornography which might support sexuality exploration for (non-heterosexual) young people but might also reinforce stereotypes and violence. Dominant masculine norms can also affect their SRH and of their sexual partners; through sexual risk behaviour, multiple sexual relationships, and reluctance to access SRHR services and counselling [110].

Comprehensive Sexuality Education

Comprehensive Sexuality Education (CSE) in combination with the development of life skills is an evidence-based strategy that positively influences outcomes on all SRHR indicators and gender equality. The International technical guidance on sexuality education - an evidence-informed approach published by UNESCO in 2018[111] has been informed by the results of two studies (2008, 2016): one review consisted of 22 rigorous systematic reviews and 77 randomized controlled trials in several countries of which more than half were situated in low or middle income countries. This review reaffirmed that curriculum-based sexuality education programmes contribute to reduced risk taking and number of

[108] Some examples:
- Sani, A.S., Abraham, C., Denford, S. et al., 2016. School-based sexual health education interventions to prevent STI/HIV in sub-Saharan Africa: a systematic review and meta-analysis. BMC Public Health 16, 1069 (2016). https://doi.org/10.1186/s12889-016-3715-https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-016-3715-4;
- Knopf, A. S., McNealy, K. R., Al-Khattab, H., Carter-Harris, L., Oruche, U. M., Naanyu, V., & Draucker, C. B., 2017. Sexual learning among East African adolescents in the context of generalized HIV epidemics: A systematic qualitative meta-synthesis. PloS one, 12(3), e0173225. https://doi.org/10.1371/journal.pone.0173225 - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5344379/;
- Shayo, F. K., & Kalomo, M. H., 2019. Prevalence and correlates of sexual intercourse among sexually active in-school adolescents: an analysis of five sub-Sahara African countries for the adolescent's sexual health policy implications. BMC public health, 19(1), 1285. https://doi.org/10.1186/s12889-019-7632-1 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6790023/#__ffn_sectitle

[109] Arrey AE, Bilsen J, Lacor P, Deschepper R (2015) Sexual Behaviour among Sub-Saharan African Migrant Women with HIV/AIDS in Belgium: A Qualitative Study. International Journal of Health Sciences & Research (IJHSR) 5: 479–490

[110] Greene, M.E., Berger, B.O., Hakobyan, L., Stiefvater, E., and Levtov, R.G., 2019. Getting to Equal: Men, Gender Equality, and Sexual and Reproductive Health and Rights. Washington, DC: Promundo-US - https://promundoglobal.org/wp-content/uploads/2020/02/BLS19364_PRO_Men-and-SRH-report_018.1-WEB.pdf

[111] United Nations Educational, Scientific and Cultural Organization, Joint United Nations Programme on HIV/AIDS, United Nations Population Fund, United Nations Children's Fund, United Nations Entity for Gender Equality and the Empowerment of Women, World Health Organisation, 2018. International technical guidance on sexuality education: an evidence-informed approach. UNESCO, 2018 - https://unesdoc.unesco.org/ark:/48223/pf0000260770

sexual partners, increased use of condoms and contraception and enhanced attitudes and knowledge on sexuality, behaviours and risks associated with pregnancy and STIs/HIV[111]. Another review conducted in 2015 by Haberland[112] showed that gender is an essential element of effective sexuality education programs to contribute to improved health outcomes as it allows for discussing context specific social and cultural norms around gender. The complementation of sexuality education with strengthened youth-friendly services, condom distribution and engaged key gatekeepers (teachers and parents) will be more impactful also in reaching marginalized young people[111]. Since the ESA commitment on CSE that was signed by 21 countries, UNESCO indicators have shown that 15 of 21 countries provide CSE in primary and secondary schools and 18 of 21 countries have CSE teacher training programs.[113] Examples of CSE programs provided in schools include 'Life Orientation' (South Africa), 'Family Life Education' (Senegal), 'Family Life and HIV Education (Nigeria), and 'Programa Geração Biz' (Mozambique)[114]. UNESCO supported 23 countries in sub-Saharan Africa in using the Sexuality Education Review and Assessment Tool to assess their national programmes. In 10 countries, curriculum content was reported as the weakest of four analysed components: content, teacher training, policy environment, programme objectives and design. The Forum for African Women Educationalists and the African Population and Health research center reported in 2019 that while many countries in sub-Saharan Africa recognize and realized the need for comprehensive sexuality education for young people, most countries lack M&E frameworks and that the content is designed without engagement from adolescents and that social taboo topics such as abortion or homosexuality are not discussed at all[114]. It highlighted the need for increased attention to relationships, sexual and reproductive health, and social norms and gender to make life skills training more relevant and effective. CSE implementation faces strong social opposition at multiple levels. Resistance from parents seems especially strong in Western Africa; five of the seven countries where a majority of parents said no to the question whether they believe 12- 14-year olds should be taught about condoms as part of HIV/AIDS prevention – a key element of a comprehensive sexuality education programme – were in Western Africa. The lowest support, 32%, was registered in The Gambia[115].

There is a lot of SRHR related information available online and access to SRH information for young people is easier than 10 years ago. In sub-Saharan Africa the total number of people with mobile phones outnumber the people with electricity: in 2016 almost 40% had mobile phones[116] and especially young people have online access. However, young people do not know how to find trustworthy online sources. Often, very remote rural areas are not covered by the web which challenges new digital SRHR approaches.

[112] Haberland, Nicole, 2015. The Case for Addressing Gender and Power in Sexuality And HIV Education: A Comprehensive Review of Evaluation Studies. International perspectives on sexual and reproductive health, 2015. 41. 31-42. 10.1363/4103115 - https://www.guttmacher.org/journals/ipsrh/2015/03/case-addressing-gender-and-power-sexuality-and-hiv-education-comprehensive

[113] United Nations Educational, Scientific and Cultural Organization, website accessed on Mar 2020 – UNESCO. https://opendata.unesco.org/focus_area/Health%20and%20HIV%20education

[114] Frederick Murunga Wekesah, Vivian Nyakangi, Michael Onguss, Joan Njagi, and Martin Bangha. 2019. Comprehensive Sexuality Education in Sub-Saharan Africa. Nairobi, Kenya: African Population and Health Research Center (APHRC)

[115] United Nations Educational, Scientific and Cultural Organization; Global Education Monitoring Report, 2019. Policy Paper. Facing the facts: the case for comprehensive sexuality education. UNESCO, 2019. https://www.gfmer.ch/SRH-Course-2019/adolescent-health/pdf/UNESCO-CSE-2019.pdf

[116] The economist – website, accessed in December 2019 - https://www.economist.com/graphic-detail/2017/11/08/in-much-of-sub-saharan-africa-mobile-phones-are-more-common-than-access-to-electricity

WHAT ARE THE GAPS?

In this chapter gaps related to access to quality services in SRHR in sub-Saharan Africa are described.

Within the recent demand of a more holistic view of SRHR, it has been highlighted that SRHR issues such as gender-based violence, access to safe abortion services, and sexual rights for adolescents and the LGBTI+ community has been neglected in health and development initiatives, including the movement towards UHC (Starrs et al., 2018). Addressing SRHR within UHC has generally found practical expression in expanding coverage of certain SRH services, mainly reproductive health services such as maternal and antenatal care. Sexual and rights components of SRHR receive less attention in national UHC schemes. Moreover, the inclusion of SRH services in basic health packages within UHC reforms does not guarantee that it is accessible for all the population, especially for the most vulnerable groups as the risk protection scheme that the benefit package applies to does not cover the entire population (but only subgroups such as civil servants or those actively paying premium to enrol), and other (e.g. financial, geographical, responsiveness) access barriers may continue to persist. While the attractiveness of UHC in relation to SRHR relied in its affirmation of the right to health, which links to the principle of universality and implies addressing key social determinants of health with multisector initiatives and adopting a rights approach. It also demands attention to the fact that universality does not translate automatically into equity. Equity needs to be built in the movement towards UHC by focusing and reaching first the most vulnerable groups, including women and adolescents. With equity in access we refer to individuals in need of services are able to access them irrespective of their ability to pay, socioeconomic status, geographic location, ethnicity, education or gender and are empowered to use these services as defined by UNFPA in 2019[117].

Inequity in access

In several countries in sub-Saharan Africa, progress can be observed in increasing access to SRH services contributing to a decreased maternal mortality[118]. A supplement of the Journal of Adolescent health (2019) on the progress in the 25 years since the ICPD and prospects for the next 25 years reflects the milestones in expanding access to quality ASRHR services[119]. Evidence shows that some indicators such as intimate partner violence and reproductive cancers have worsened, but that significant declines are observed in adolescent pregnancy, child marriage, and female genital mutilation, increased funding for programs and research targeting adolescents; and a significant growth in the number of evidence-informed policies, normative documents, and guidelines on adolescent-responsive SRHR programming. However, the poorest populations, adolescents, people in countries facing conflict or insecurity, and women with specific health needs (e.g. HIV positive women), people with disabilities and LGBTQI people have not yet shared equally in this development, and substantial inequalities across and within countries in key indicators remain. As indicated above and as reported by one of the key informants, there are great variations in terms of progress of access of SRHR services looking at adolescent pregnancies, unmet need and unsafe abortions within the region but also within countries. This shows

[117] United Nations Population Fund, 2018. Sexual and Reproductive Health and Rights: An essential element of Universal Health Coverage. UNFPA, 2018 - https://www.unfpa.org/sites/default/files/pub-pdf/SRHR_an_essential_element_of_UHC_SupplementAndUniversalAccess_27-online.pdf

[118] Alkema L, Chou D, Hogan D, et al. Global, regional, and national levels and trends in maternal mortality between 1990 and 2015, with scenario-based projections to 2030: a systematic analysis by the UN Maternal Mortality Estimation Inter-Agency Group. Lancet. 2016;387:462–74.

[119] [119] W. Kabiru, C. , 2019. Adolescents ' Sexual and Reproductive Health and Rights : What Has Been Achieved in the 25 Years Since the 1994 International Conference on Population and Development and What Remains to Be Done ? *Journal of Adolescent Health*, *65*(6), S1–S2. https://doi.org/10.1016/j.jadohealth.2019.09.010

that progress is not evenly distributed and inequity in terms of access exist. Inequities in accessing SRH services are affected by income inequality, the quality and reach of health systems, laws and policies, education, social and cultural norms, and people's exposure to information and sexuality education.

Unequal access of the poorest of the poor

Generally, access to SRH services is lowest among the poorest 20% of households and highest among the richest 20%[120]. A study published in 2019 on trends in utilization and inequality in the use of reproductive health services in sub-Saharan Africa, showed mixed results. While the increase in use of reproductive health services in several sub-Saharan Africa countries over the last 20 years is considered substantial, the study emphasized that that the levels of inequality in the use of reproductive health services remain high and are pro-rich, especially in East, Central and West Africa[120]. Poverty and financial barriers still limit access to SRHR services[121],[122]. Poor women and adolescent girls in rural areas face challenges in accessing services as services are often located far away and are associated with costs. Distance to services may limit access as transportation costs or opportunity costs for women leaving their homes or livelihoods are too high[122,123.] In addition, costs of the services including out of pocket patient payments and the impact of these costs on household budget also hinder access[124]. According to one of our key respondents, especially when people have limited resources to invest in health services and get sick, they will only access health services when they have tried everything else and their health status worsen. These investments further affect their household budgets and increase their poverty. This is also confirmed by a scoping review (2018) and a commentary in the BMJ Journal of Global Health (2019)[125] of sub-Saharan Africa[124] in which catastrophic health expenditure (when out of pocket payments for the services exceeds the household capacity to pay), or impoverishment (when the average household consumption after health care payment is below the international or national poverty line) are described to be prevalent in sub-Saharan Africa and mostly affect the poorest. Catastrophic health expenditure is shown to be associated with adolescent pregnancy and childbearing among the poorest households deepening impoverishment and exacerbate social inequity [126]. According to the scoping review, patients with HIV, TB and Malaria face the highest incidence of catastrophic expenditure due to their continued (or repeated in case of Malaria) health expenses and medication[124]. In addition, women are more likely to experience catastrophic health expenditures, and

[120] Abekah-Nkrumah, G., 2019. Trends in utilisation and inequality in the use of reproductive health services in Sub-Saharan Africa. BMC Public Health 19, 1541 (2019). https://doi.org/10.1186/s12889-019-7865-z https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-019-7865-z

[121] Sally Griffin, 2006. Literature review on Sexual and Reproductive Health Rights: Universal Access to Services, focussing on East and Southern Africa and South Asia https://pdfs.semanticscholar.org/cf0f/03001f2303db42d6955f67cfbf757bdf92b9.pdf

[122] Kyei-Nimakoh, M., Carolan-Olah, M. & McCann, T.V., 2017. Access barriers to obstetric care at health facilities in sub-Saharan Africa—a systematic review. Syst Rev 6, 110 (2017). https://doi.org/10.1186/s13643-017-0503-x https://systematicreviewsjournal.biomedcentral.com/articles/10.1186/s13643-017-0503-x

[123] van Eerdewijk A, Kamunyu M, Nyirinkindi L, Sow R, Visser M, Lodenstein E. 2018. The State of African Women report. 2018. Available through: https://rightbyher.org/wp-content/uploads/2018/08/SOAW-Report-FULL.pdf

[124] Njagi, P., Arsenijevic, J. & Groot, W., 2018. Understanding variations in catastrophic health expenditure, its underlying determinants and impoverishment in Sub-Saharan African countries: a scoping review. Syst Rev 7, 136 (2018). https://doi.org/10.1186/s13643-018-0799-1 https://systematicreviewsjournal.biomedcentral.com/articles/10.1186/s13643-018-0799-1

[125]Nabyonga-Orem J, Nabukalu JB, Okuonzi SA., 2019. Partnership with private for-profit sector for universal health coverage in sub-Saharan Africa: opportunities and caveats. BMJ Global Health 2019;4:e001193 - https://gh.bmj.com/content/4/Suppl_9/e001193.full

[126] Mori, A.T., Kampata, L., Musonda, P. et al., 2017. Cost-benefit and extended cost-effectiveness analysis of a comprehensive adolescent pregnancy prevention program in Zambia: study protocol for a cluster randomized controlled trial. Trials 18, 604 (2017). https://doi.org/10.1186/s13063-017-2350-4 https://trialsjournal.biomedcentral.com/articles/10.1186/s13063-017-2350-4

is domestic violence against women shown to be significantly associated with high catastrophic health expenditures[127].

Human rights and gender: unequal access of adolescents and LGBTQI and limited attention for quality of care

Adolescents

Major challenges in terms of accessing SRHR services and information are particularly relevant for adolescent and young people [128] as they are vulnerable and at risk for SGBV, child marriage, (unintended) teenage pregnancy, unwanted sex or marriage, unsafe abortions, and STIs including HIV. Kabiru (2019) identified the critical gap in efforts to implement adolescent SRHR policies and programs, which are impeded by extensive resistance to provide comprehensive SRHR information and services to adolescents because of social norms and taboos around adolescents' sexuality. In addition, a major gap remains between continental and regional policies and the actual implementation of CSE on the ground. Gender-responsive and life-skills-based CSE is only covered in the national curriculum by 15% of the 78 countries analysed in UNESCO's 2016 Global Education Monitoring Report. Fifteen out of twenty-one countries within the ESA commitment reported providing CSE and life skills in at least 40% of primary schools, and 12 countries in at least 40% of secondary schools. Fifteen countries have developed a strategic plan or national policy on sexuality education for out-of school youth. The countries vary in the extent to which teachers and health workers are trained in CSE and life skills, in either pre-service and in-service programmes.[129] Also the impact of CSE strongly relies on the quality. Patriarchal, cultural and social values, norms and (negative or judgmental) attitudes of service providers constrain access to SRHR services, especially in contexts where high fertility is valued or where pre-marital or young people's sexuality is stigmatized or shamed[77]. Provider bias with respect to young women's age, marital status and their parity constrain young women's access to contraceptives and prevent them to avoid unintended pregnancies - as shown by the review done by M. Campbell et al. (2006) , the study in Uganda by G. Nalwadda et al. (2016), the study in 33 countries in sub-Saharan Africa by E. Radovich et al. (2018) and the recent report by Guttmacher-Lancet Commission (2018) amongst many others. One of the key informants mentioned that the attitudes of health care providers are crucial in ensuring access to SRHR services especially for young people and LGBTI. According to one key informant, patriarchal norms in rural areas where women have to seek permission from the spouses and men to access FP services are crucial. *"Even when you look deeply, it is the patriarchal society driving the conversation on SRHR, the 'place' of a women in society and her ability to make her own decisions."* [key informant]

Social and patriarchal norms around SRHR and related stigma of seeking SRHR services impacts the choices and decisions of individuals and prevent them from seeking services. Specific restrictive laws or policies may further block the access to services by adolescents and women or when third party (such

[127] Brinda, E.M., Andrés, R.A. & Enemark, U., 2014. Correlates of out-of-pocket and catastrophic health expenditures in Tanzania: results from a national household survey. BMC Int Health Hum Rights 14, 5 (2014). https://doi.org/10.1186/1472-698X-14-5 https://bmcinthealthhumrights.biomedcentral.com/articles/10.1186/1472-698X-14-5

[128] *A large percentage of the population (32%) in sub-Saharan Africa consist young people (age 10 – 24 years) according to the UNFPA State of World population 2016.*

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

as husbands and/or parents) authorization may be required[130]. This results in a higher unmet need for modern contraceptives among unmarried sexually active women, than among married women (Singh and others, 2018). According to one of the key informants the age of consent and agency are big issues for young people, especially girls, to access services: power dynamics play a crucial role*: who can decide to use and provide SRHR services*. This is not only related to gender or age but also to sexual orientation and religion. Also in the area of quality of SRHR services for young people and adolescents there are many challenges. There is generally limited attention for youth needs and youth friendly services are not effective as these are delivered piecemeal and not sufficient in quality nor quantity[131]. There is no clear evidence informed model nor vision for YFHS (although there are many checklists available, these are only used to a certain extent). Taking into account that there is no homogenous group of young people, there is a need for more understanding of the needs of young people in different contexts. In programs and policies, there is still limited focus on adolescent boys despite the emphasis on needed efforts to be made to include their active involvement in responsible parenthood, sexual and reproductive behavior, including family planning; prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV; prevention of unwanted and high-risk pregnancies.

LGBTQI

Furthermore, ethnic minorities, sex workers, people with disabilities, and LGBTQI people face marginalization and stigma affecting their access to services and information. Major marginalization of LGBTQI people and their vulnerability to poor SRHR outcomes, including HIV infection, have been reported. LGBTQI people are faced with high levels of sexual and other violence. However, limited data is available around LGBTQI. Specifically, LGBTQI people specifically face challenges in terms of attitudes of service providers including denial of care, discriminatory attitudes and pathologization. The social norms aspects will be further described in chapter 3.3. Same sex relationships are still criminalized in many countries in sub-Saharan Africa: legal frameworks, policies and laws that criminalize same-sex relationships, sex work and drug use can force people into hiding and prevent them from seeking or receiving the information and services they need. There are major setbacks in terms of human rights and LGBTQI. The Amnesty International's report Making Love a Crime: Criminalization of same-sex conduct in sub-Saharan Africa show that "homosexual acts" are being increasingly criminalized across Africa. Violations of LGBTQI rights are underreported and often not properly prosecuted, leading to widespread impunity and limited support for victims[132,133]. No adequate police and government response exist to protect one part of its population from violence. The legal and policy barrier is specifically addressed in chapter 3.1.

Limited attention for quality of care

Poor quality care due to a lack of adequate staffing, training, infrastructure and supplies is known as "too little, too late" (TLTL) resulting in high maternal mortality and morbidity. It was also reflected upon

[130] Ann Strode, Rofiah Sarumi, Zaynab Essack & Priya Singh, 2018: A feminist critique of legal approaches to adolescent sexual and reproductive health rights in Eastern and Southern Africa: Denial and divergence versus facilitation Agenda

[131] Chandra-Mouli, V., Lane, C., & Wong, S., 2015. What Does Not Work in Adolescent Sexual and Reproductive Health: A Review of Evidence on Interventions Commonly Accepted as Best Practices. Global health, science and practice, 3(3), 333–340. https://doi.org/10.9745/GHSP-D-15-00126 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4570008/

[132] Amnesty International, 2013. Making love a crime: criminalization of same-sex conduct in sub-Saharan Africa. London, Amnesty International 2013 https://www.amnesty.org/download/Documents/8000/afr010012013en.pdf

[133] United Nations, 2015. Ending Violence and Discrimination against Lesbian, Gay, Bisexual, Transgender and Intersex People. UN statement, 2015 - http://www.who.int/hiv/pub/msm/Joint_LGBTI_Statement_ENG.pdf?ua=1

by key informants that the quality of the services strongly depend on the skills of the providers – especially also in terms of IUDs, MVAs and implants. These commodities require specific skills and without these, the choice remains limited (condom and pills). On the other side, the routine over-medicalization is known as "too much too soon" (TMTS). TMTS refers to the unnecessary use of interventions that are not evidence-informed, and the use of life-saving interventions which can be harmful and costly when applied routinely (such as caesareans)[134]. The relationship and interaction between client's rights and providers' needs is also central to the quality of care.

Hogan et al.[135] pointed to the fact that in the measurement of UHC and consequently SDG3, particularly in the indicators constituting UHC index, quality of care is hardly taken into account. Besides, the usual indicators focus on a limited subset of indicators, covering mostly primary level service delivery. The Healthcare Access and Quality Index, for which baseline data have been estimated and published recently, aims to broaden that perspective, and includes indicators that also cover aspects of hospital quality of care, using the concept of amenable mortality across a number of conditions[136]. This is important in raising awareness of stakeholders on the current status of the mostly neglected aspects of quality of care, as a starting point for improvements.

Lack of integrated policies addressing both climate change and SRHR

The systematic review (2019) published in the Lancet showed that there is a growing evidence base which links women's met needs for family planning with reduced vulnerability to climate change and enhanced resilience in the face of climate change impacts[137]. Family planning can be seen as a key, rights-based and cost-effective climate adaptation strategy[138]. Low income and high fertility communities are seriously affected by climate change. Coping mechanisms of these communities relate to negative SRHR outcomes, including violence within the household according to Karen Newman of the Population and Sustainability Network (UK)[139]. However, family planning or SRHR are only integrated to a limited extent into proposals, projects or policies addressing climate change. Resilience should be further enhanced through integrating SRHR in climate change adaptation and mitigation policies and practices. An example comes from Madagascar, the Blue Ventures project which integrated community based family planning services with environmental conservation initiatives which led to increased uptake of contraceptives and decline in fertility[140].

[134] Suellen Miller, Edgardo Abalos, Monica Chamillard, Agustin Ciapponi, Daniela Colaci, Daniel Comandé, Virginia Diaz, Stacie Geller, Claudia Hanson, Ana Langer, Victoria Manuelli, Kathryn Millar, Imran Morhason-Bello, Cynthia Pileggi Castro, Vicky Nogueira Pileggi, Nuriya Robinson, Michelle Skaer, João Paulo Souza, Joshua P Vogel, Fernando Althabe, 2016. Beyond too little, too late and too much, too soon: a pathway towards evidence-based, respectful maternity care worldwide. *The Lancet*, Volume 388, Issue 10056, 29 October–4 November 2016, Pages 2176-2192https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)31472-6/fulltext

[135] Daniel R. Hogan, Gretchen A. Stevens, Ahmad Reza Hosseinpoor, Ties Boerma., 2018. Monitoring universal health coverage within the Sustainable Development Goals: development and baseline data for an index of essential health services. Lancet Glob Health 2018; 6: e152–68

[136] GBD 2016 Healthcare Access and Quality Collaborators, 2018. Measuring performance on the Healthcare Access and Quality Index for 195 countries and territories and selected subnational locations: a systematic analysis from the Global Burden of Disease Study 2016. *Lancet* 2018; 391: 2236–71 https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30994-2/fulltext

[137] Patterson KP, Mogelgaard K, Kabiswa C, Ruyoka R., 2019. Building resilience through family planning and climate adaptation finance: systematic review and opportunity analysis. *The Lancet Planetary Health* 2019 September 2019;3:S12.

[138] Population & Sustainability Network: Promoting Reproductive Rights for Sustainable Development – Website Population dynamics & climate change (accessed Dec 2019) - https://populationandsustainability.org/advocacy/population-climate-change/

[139] Mtb Bulletin of the Netherlands Society for Tropical Medicine and International Health, 2019. Climate Change and Health https://issuu.com/nvtg_mt/docs/2019_mt_03-web/30

[140] Laura Robson, Martine Holston, Caroline Savitzky, Vik Mohan, 2017. Integrating Community-Based Family Planning Services with Local Marine Conservation Initiatives in Southwest Madagascar: Changes in Contraceptive Use and Fertility. Stud Fam Plann. 2017 Feb 16 Published online 2017 Feb 16. doi: 10.1111/sifp.12016https://onlinelibrary.wiley.com/doi/epdf/10.1111/sifp.12016

Lack of access to SRHR services for displaced people

Competing priorities ensuring access to basic lifesaving services, contribute to a lack of quality SRHR services according to UNFPA (2019) as these are often not perceived as directly lifesaving. The focus predominantly goes towards safe motherhood interventions while programs to prevent and respond to SGBV, family planning and comprehensive contraception services and safe abortion care, as well as adolescent SRHR are under-prioritized. This is also partly due to the highly politicized nature of the services as well as the misconceptions of health providers and communities regarding legal restrictions[140.] The following SRHR service delivery gaps have been identified by IAWAG (2015): *limited specific focus on adolescent reproductive health and marginalised groups, lack of full systematic MISP implementation, limited emergency obstetric and new-born care, absences of comprehensive abortion care, including safe abortion and post-abortion care at the primary care level, limited available long-acting and permanent FP methods and emergency contraception, inadequate prevention and management of sexual violence, limited antiretroviral therapy at the primary care level, inadequate diagnosis and treatment of STIs and cervical cancer.* Singh et al. (2018) highlighted the lack of access to SRHR services in humanitarian settings specifically addressing the needs of vulnerable and hard to reach populations such as LGBTI and adolescents. Awareness of SRHR services, language barriers and knowledge of how the health systems functions are also major challenges. Mental health is relevant to many aspects of SRHR but services are not integrated into SRHR interventions. Besides the trauma people may have due to the crisis itself, mental health problems can be related mental and psychological consequences of miscarriage, abortion or complications stemming from pregnancy and childbirth, lack of support following childbirth, gender-based violence (GBV) and HIV and AIDS. Among adolescents, suicide is the second leading cause of death (UNFPA, 2008; WHO, 2019).

Other barriers to access SRHR services and information

Limited availability of human resources, commodities, privacy and choice

The unreliable supplies of contraceptives, lack of proper equipment and/or trained staff, the limited availability of preferred choice of method and lack of privacy and confidentiality also play key roles. A study conducted in 10 African countries in 2018 showed that stock outs and logistics management problems are very common. The study showed the gaps between reported and actual available products and services[141]. Another review conducted by Mukasa et al. in 2017 showed similar results when looking at the supply chain of access to commodities of public and private health facilities in low and middle income countries. The review included studies in 10 African countries and showed a strong relation between supply chain system inefficiencies and stock outs of contraception, mostly caused by weak logistical management information systems and limited trained staff for supply chain management. Issues of infrastructure and the lack of accountability mechanism for stock outs at national and local levels are mentioned to be contributing factors[142]. Partly due to the limited available data on stocks and consumptions and insufficient management capacity, there is limited coordination between central and facility levels . As a result many facilities are facing either stock outs (or stock

[141] Moazzam Ali, Madeline Farron, Thandassery Ramachandran Dilip, Rachel Folz, 2018. Assessment of Family Planning Service Availability and Readiness in 10 African Countries. *Global Health: Science and Practice* Oct 2018, 6 (3) 473-483; DOI: 10.9745/GHSP-D-18-00041 - http://www.ghspjournal.org/content/6/3/473

[142] Bakali Mukasa, Moazzam Ali, Madeline Farron & Renee Van de Weerdt, 2017. Contraception supply chain challenges: a review of evidence from low- and middle-income countries, The European Journal of Contraception & Reproductive Health Care, 22:5, 384-390, DOI: 10.1080/13625187.2017.1394453 - https://www.tandfonline.com/doi/full/10.1080/13625187.2017.1394453

overs). Interviews confirmed that there is a discrepancy between the actual and reported demand of products, as is with actual and reported stock outs. Also an assessment reported by UNFPA and FP2020 in 24 countries that health services run out of stock of some commodities for 75% of the time[80].
In addition to the stock outs, a global shortage of 7.2 million health workers is reported with more than 92% of the maternal and newborn mortality occurring in countries where only 42% of the world's medical, midwifery and nursing personnel are living and working. These barriers are in line with the findings from the key informant interviews during which the inadequate functioning of the supply chain, lack of human resources, trained service providers, severe stock outs and limited choice was often mentioned to contribute to limited coverage.

Myths and misconceptions around SRHR

Myths, misperceptions or a lack of understanding about SRHR issues influence decision-making and therefore accessing SRH services. Also with respect to contraceptive methods there are many misconceptions, including a fear of side-effects. Sedgh and Hussain[143] showed that the most commonly reported reasons for non-use of contraceptives include infrequent sex and concerns about side effects or health risks.

CONSIDERATIONS FOR SIDA'S STRATEGY

- Plesons et al.[144] further outlined opportunities and challenges, leading to strategic actions to achieve progress in ASRHR:
    - mobilize and make full use of political and social support for ASRHR policies and programs through building alliances with like-wise donors to really take a share in making sure that access for adolescents in addressed.
    - Invest in making ASRHR data and evidence available to strengthen advocacy, policies, and programs;
    - manage the implementation of ASRHR strategies at scale with quality and equity
- To support social protection and prevent inequity in access: strengthen social protection policies to ensure that the most vulnerable populations are protected from catastrophic health expenditures and impoverishing effects of health payments. Alternative ways of financing could be explored, such as voucher systems.
- To reduce inequality in access: best practices in terms of policies can be explored in countries where utilization of services increased and inequality reduced irrespective of the per capita income. For example the health policy and implementation strategy of Rwanda could be further explored to extract lessons which might be used to support other countries with limited progress
- To integrate SRHR and climate change: a policy brief developed by the population reference bureau in 2018[145] highlights several strategies to promote inclusion of family planning in climate change adaptation strategies to strengthen resilience, improve health and enhance women's economic

[143] Sedgh G, Hussain R., 2014. Reasons for contraceptive nonuse among women having unmet need for contraception in developing countries. Stud Fam Plan. 2014;45(2):151–69. https://www.ncbi.nlm.nih.gov/pubmed/24931073
[144] Plesons, Claire B. Cole, Gwyn Hainsworth, Ruben Avila, Kalisito Va Eceéce Biaukula, Scheherazade Husain, Eglė Janušonytė, Aditi Mukherji, Ali Ihsan Nergiz, Gogontlejang Phaladi, B. Jane Ferguson, Anandita Philipose, Bruce Dick, Cate Lane, Joanna Herat, Danielle Marie Claire Engel, Sally Beadle, Brendan Hayes, Venkatraman Chandra-Mouli, 2019. Forward, Together: A Collaborative Path to Comprehensive Adolescent Sexual and Reproductive Health and Rights in Our Time, Journal of Adolescent Health, Volume 65, Issue 6, Supplement, 2019, Pages S51-S62, ISSN 1054-139X, https://doi.org/10.1016/j.jadohealth.2019.09.009.
[145] Kathleen Mogelgaard and Kirsten Patterson, 2018. Building resilience through family planning and adaptation finance – Policy Brief. Population reference bureau, March 2018. https://www.prb.org/wp-content/uploads/2018/03/18-057-Building-Resilience-Through-FP-and-Adaptation-Finance-2018-03-20-1555_FINAL.pdf

empowerment. The recommendations focus on strengthening the evidence base for the inclusion of women's empowerment, including family planning, in multi-sectoral adaptation approaches, engage with regional and national decision-makers and stakeholders on adaptation strategies, integrate women's empowerment , including family planning, in multi-sectoral adaptation proposals and policies.

- To improve supply chains to prevent stock outs: support national level political commitment to strengthen supply chains for modern contraception, and stimulate active involvement of all stakeholders at country level and effective logistical management information systems.
- To improve the quality of care: keep it on the agenda and stimulate through policy to include attention for the quality of care, include training of providers in respectful care, adherence to best practices and interpersonal communication can be suggested (Miller and others, 2016). Strategies to improve the quality of care should also consider the needs of the providers such as training, supplies, guidance, respect, encouragement and feedback.
- To promote the access to SRHR information, the establishment of national curricula for CSE should be stimulated. Engaging with Media to providing other ways of accessing to comprehensive SRHR information could be explored.

The role of private sector in accessing SRHR services

For both achieving the SDGs and goal of universal access to family planning stated in FP2020, engagement with the private sector is acknowledged to be critical (GRI website, 2018; Riley et al., 2018) as in many countries in sub-Saharan Africa the public sector cannot provide these services to the whole population[146]. The effective private sector can contribute to the national health response and public sector gaps in health care delivery, also with respect to family planning. Private sector is not 'one homogenous group of actors' but consist of different players such as (multinational) corporations (as part of their corporate social responsibility), NGOs, private institutions (such as private foundations, private hospitals and clinics), and private individuals (health care providers and consultants). In general, their role is in direct provision of health care, the management of health care institutions, the manufacturing of health care products or the financing of health care products and services, which are not owned or controlled by the government. The private sector can be classified as follows: private for-profit and private not-for-profit, formal (for-profit healthcare providers registered in-country and operate commercially) or informal (with unknown professional qualification operating outside the formal requirements), domestic or foreign[146,147.] Below we will further explore the role of private outlets and private providers in accessing SRHR services, and private sector initiatives in SRHR.

Private health care

A study on access and choice to modern contraceptives in Ethiopia, DRC and Nigeria (Riley et al., 2018) highlights that the private sector is the preferred source of obtaining modern contraceptives for many (young) women as this source is perceived as high quality, available, convenient and respecting privacy. In addition, according to one of the key informants the private sector is the preferred source as there is less provider stigma experienced by young women. The study done by Radovich et al, in 2018 in 33

[146] Nabyonga-Orem J, Nabukalu JB, Okuonzi SA., 2019. Partnership with private for-profit sector for universal health coverage in sub-Saharan Africa: opportunities and caveats. BMJ Global Health 2019;4:e001193. https://gh.bmj.com/content/4/Suppl_9/e001193.full

[147] World Health Organisation, 2018. The private sector, universal health coverage and primary health care – technical series on primary health care. WHO, 2018. https://www.who.int/docs/default-source/primary-health-care-conference/private-sector.pdf?sfvrsn=36e53c69_2

countries in sub-Saharan Africa[148] emphasized the current evidence for the popularity of drug shops as preferred access points for young and unmarried women. A systematic review published in 2016 reported private sector providers to be more responsive to client preferences, have shorter waiting lines and offer greater confidentiality[149].

However, the barrier young women face with accessing private sector is associated with costs. This finding was also confirmed by the study done by Radovich. A commentary published in the BMJ Journal of Global Health in 2019, further highlighted other concerns related to private for-profit providers (both informal and formal) related to the quality of services provided, the variation in capacities, unethical practices – which seems especially related to the informal private providers -, and medication based on affordability rather than dosage requirements. Private providers do provide services at times when public health facilities are closed and are more flexible to ensure timely access[149]. Bart Jacobs et al. [150]considered the potential impact of the private sector on increasing accessibility of health services to the very poor and marginalized people to be inadequate as mostly the private qualified health providers reside in economically attractive places. While in general people are able to enjoy the benefits of contraceptive goods and services delivered using retailers and the channel systems, the distribution of contraceptives to the poor remains limited - as they often live in remote areas without good roads. The environment of the urban poor is not always supportive for distributing modern contraceptive services. So, the contribution of private providers to improve access to the very poor is limited in many countries in sub-Saharan Africa due to the associated costs and limited distribution of private health facilities in remote areas[146] and might even underline inequality in access to services[149].

Private sector initiatives

With private-public engagements or partnerships in SRHR in health we refer to a formal collaboration between the public sector and private sector for the delivery of SRHR services, products, equipment, research, education or addressing social norms. These partnerships, in which each player focus on their strong areas, aim to enhance the capacity, quality and effectiveness of service delivery through sharing expertise and lessons learned. Private-public partnerships (PPPs) can also potentially contribute to the public sector gap in access to SRHR services.

A systematic review conducted in 2016 of public-private engagements in health care delivery in Southern Africa identified 52 initiatives representing different models: social marketing, sector-wide approach (SWAp), contracting out, voucher programmes, public – private mix (PPM) approach, DP regulation, financing, and public-private partnership (PPP). Among these public private partnerships, the following were identified: franchising, global PPP, public-private integrated partnership, Alzira model PPP, co-locations PPP and private financing initiative. Most reported initiatives relied on external funding or technical assistance, only 35% operate independent of international partners (mostly in South Africa). The review showed great variation within the Southern region in terms of numbers of PPPs: in Namibia only 1 PPP was reported, while there have been 19 reported in South Africa.

[148] Radovich E, Dennis ML, Wong KLM, et al.: Who Meets the Contraceptive Needs of Young Women in Sub-Saharan Africa? J Adolesc Health. 2018; 62(3): 273–280.

[149] Eleanor Beth Whyle, Jill Olivier, 2016. Models of public–private engagement for health services delivery and financing in Southern Africa: a systematic review, Health Policy and Planning, Volume 31, Issue 10, December 2016, Pages 1515–1529, https://doi.org/10.1093/heapol/czw075 - https://academic.oup.com/heapol/article/31/10/1515/2567069

[150] Jacobs B, Ir P, Bigdeli M, Annear PL, Van Damme W. 2012, Addressing access barriers to health services for the poor: an analytical framework for selecting appropriate interventions in low income countries, Health Policy and Planning , 2012, vol. 27 (pg. 288-300)

Interesting, the review showed that the most reported PPP model is the social marketing initiative (12) reported in 6 countries and mostly driven by Populations Services International or an affiliate which all depend on external support. Other well-known and relevant organisations to drive social marketing models in the area of SRHR in sub-Saharan Africa are: Marie Stopes International providing contraception and safe abortion services and DKT International providing family planning, HIV/AIDS prevention and safe abortion products and services. The identified social marketing initiatives by the review aimed at behaviour change associated with condom use and safe sexual practices for HIV and AIDS prevention through branding and advertisement for male and female condoms and TV shows. The second most reported PPP is contracting out (8) and includes the delegation of health care service delivery responsibility to the private partner in exchange for a fee, and mostly concerned medical services in hospitals and clinics. The Global PPP was also identified in several countries which include a collaboration between international donors and national governments, often funded by a multinational health initiative. In the decision making both government and non-government players participate. Examples of these collaborations are mostly aimed at HIV prevention and care or detection (the African Comprehensive HIV/AIDS partnership, the Khayelitsha ART programme with Medicine Sans Frontiers and the Global Fund), but also one addresses the treatment of women's cancers and Pink Ribbon, Red Ribbon with PEPFAR and the Gates Foundation. Specifically highlighted in the review is a partnership aiming to provide HIV services, improve working conditions and stimulate sales of fair trade marketing campaigns of the Apparel Lesotho Alliance to Fight AIDS. This partnership is between the Ministry of Health in Lesotho, USAID, DFID, international clothing companies and the Lesotho garment industry. In literature several public-private partnerships can be identified which focus on work-place policies to address HIV and AIDS, also as part of corporate social responsibility as is the case for Heineken and SABMiller[151] in the countries they are operational in sub-Saharan Africa. The Swedish Workplace HIV and AIDS programme is another example, supporting 600 workplaces in 10 countries in sub-Saharan Africa. This is an initiative run by NIR in collaboration with the Swedish Industrial and Metalworkers' Union (IF Metall), the Swedish International Development Cooperation Agency (Sida) and several Swedish companies.

Limited engagement between the public and the private sector was reported by the key respondents. There are several hurdles for engagement with the private sector mentioned in the area SRHR: the return of investment is very low and there is a lot of mistrust of private sector players. There are very strict regulations in terms of collaboration between governments, donors and private sector players. Poverty influences all SDGs, and if GNP improves, more opportunities will arise for the private sector. During the interviews with key informants, the social marketing model was mentioned as most promising and the Female Condom Partnership. Although reference was made to several small scale good private sector initiatives, mostly based on projects or pilots (for example Philips in Kenya), no additional good private sector initiatives or true good practice of public-private partnership towards increased access to quality SRHR services could be identified from the interviews.

[151] Ibou Thior, 2016. Alcoholic Beverage Companies and the HIV Response in Sub-Saharan Africa: A Case Study of HIV Programs at Heineken and SABMiller. AIDSFree, USAID and PEPFAR, 2016 - https://aidsfree.usaid.gov/sites/default/files/2016.3.23.alcoholcasestudy_tagged.pdf

3.3 Social Norms

INTRODUCTION

This chapter reflects on the changing 'social norms'[152] that continue to shape the discourse on gender equality, sexual orientation and gender identity (SOGI), safe abortion, and adolescents' access to SRHR across sub-Saharan Africa. The reflections focus on the dynamics of normative influence and practices shaping the afore-mentioned topics and changing trends at the Regional Economic Communities (RECs) in Africa. It discusses ways in which social norms change intersects with changes in the institutional, economic, social-cultural and religious factors that contribute to sustaining adverse SRHR outcomes for women and girls in sub-Saharan Africa.

While the jury is still out as to what exactly constitute 'social norms,' Beniamino and Holly (2018) distinguish between legal norms (written laws and regulations, enforced by state institutions); moral norms (internally-driven, value-based behavioural influences beliefs); and social norms (context-specific, externally-derived rules of obligation, considered {in}appropriate, and {un}acceptable behaviour shared by people in the same group or society). Social norms are further conceptualised as the combined effect of descriptive norms (belief of what others do) and injunctive norms (belief about others {dis}approval of one's actions). Practitioners working to effect policy changes in SRHR in sub-Saharan Africa are also particularly interested in gender norms as an intersecting construct for social behaviours and practices shaping the SRHR outcomes for women and girls in particular.

In line with the perspectives of several authorities on social norms[153,154,155], evidence shows that the SRHR landscape across sub-Saharan Africa is shaped by a combination of legal, moral and social (gendered) norms.[156157] Thus, despite the focus on social norms, the discussion here is frequently interspersed with the influences of the other norms as well.

WHAT IS THE SITUATION? INCLUDING GAPS

Gender equality

Despite enormous progress, gender equality remains an important goal in sub-Saharan Africa. West Africa is the most male-dominated region on the continent, according to UNDP's 2017 Gender Inequality Index (GII).[158] The countries in West Africa all sit at the bottom of the global GII rankings. Gender inequality is also reflected in the human development divide between men and women, as measured by UNDP's Human Development Index (HDI). This means that there are very high levels of inequality between males and females in the region in terms of access to healthcare, educational levels and general living standards.[159] Similar gender inequalities can be found in political representation, with

[152] Beniamino, and Holly, S. (2018). Social Norms and Adolescents' Sexual Health: An introduction for practitioners working in Low and Mid-income African countries. Afr J Reprod Health. 2018 March ; 22(1): 38–46. doi:10.29063/ajrh2018/v22i1.4.
[153] Stuntz W Self-Defeating Crimes. Virginia Law Review 2000;86:1871–82.
[154] Dubreuil B and Grégoire J-F. Are moral norms distinct from social norms? A critical assessment of Jon Elster and Cristina Bicchieri. Theory and Decision 2012;75(1):137–52.
[155] Haidt J The Moral Mind: How 5 Sets of Innate Intuitions Guide the Development of Many Culture-Specific Virtues, and Perhaps Even Modules. In: Carruthers P, Laurence S, Stich S, editors. The Innate Mind New York: Oxford University Press; 2007 p. 367–91.
[156] Oronje et al. BMC International Health and Human Rights 2011, 11(Suppl 3):S8 http://www.biomedcentral.com/1472-698X/11/S3/S8
[157] Müller, et al., 2016. "You have to make a judgment call". – Morals, judgments and the provision of quality sexual and reproductive health services for adolescents in South Africa. Social Science & Medicine. 2016. 148; 71-78
[158] The GII measures inequality in achievement between men and women in three areas: reproductive health; empowerment, including political representation; and labour markets, including real wages. See: http://hdr.undp.org/en/content/gender-inequality-index-gii
[159] The GDI is part of UNDP's Human Development Reports, and is a ratio of female/male development based on the HDI. The groups are classified as Group 1: High Equality, where the absolute deviation in HDI between men and women is less than 2.5%; Group 2: Medium High Equality, where the absolute deviation is between 2.5% and %; Group 3: Medium Equality, where the absolute deviation is between 5% and

women accounting for as few as 5.8% of elected representatives in the Nigerian parliament, 7.2% in Benin and 8.8% in Mali.[160] The labour market shows similar patterns.

These broader shades of inequalities are reflected in SRHR outcomes. West Africa has high rates of child marriage and three countries–Niger, Burkina Faso, and Mali – are among the top 5 countries with the highest number of children in Africa married before the age of 18 years.[161] Child marriage endangers the SRHR of girls and deprives them of the opportunity to acquire an education and access healthcare. For example, more than 80% of married 15 to 19-year-old women in Senegal, Niger, Burkina Faso, Côte d'Ivoire and Cameroon do not have the final say on their healthcare.[162]

Evidence shows that increasing educational achievement among women and girls is linked to better SRH outcomes, including lower rates of HIV infection, delayed childbearing, safer births and safer abortions.[163][164] However, cultural and social norms mean that girls in families affected by HIV are the ones who drop out of school to care for sick parents or generate income for the family and in many places schools are not guaranteed safe learning environments for young women.[165][166] Studies by Plan International across Western and Eastern Africa found violence in primary and secondary schools to be prevalent.[167] The report states that inappropriate sexual relations between male teachers and female students, including transactional sex to cover school fees and the cost of school materials and sex for grades are common.

Adolescent girls and young women continue to be disproportionately affected by HIV, with women constituting more than half of all people living with HIV in 2015.[168] In Eastern and Southern Africa, HIV is not only driven by gender inequality, but it also entrenches gender inequality, leaving women more vulnerable to its impact and with young women (15-24 years) more likely to acquire HIV five to seven years earlier than their male peers.[169,170]

Across sub-Saharan Africa, discriminatory social and cultural norms are translated into laws that act as barriers to women and girls accessing SRH services, increasing their vulnerability to poor SRH outcomes. For example, mandatory parental consent has been shown to deter young women from accessing vital SRH services due to fear of disclosure or violence.[171] A 2017 study on SRHR among young people in selected countries in Africa and Asia found young women frequently lacked the freedom to access contraceptives, particularly when parental or spousal consent was required due to their being under the legal age of consent.[172] Age-restrictive legal norms, such as those that ban contraception under a

7.5%; Group 4 (Medium-Low Equality) where absolute deviation is between 7.5% and 10%; and Group 5 (Low Equality) where absolute deviation from gender parity is greater than 10%

[160] Inter-Parliamentary Union (IPU) (2019). Women in National Parliaments. 1 February 2019. http://archive.ipu.org/wmn-e/classif.htm

[161] Percentage of women 20-24 years old who were first married or in union before they were 18 years old. Source: UNICEF global databases 2018, based on Multiple Indicator Cluster Surveys (MICS), Demographic and Health Surveys (DHS), and other national surveys.

[162] UNAIDS (2014) 'The Gap Report'[pdf]

[163] UNFPA (2013) 'State of the World Population 2013: Motherhood in childhood: facing the challenges of adolescent pregnancy.' (Accessed 11/01/2020)

[164] DeNeve JW. et al. (2015) 'Length of secondary schooling and risk of HIV infection in Botswana: evidence from a natural experiment.' Lancet Glob Health, Vol 3, No. 8, e470–e477

[165] UNAIDS (2015) 'Empower young women and adolescent girls: Fast-Track the end of the AIDS epidemic in Africa'[pdf]

[166] Clinton Foundation and Bill & Melinda Gates Foundation (2015) 'No Ceilings: The Full Participation Report'[pdf]

[167] Plan International (2013) 'A girl's right to learn without fear: Working to end gender-based violence in school'[pdf]

[168] The Foundation for AIDS Research (amfAR) (2015) 'Statistics: Women and HIV/AIDS'

[169] WHO (2017) 'Consolidated guideline on sexual and reproductive health and rights of women living with HIV'[pdf]

[170] Dellar, R.C. et al (2015) 'Adolescent girls and young women: key populations for HIV epidemic control' JIAS 18(Supplement 1):19408

[171] Center for Global Development (2009) 'Start with a Girl: A New Agenda for Global Health'[pdf]

[172] Orza, L. et al (2017) 'Searching for the Second R in Sexual and Reproductive Health and … Rights' Jour of Adolescent Health, Vol 60, Issue 2, Supplement 2, Pages S10–S14

certain age, act as barriers to healthcare for young women, while women belonging to other key affected populations are negatively affected by laws that ban sex work and homosexuality.[173]

Poverty is an overarching factor that exacerbates negative SRHR outcomes in sub-Saharan Africa and is further complicated by gender inequalities. Poor women are often economically dependent on men. The need for economic support may partly drive earlier marriage and existing gender inequalities may make it difficult for young women to insist on safer sexual practices. The poorest women may have little choice but to adopt behaviours that put them at risk of STIs, including transactional and intergenerational sex, earlier marriage, and entering in relationships that expose them to violence and abuse.[174] Across sub-Saharan Africa, studies show poorer women more likely to experience earlier sexual debut, to have multiple sexual partners and partners who are six or more years older and to report having had sex for material or financial support.[175][176] Poverty can also push girls into relationships with older men for the promise of money or gifts. Age-disparate sexual relationships between young women and older men are common across sub-Saharan Africa, exposing young women to unsafe sexual behaviours, low condom use and an increased risk of STIs.[177]

Across sub-Saharan Africa, intimate partner violence is typically underpinned by dominant cultural and social norms about masculinity, femininity, and sexuality.[178] Research shows that gender inequality results from the patriarchal nature of many societies in sub-Saharan Africa, where control of women and the exhibition of masculinity are highly valued.[179] Violence against women, including intimate partner violence and rape, is one consequence of gender inequality. However, such violence also reinforces and perpetuates gender inequality at both societal and relationship levels.[21] Differentiated treatment according to gender is particularly acute during adolescence, when many girls are faced with the prospect of marriage (often before reaching the age of 18), adolescent pregnancy, and gender-based violence, as well as a heightened risk of HIV transmission.

One way the RECs are working to address gender inequality is by adopting national gender strategies and implementing legislative reforms. This is evident, in the case of child marriage. For example, all West African countries are signatories of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, the African Youth Charter, and the African Charter on the Rights and Welfare of the Child. These commitments match the ECOWAS states' political will behind national campaigns and action plans to end child marriage. However, passing laws and devising national strategies are not enough. Legal loopholes and customary practices often weaken women's rights. Girls can still marry under the age of 18 in 11 West African countries.[180]

It is imperative to embrace the challenge of transforming social norms and allow women and men to benefit equally from development opportunities. Discriminatory social norms weaken the

[173] The Global Coalition on Women and AIDS (2014) 'Advancing young women's sexual and reproductive health and rights in the context of HIV'[pdf]
[174] Pascoe, SJS. et al (2015) 'Poverty, Food Insufficiency and HIV Infection and Sexual Behaviour among Young Rural Zimbabwean Women' PLoS ONE 10(1): e0115290. doi:10.1371/journal.pone.0115290
[175] Pascoe, SJS. et al (2015) 'Poverty, Food Insufficiency and HIV Infection and Sexual Behaviour among Young Rural Zimbabwean Women' PLoS ONE 10(1): e0115290.
[176] Krugu et al., (2019). Mapping of CSO's working with young people's SRHR needs and social norms transformation in Zambia
[177] UNAIDS (2015) 'Empower young women and adolescent girls: Fast-Track the end of the AIDS epidemic in Africa'[pdf]
[178] Santana, M.C. et al (2006) 'Masculine gender role associated with increased sexual risk and intimate partner violence perpetration among young adult men' Journal of Urban health 83(4):575-585
[179] Jewkes, R.K. et al (2010) 'Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study' The Lancet 376:41-48
[180] Pew Research Center (2016). Many countries allow child marriage. https://www.pewresearch.org/fact-tank/2016/09/12/many-countries-allow-child-marriage/

implementation and efficiency of gender-sensitive policies, exposing women and girls to ongoing discrimination. For example, despite huge investments to eradicate female genital mutilation (FGM) in Burkina Faso, the rates remain notably high due to the practice's social acceptance. Two-thirds of women have been victims of FGM, and while the majority of the population believes that this practice should be eradicated, 50% of men prefer marrying a circumcised woman.[181]

Sexual Orientation and Gender Identities

In East Africa, the continued criminalization of private consensual sexual acts between adults of the same sex, as well as the outlawing of diverse gender expressions, are indicators of States' interest to entrench discrimination and violence based on real or perceived Sexual Orientation and Gender Identities (SOGI). None of the East Africa countries have anti-discrimination legislation and hate crime laws to protect persons from bias or discrimination on the grounds of their SOGI. Reports indicate that violence and discrimination remain the most concerning legal, social issues facing LGBTIQ persons and communities in the East Africa region.[182] These discrimination grounds become more relevant in asylum cases for LGBTIQ persons who face rights violations and protection challenges during asylum processing. Geo-conflicts in Somalia, DR Congo, Sudan and South Sudan have continued to drive out LGBTIQ refugees towards Kenya, Tanzania and Uganda.[183] The asylum flights pose a legal paradox where countries that criminalize same-sex relations continue to abide by their international obligations to protect LGBTIQ refugees and asylum seekers within their borders but at the same time continue to prosecute and persecute their LGBTIQ citizens.

Same-sex sexual acts continue to be a taboo subject in almost all West African countries, particularly in countries such as Ivory Coast, Burkina Faso, Senegal and Benin, where the existence of LGBTI people is often completely denied.[184,185] Public opinion and the media usually consider sexual orientation as a "choice" that reflects a "sexual perversion" or even motivated by "economic incentive".[186] The growth in widespread general homophobia has justified multiple forms of violence against LGBTI people: from arbitrary detention by the police, school exclusion, denial of medical attention, expulsion from the home, arbitrary dismissal from employment to lynching and murder.[187] The growth of homophobia has found new ways of operating by harassing, exposing and humiliating LGBT persons through false social network profiles.[188] Across West Africa, it is common to read extremely pejorative content regarding same-sex sexual acts, denigrating references of LGBT people, equating it with paedophilia and prostitution, as well as negative descriptions of human rights defenders.[189]

[181] Kudo (2018). Female Genital Cutting and Long-term Adjustment of Marriage Markets: Evidence from West Africa. http://www.ide.go.jp/library/Japanese/Publish/Download/Report/2017/pdf/2017_2_40_012_ch01.pdf

[182] Global Philanthropy Project (GPP), The 2015-2016 Global Resources Report: Philanthropic & Government Support for Lesbian, Gay, Bisexual, Transgender, and Intersex Communities (2018).

[183] UNHCR Global Report 2012 - East and Horn of Africa: https://www.unhcr.org/en-in/51b1d6310.pdf

[184] "Sicap: Une bande d'homo arrêtée pour vidéos obscènes", Seneweb.com, 17 September 2018

[185] See the following: "Justice : première condamnation pour pratique homosexuelle en Côte d'Ivoire", Abidjan Net, 14 November 2016; "Pour la première fois, la Côte d'Ivoire condamne deux hommes pour homosexualité", 18 November 2016; "Côte d'Ivoire : des homosexuels condamnés à 18 mois de prison", Afrique sur 7, 16 November 2016; "Ivory Coast officials refuse to explain why two gay men were jailed", The Guardian, 26 January 2017

[186] "Poverty responsible for rise in homosexuality", Graphic Online, 3 November 2018. https://www.graphic.com.gh/news/general-news/poverty-responsible-for-rise-in-homosexuality.html

[187] "Scandale: Un homosexuel a été battu puis déshabillé en pleine rue à Abidjan", Net Afrique, 25 April 2018; "Bamako (Mali): lynchage sordide d'un homosexuel dans la rue", Fdesouche, 20 February 2018; "Vidéo – Déchaînement de violence contre une personne transsexuelle à Bamako", Net Afrique, 11 October 2018

[188] "Gays in Mali are hunted and humiliated online", The Observers, 18 September 2017. https://observers.france24.com/en/20170918-investigation-malian-pages-hunting-down-humiliating-gay-people-12

[189] See, for example: " Côte d'Ivoire : des homosexuels condamnés à 18 mois de prison", Afrique sur 7, 16 November 2016; "Homosexualité : Un haut cadre d'une entreprise privée chassait sur Facebook les...", Seneweb, 30 May 2018; "Homosexualité : Sur les pas de la communauté LGBT de Bobo-Dioulasso", Le Faso, 30 May 2016

One notable challenge in West Africa is that there is no political will to support and respect the rights of LGBT persons. There is a certain level of political will when it comes to health issues and HIV/AIDS, related to the taking care of men who have sex with men (MSM). However, it is exclusively focused on this group to the detriment of women who have sex with women and trans persons. The region is characterized by its socio-cultural and legislative diversity, which makes LGBT communities face distinct legal differences. These go from the explicit criminalization (in countries such as Gambia, Guinea, Liberia, Mauritania, Nigeria, Senegal, Sierra Leon, and Togo) to countries with a certain level of anti-discrimination protection (such as Cape Verde).[190] It can be said that the HIV/AIDS epidemic has opened some space for LGBT activism in the region. The focus of the issue regarding MSM has shaped the emergence of the LGBT community and given certain access to funding. Therefore, the rights of LGBT people in the region are mostly addressed through public health campaigns on HIV. This approach has however, brought some consequences for lesbians, bisexual women and trans persons whose issues remain marginalised.

It could be argued that in a few countries in Southern Africa, some advancements in legislative protections and guarantees of equality often outpace changes in public sentiment. Even South Africa, the first country with constitutional protection from discrimination based on SOGI, has and continues to struggle with a lack of societal acceptance of sexual and gender minorities, and reports of anti- LGBT violence seem to come through the news regularly. Yet the past few years have seen a number of legislative and court victories for LGBTI people across the sub-region, proving that progress is possible in the face of resistance. Importantly, the governments of non-criminalizing countries have signalled support for SOGI issues in several areas, including ending discrimination in education and supporting LGBTI asylum-seekers. In terms of marriage equality, constitutional rights, and legal protections from discrimination for LGBTI people, South Africa is undoubtedly a regional leader. At the same time, South Africa's high rates of rape and homophobic crime, perpetrated disproportionately against lesbians of colour in poorer townships, demonstrate that robust legislation does not necessarily translate to societal acceptance.[191] A 2017 report on violence faced by the LGBT community in South Africa found that a shocking four out of ten LGBT South Africans know of someone who has been murdered for their sexual orientation or gender identity; that number rises to 49% for black LGBT people in the country.[192]

Given the high number of criminalizing states in Sub -Saharan Africa more generally, nearby countries like South Africa where consensual same-sex acts are legal become a destination for LGBT asylum-seekers. Despite having laws guaranteeing refugee status to LGBT persons fleeing persecution, many gay, lesbian, and trans refugees are turned away at the border.[193] Queer human rights activists lobbied the government to address the situation, as many LGBT refugees being discriminated against were remaining in the country undocumented. In September 2018, the Department of Home Affairs agreed to have its officials undergo sensitisation training.[194]

On the economic front, gender identity expression can be a barrier to employment, where in most countries, trans people are unable to change their gender marker on their identity cards, diplomas and other necessary documents.[195] Some trans people have been forced to abandon their sources of

[190] Since 2008, article 45(2) of the New Labour Code of Cape Verde prohibits an employer soliciting information of the "sex life" of their employees. Article 406(3) imposes sanctions on employers who fire employees on the basis of their sexual orientation

[191] UNAIDS (2015) 'Empower young women and adolescent girls: Fast-Track the end of the AIDS epidemic in Africa'[pdf]

[192] UNAIDS (2015) 'Empower young women and adolescent girls: Fast-Track the end of the AIDS epidemic in Africa'[pdf]

[193] UN Women (2015) 'Championing Gender Equality in the HIV Response: The experiences of five programme countries'[pdf]

[194] Association for Women's Rights in Development (AWID) (2014) 'Beyond Investing in Women and Girls: Mobilizing Resources'

[195] Zhan Chiam et al., Trans Legal Mapping Report 2017: Recognintion before the law (Geneva: ILGA, Novemeber 2017). https://ilga.org/downloads/ILGA_Informe_de_Mapeo_Legal_Trans_2017.pdf

income completely, and on occasion, are arrested for the crime of "identity theft."[196] These events pose further implications for poverty reduction programmes at the national level. In the last few years, issues related to SOGI have not seen much progress in Central Africa. These issues continue to be perceived as taboo and "contrary to African values." Also, many people still believe that these are issues "imported from Europe."

Across SSA, it is hard to imagine a country in which attacks on feminism, sexual rights, and LGBTI agendas did not take place in the last years. The motivating force behind the abuses is often to elicit fear, to achieve a political outcome and/or also to project a national or cultural identity grounded in heteronormativity. Surveillance of defenders—both in physical terms and in social media—has become even more common, as have efforts to expose activists to risks and denigration. Add to this the fact that organising to challenge gender norms, to seek bodily autonomy and, to bring down patriarchal structures is always seen as a threat to the fabric of the family, the State and society overall. A significant event that took place in 2018 stand out for marking blunt attacks on civil society in intergovernmental spaces in Africa, revealing the lengths to which governments will go to project an identity, to intimidate those who resist "falling into line" and to protect what they see as ownership of the space and the discourse on SOGI. In June 2018, the African Union's Executive Council led the African Commission on Human and Peoples' Rights to revoke the observer status of the Coalition of African Lesbians (CAL). The Executive Council of the AU reasoned that CAL promoted "un-African values" and therefore should not be allowed to continue its participation at African Commission meetings as an official civil society member. Despite CAL's longstanding history of strategic work at the Commission, and the Commission's own work to further attention to violence and discrimination based on SOGI, pressure from the African Union proved too much.[197] CAL was used as a scapegoat to demonstrate to other organisations that particular agendas and civil society participation in these spaces are at risk. Emerging normative beliefs on SOGI rely on creating a mythical "perfect" patriarchal, heteronormative, gendered past. Inherent to these arguments is the normative beliefs that parents are always best suited to make decisions for their children, which denies both the evolving capacities of young people (particularly concerning sexuality) and the fact that parents are sometimes those who cause harm. This argument also gives parents ultimate authority in overseeing their children's education and therefore the rights to deny sexuality education and information about contraception, abortion, homosexuality, trans identity, bodily autonomy and condom use.

Safe abortion

Abortion remains legally restrictive in most African countries, and efforts to repeal laws in order to reverse the situation attract strong opposition and controversy. The opposition to the provision of abortion is grounded in cultural, religious and individual norms and values. Culturally, it is argued that abortion is a 'foreign' practice (despite public health evidence to the contrary[198]) and that in Africa, children belong to the society and women should not be given the autonomy in making abortion

[196] "Les femmes transgenres africaines discriminées au travail", Blog : Tous Pour Un Monde Meilleur, 10 Jan 2020.

[197] Joint Statement: The Executive Council of the African Union moves towards dismantling the main body tasked with the protection of human rights in Africa. https://www.cal.org.za/2018/09/07/joint-statement-the-executive-council-of-the-african-union-moves-towards-dismantling-the-main-body-tasked-with-the-protection-of-human-rights-in-africa/

[198] Singh et al., (2018). Abortion Worldwide 2017: Uneven Progress and Unequal Access. https://www.guttmacher.org/sites/default/files/report_pdf/abortion-worldwide-2017.pdf

[198] Starbird E, Norton M and Marcus R, Investing in family planning: key to achieving the Sustainable Development Goals, *Global Health: Science and Practice,* 2016, 4(2):191–210, http://dx.doi.org/10.9745/GHSP-D-15-00374.

decisions. Even in countries where abortion laws are less restrictive, access to abortion services is still a challenge because of the negative attitudes of healthcare providers.[199]
Across all regions of Africa, patriarchal power lies at the core of understanding abortion as a contested and political issue. Men are viewed as the norm, and their life experiences are most often used as the basis on which to determine social needs, articulate policy requirements, and assign resources.[200]
The logical consequence of a male-dominated social norm in Africa is that experiences that are not directly informed by men's experiences, such as pregnancy, childbirth, abortion, and violence against women, are not seen as priority areas. Critical areas that impact significantly on women's health and lives, such as unsafe abortion, cannot compete with traditional development priorities such as unemployment and poverty.

A male-dominated paradigm of development across sub-Saharan Africa makes (i) abortion not seen as an important social issue; (ii) abortion seen as immoral and wrong, most often based on interpretations of religious texts by religious gatekeepers; and (iii) abortion is culturally problematic, as it challenges women's fundamental role and responsibility to bear children.[201] Most often, abortion is neglected by policymakers because it affects women and because its significance and impact are not fully comprehended. Organised religion has played a powerful role in challenging the right of women to take control of their bodies and in moulding the moral foundations for contemporary social constructions of "sex" and "sexuality".[202]

Thus, religious ideology and practices have helped institutionalise the idea of male dominance in all decision-making including reproduction, which in turn served to alienate women from their bodies. This serves to reinforce the idea of women not owning and taking control of their bodies but rather viewing their bodies as vessels for men, for future children and for reproduction to serve social needs. The dominant norm is thus If children are seen as God-given and women are merely the vessels to carry the life, they are seen as having no right to interfere with it.[203]
The cultural value placed on birthing and childbearing in Africa is also a significant factor that shapes women's reproductive decisions and places a particularly difficult onus on those women who opt to terminate a pregnancy.[204] Women bear the burden of reconciling high social and familial expectations with the rough realities of surviving pregnancy, childbirth, and childrearing in an economically harsh and challenging context. Even as abortion becomes more frequent, it is more often morally condemned in the context of religiously conservative and pro-natalist cultural beliefs.

Adolescent access to SRHR

Social norms and taboos relating to gender and sexuality can create a culture of silence, particularly among adolescent girls, which prevents them from asking about issues relating to their SRHR. The lack

[199] Chavkin W et al., Conscientious objection and refusal to provide reproductive healthcare: a White Paper examining prevalence, health consequences, and policy responses, *International Journal of Gynecology & Obstetrics,* 2013, 123(Suppl. 3):S41–S56.
[200] Braam and Hessini (2004). The Power dynamics perpetuating unsafe abortion in Africa. African Joul of Reproductive Health. 8,1; 43-51
[201] Braam and Hessini (2004). The Power dynamics perpetuating unsafe abortion in Africa. African Joul of Reproductive Health. 8,1; 43-51
[202] Blystadet al. (2019). The access paradox: abortion law, policy and practice in Ethiopia, Tanzania and Zambia. International Journal for Equity in Health. https://doi.org/10.1186/s12939-019-1024-
[203] Blystadet al. (2019). The access paradox: abortion law, policy and practice in Ethiopia, Tanzania and Zambia. International Journal for Equity in Health. https://doi.org/10.1186/s12939-019-1024-
[204] Chiweshe and Macleod (2018). Cultural de-colonization versus liberal approaches to abortion in Africa: The politics of representation and voice doi: 10.29063/ajrh2018/v22i2.5

of a confidential and judgment-free environment can also be a barrier to girls obtaining SRHR information and expressing their concerns.[205]

Education allows girls to gain a better knowledge of their SRHR.[206] It lowers exposure to intimate partner violence and increases their chances of becoming financially secure and independent.[207] In SSA, the most effective interventions that reduce the risk of HIV infection among adolescent girls, are the ones that keep them in school. These include making education free for girls, supporting orphans and other vulnerable children to stay in school, and conditional cash transfers that reward parents for keeping their daughters in school.[208,209,210] A cash transfer programme in Malawi reduced the school dropout rate of girls by 35% and resulted in a 40% reduction in early marriages, a 30% reduction in teenage pregnancies and a 64% reduction in HIV risk within 18 months.[211] Keeping girls in school also can expose them to comprehensive sexuality education (CSE) – evidence show CSE that explicitly focuses on gender rights and gender power dynamics is five times more effective than CSE programmes that do not, particularly in reducing unwanted pregnancies and new STIs infections.[212]

Thus, scaling up comprehensive, integrated, and youth-friendly SRHR services for young women and adolescent girls is vital. Condom programming designed to reach young people, such as through schools, can increase accessibility and use among those who are sexually active.[213] Removing barriers like parental and spousal consent is critical for scaling up services and increasing access.[214]

CONSIDERATIONS FOR SIDA'S STRATEGY

- Transforming discriminatory social norms requires a solid understanding of the political economy and territorial realities. These efforts must be endogenous. Interventions are needed at regional, national, and grassroots levels and require the involvement of a wide range of stakeholders, including men and boys, to change attitudes on gender roles. For example, nationwide awareness-raising campaigns to address social stigma, condemn victim shaming and support survivors of gender-based violence have proven efficient.[215] Legal reforms to protect women's rights can also be backed by legal literacy programmes to help women, families and communities understand their legal rights to health and integrity. Sida could support networks such as the association of women lawyers to expand legal literature to the grassroots. Ultimately, women and girls play a crucial part in transformation programmes and should no longer be perceived stereotypically as "victims" but rather as powerful agents of change.
- Since addressing these sensitive SRH topics need to be endogenous, Sida could support national governments to generate and manage data and present it in a language that can convince policy

[205] Svanemyr, J., Amin, A., Robles, OJ., Greene, ME (2015) 'Creating an Enabling Environment for Adolescent Sexual and Reproductive Health: A Framework and Promising Approaches' Journal of Adolescent Health, January 2015, Vol 56, No 1, pS7–S14
[206] UNAIDS, United Nations Population Fund (UNPA) & United Nations (UN) (2004) 'Women and HIV/AIDS: Confronting the Crisis'[pdf]
[207] United Nations Population Fund (UNFPA) (2013) 'Motherhood in Childhood: Facing the challenge of adolescent pregnancy'[pdf]
[208] World Bank, UNICEF (2009) 'Abolishing school fees in Africa: lessons from Ethiopia, Ghana, Kenya, Malawi, and Mozambique'[pdf]
[209] Halifors, D. et al (2011) 'Supporting adolescent orphan girls to stay in school as HIV risk prevention: evidence from a randomized controlled trial in Zimbabwe' American Journal of Public Health 101(6):1082-1088
[210] Baird, S.J. et al (2012) 'Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi: a cluster randomised trial' The Lancet 379(9823):1320-1329
[211] Remme M., Vassall A., Lutz B., Luna J., Watts C. (2014) 'Financing structural interventions: going beyond HIV-only value for money assessments.' AIDS. 2014 Jan 28;28(3):425–34.
[212] UNAIDS (2017) 'When women lead change happens: Women advancing the end of AIDS'[pdf]
[213] Papo, J.K. et al (2011) 'Exploring the condom gap: is supply or demand the limiting factor - condom access and use in an urban and a rural setting in Kilifi district, Kenya' AIDS 25(2):247-255
[214] UNAIDS (2015) 'Empower young women and adolescent girls: Fast-Track the end of the AIDS epidemic in Africa'[pdf]
[215] Ferrant and Hamel (2018). Gender equality in West Africa? The key role of social norms. https://oecd-development-matters.org/2018/03/08/gender-equality-in-west-africa-the-key-role-of-social-norms/

makers on the need for paradigm shift in those topics. At the same time, Sida can support regional and national level research institutions to generate context specific data aim at influencing the discourse on specific SRHR topics.

- LGBTIQ issues are highly sensitive across sub-Saharan Africa. Evidence shows that approaching the topic from a public health perspective (arguing that avoiding the topic means that LGBTIQ people not accessing services and can remain communities where HIV thrives, putting the entire population at risk) allows people to come to the table. Sida can identify national public health associations and work with them to shape the discourse on LGBTIQ persons rights.
- Gender inequality and other topics such as GBV, abortion and LGBTIQ are shaped by power dynamics in patriarchal settings. Advocacy remains crucial and Sida can support advocacy networks, starting by identifying national and regional level "fight" networks and what they need to sustain their work. Support civil society to mount advocacy efforts aim at removing barriers like parental and spousal consent is critical for scaling up services and increasing access for adolescents. Support civil society networks to keep national governments on their toes to implement child marriage policies. Civil society networks such as national level Girls Not Brides networks can be strengthened.
- Since keeping girls in school is the best vaccine against SRHR adverse outcomes, Sida could support national governments to implement (or regional campaigns to support) free education policies. Also, with the aim of keeping girls in school by addressing poverty, conditional cash transfers that reward parents for keeping their daughters in school has been proven effective.
- The implementation of gender-responsive life-skills-based CSE has been proven to improve SRHR outcomes for girls. In some setting there are challenges to implement CSE at schools. Sometimes when it is brought under another label it is more accepted. The implementation of CSE policies across sub-Saharan Africa are faced by the challenge of labelling CSE to mean indoctrinating young people on LGBTIQ. Locally-generated, context-specific data to dispel these beliefs are urgently needed. Sida could work with both regional and national networks of researchers and academics to address this. Also, sustaining initiatives such as the O3 programme that provides funding support to UNESCO and UNFPA at the regional level remains crucial.
- Evidence shows that governments of non-criminalizing countries have signalled support for SOGI issues in several areas, including ending discrimination in education and supporting LGBTI asylum-seekers. Sida can use the UN UPR mechanism to work with national governments and civil society groups to implement these policies and commitments at the national level. Human rights abuses related to SOGI that occurs at the borders require that national governments train their border officials on these issues.
- Evidence points to a few options to address unsafe abortion and safe women lives in Africa. Expanding legal space for abortion ensure that women do not have to risk their health by resorting to clandestine abortion. Efforts for legal reforms must be accompanied by political will and full implementation of the law to allow all women—despite inability to pay or reluctance to face social stigma— access to legal and safe abortion.[216] The available data also show that laws by themselves do not guarantee access. Policy makers and health providers are as much influenced by social norms as the general population. Efforts aimed at legal reforms should be complemented by strategies to address social norms at multiple levels, including providers, legal and political

[216] Singh et al., (2018). Abortion Worldwide 2017: Uneven Progress and Unequal Access. https://www.guttmacher.org/sites/default/files/report_pdf/abortion-worldwide-2017.pdf

authorities. Organizations such as IPAS and the International Federation of Gynaecology and Obstetrics (FIGO) are deploying regional safe abortion advocacy initiatives to work towards increased access to safe abortion[217].

- Across sub-Saharan Africa, highly restrictive laws on abortion continue to produce counterproductive results - making those that do occur more likely to be unsafe and promoting quackery practices.[218] In such contexts, improving the quality and coverage of post-abortion care remains crucial to saving lives and protecting women's health. Also, providing accurate information on how to safely use misoprostol should be widely conveyed to help make clandestine abortions safer, improve women's health and chances of survival, and reduce the heavy financial burden of providing post-abortion care, which poor African countries continue to struggle with budgetary allocation to health. Where abortion is legal, it is important to ensure that women can choose between equally safe methods of surgery or medication.
- Support national governments through the AU (most of whom have developed ending CM strategies following the AU campaign) to end CM can be a significant contribution to addressing unsafe abortion. Also, governments are much willing to come to the table on CM than abortion. Thus, CM, teenage pregnancy prevention and MM remain the best entering points to addressing abortion. Civil society actors such as Girls Not Brides, FIGO and the UN agencies can be important partners to Sida in this direction.
- When working with a regional approach and to facilitate collaboration with RECs, it is important to understand and know their planning cycles and their agendas. For example, ECOWAS and SADC strongly focus on Child Marriage. Opportunities can also be found in other sectors such as the education sector to achieve progress in the area of SRHR. An example of a regional program which showed SADC taking ownership and implementing a regional initiative was the Care and Support for Teaching and Learning, funded by the Swiss Agency for development and cooperation[219]. This program was adopted by the Ministries of Education of members states while aiming to contribute to "*HIV&AIDS, SRHR and other health needs of children and youth, especially vulnerable girls* ".

The Community for Understanding Scale Up (CUSP)[220] published a paper outlining lessons from five CUSP programs[221] on social norms change for implementation at scale[222]. Based on this they make recommendations for donors and implementers to scale social norms initiatives effectively and ethically:

1. Invest in longer term, sustainable social change processes to address core drivers of gender equality as social change processes and community mobilization take time
2. Maintain fidelity to change mechanisms: successive "staircase" components that are integral to creating and sustaining social change.

[217] De Vries et al. (2019). Advocating safe abortion: outcomes of a multi-country needs assessment on the potential role of national societies of obstetrics and gynecology. International Journal of Gynaecology and Obstetrics. https://doi.org/10.1002/ijgo.13092
[218] Singh et al., (2018). Abortion Worldwide 2017: Uneven Progress and Unequal Access. https://www.guttmacher.org/sites/default/files/report_pdf/abortion-worldwide-2017.pdf
[219] http://www.cstlsadc.com/
[220] CUSP is a group of nine organisations working across four regions with robust experience in developing evidence-based social norms change methodologies and supporting their scale-up across various regions and contexts - the Center for Domestic Violence Prevention (CEDOVIP), Intervention with Microfinance for AIDS and Gender Equity (IMAGE), the Institute for Reproductive Health at Georgetown University, Oxfam, Puntos de Encuentro, Raising Voices, Salamander Trust, Sonke Gender Justice, and Tostan.
[221] GREAT, IMAGE, SASA!, Stepping Stones, and Tostan
[222] Leah Goldmann, Rebecka Lundgren, Alice Welbourn, Diane Gillespie, Ellen Bajenja, Lufuno Muvhango & Lori Michau (2019) On the CUSP: the politics and prospects of scaling social norms change programming, Sexual and Reproductive Health Matters, 27:2, 51-63, DOI: 10.1080/26410397.2019.1599654

3. Fund women's rights organisations skilled in holistic whole-community approaches to facilitating pathways for positive social change, as lead grantees.
4. Prioritise community accountability and demand: determining in which communities to scale, ensuring their meaningful input from the outset and accountability to communities throughout, can avoid harm and avert risky or futile programming.
5. Critically examine the government and marketplace's role in scale: experiences with unsuccessful scale often included a lack of explicit internalised gendered principles by the donor, government, and/or the implementing organisation. Donors should reconsider funding technical organisations to engage in feminist, political work on social justice which may not fit well with their own organisational culture.
6. Diversify evaluation methods, beyond linear evaluation designs: rethink evaluation approaches to produce evidence that guides scale-up processes and fully represents the voices of activists and communities from the Global South.

In line with the literature also key informants expressed the need for the implementation of complex programs that need long-term planning and investments. Risks with the current way of measuring and reporting (including different formats for each donor), and projects being caught in targets and log-frames, are that activities focus on easy identifiable outcomes (e.g. a focus on policy influencing and getting policies in place). There is a demand to reduce administrational burden, support alternative ways of measuring and practice flexibility in funding to address emerging needs and fast changing environments. As one key informant said: 'If we do not work/respond fast, we become irrelevant'.

3.4 Continental and regional Accountability Mechanisms

INTRODUCTION

This chapter reflects on outcome area 4 'Increasing accountability for policy adoption and implementation, resource allocation, and quality of services'. Van Belle et al., (2018) identified three main groupings of accountability strategies: performance, social and legal accountability and showed an increasing trend of published accountability initiatives in SRHR[223]. The different accountability strategies are reflected upon in this sub-chapter.

Accountability is fundamental for applying human rights to health and achieving universal access to SRHR. A recent systematic review on accountability and SRHR published in 2018[223], report that accountability is also a key priority at UN levels through their engagement with national governments. The 'Every Women, Every Child' UN initiative resulted in the establishment of the Commission on Information and Accountability for Women's and Children's Health in 2010. Inclusiveness and transparency of and in accountability mechanisms has been identified to be key to be able to achieve a comprehensive approach to SRHR[224]. The new Global Strategy on Women's, Children's and Adolescents' Health (2016–2030)[225] also identified accountability as a key action area.

With accountability related to the relationship between governments and their citizens, we refer to the obligation of the government to account for its actions and the right of citizens to hold their governments accountable. There are many definitions for accountability across different disciplines but generally it includes 3 key components:

- Responsibility: governments and authorities have clearly defined tasks, performance standards and responsibilities for specific actions
- Answerability: governments and authorities are obliged to provide information and justification for their actions, especially towards people affected by actions and decisions.
- Enforceability: governments and authorities can be subject to formal sanctions for their actions or omissions.

In the health sector, accountability can take many forms as described by Boydell et al (2019) including financial (refers to financial allocation), performance (results of services) and political (governmental delivery of commitments). Interestingly, the paper adds another form of accountability specifically for SRHR: the priorisation and implementation of SRHR to ensure access to quality SRHR services[226].

[223] Van Belle S, Boydell V, George AS, Brinkerhoff DW, Khosla R (2018) Broadening understanding of accountability ecosystems in sexual and reproductive health and rights: A systematic review. PLoS ONE 13(5): e0196788.

[224] United Nations Population Fund, 2018. Sexual and Reproductive Health and Rights: An essential element of Universal Health Coverage. UNFPA, 2018 - https://www.unfpa.org/sites/default/files/pub-pdf/SRHR_an_essential_element_of_UHC_SupplementAndUniversalAccess_27-online.pdf

[225] Every Women Every Child, 2015 - The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030): Survive, Thrive, Transform. Every Women Every Child 2015. - https://www.who.int/life-course/partners/global-strategy/global-strategy-2016-2030/en/

[226] Victoria Boydell, Marta Schaaf, Asha George, Derick W Brinkerhoff, Sara Van Belle & Rajat Khosla, 2019. Building a transformative agenda for accountability in SRHR: lessons learned from SRHR and accountability literatures, Sexual and Reproductive Health Matters, 27:2, 64-75, DOI: 10.1080/26410397.2019.1622357 https://doi.org/10.1080/26410397.2019.1622357

3.4.1 Legal and political accountability

SDG accountability

WHAT IS THE SITUATION?

Weak accountability systems are reasons for limited implementation of global sustainable goals as monitoring and reporting are insufficient to be able to evaluate implementation. The partial failure of the MDGs were contributed to the limited accountability as stated by UNHCHR and CESR (2013). The SDGs have more specific (numerical) targets and indicators to track progress which – on paper - might contribute to increased performance[227]. In terms of accountability and the 2030 Agenda, the concept of shared responsibility for implementing the SDGs lies primarily with the national governments as only official signatories. The Agenda 2030 encourages national governments to conduct regular and inclusive reviews of the progress, and to include contributions from indigenous people, civil society, private sector and other stakeholders. Governments committed to engage in systematic *follow-up and review of the implementation of the 2030 Agenda for Sustainable Development*. There is a 'follow-up and review framework' and states do acknowledge that one of the objectives of the framework is to promote 'accountability to citizens'[228]. Although limited, these commitments to accountability could serve as the basis for civil society to hold government accountable for implementation of the SDGs[229],[230]. Each country can decide how to design and implement national level follow up and review systems which is leading to a great diversity in national accountability mechanisms for the SDGs. Therefore, it will be essential for civil society to hold governments accountable to the commitments made through National Development Plans and other related laws, policies and regional binding commitments. The High Level Policy Forum (HLPF) has a central role in overseeing the follow-up and review[227]. Governments are mandated to review the overall functioning of the HLPF every four years as presented in a founding resolution. During the UNGAs 74th session in 2019 – 2020, this review will take place for the first time. This presents a momentum for the international community to reflect upon and improve the "follow-up and review" activities.

Many countries started to reflect on their progress towards achievement of the SDGs through voluntary national reviews which are presented at HLPF meetings and is an indication of political ownership of national governments of the 2030 Agenda process[231]. Since 2016, seventeen countries from sub-Saharan Africa have been reflecting upon their progress, of which only 1 is from Central Africa (Guinea) and 9 are from Western Africa with Togo reporting for 3 times and Benin twice (see table below).

Voluntary National Reviews at HLPFs

Region	HLFP 2016	HLPF 2017	HLPF 2018	HLP2019
Western	Sierra Leone, Togo	Benin, Nigeria, Togo	Benin (2), Cabo Verde, Niger, Senegal, Togo (3) and Mali	Sierra Leone (2), Burkina Faso, Côte d'Ivoire, Ghana, Mauritania

[227]Karlsson-Vinkhuyzen, S., Dahl, A. L., & Persson, Å., 2018. The emerging accountability regimes for the Sustainable Development Goals and policy integration: Friend or foe? Environment and Planning C: Politics and Space, 36(8), 1371–1390. https://doi.org/10.1177/2399654418779995 https://journals.sagepub.com/doi/full/10.1177/2399654418779995

[228] United Nations General Assembly, 2015: para 73

[229] United Nations General Assembly, 2015: para 72

[230] United Nations General Assembly, 2015: para 77

[231] United Nations Department Economic and Social Affairs, 2019. 2019 Voluntary National Reviews Synthesis Report http://sdghelpdesk.unescap.org/sites/default/files/2019-11/252302019_VNR_Synthesis_Report_DESA.pdf

Central			Guinea	Cameroon, Central African Republic, Chad, Congo, Mauritius,
Eastern	Uganda	Ethiopia, Kenya	Sudan	Rwanda, Tanzania,
Southern	Madagascar	Botswana, Zimbabwe	Namibia	South Africa, Lesotho,
TOTAL	4 SSA countries (of 22 countries)	7 SSA countries (of 43 countries)	9 SSA countries (of 46 countries)	14 SSA countries (of 87 countries)

Various civil society actors should be engaged in reviewing SDG progress and tracking initiatives and progress outside the government, which should feedback into the review process. Civil society developed several proposals related to the HLPF review: both individual and joint recommendations based on consultation with their member such as the my organization Forus, Action for Sustainable Development, Together 2030, the Transparency Accountability & Participation (TAP) Network, and regional CSO alliances such as SDG Watch Europe. The Transparency Accountability & Participation (TAP) Network developed a SDG Accountability Handbook for civil society[232] in order to strengthen their capacity to work with governments and other partners towards implementing and achieving the SDGs. The handbook identified the following elements for working towards national-level accountability: with government institutions, with formal processes, on oversight for accountability, with informal processes (CSO SDG spotlight reports[233]), engaging the media, awareness campaigns) and with other actors (such as the private sector).

Some of the countries reflected in their voluntary national reviews on the participation of civil society, but many did not. In addition, government 'self-assessments' are not sufficient to reflect upon the progress. CSOs play a key role as watchdogs to hold their governments and international organisations accountable. For example, the Civil Society Reflection Group assesses the implementation of the 2030 Agenda and publish the yearly Spotlight Report.

WHAT ARE THE GAPS?

The Agenda lacks enforceability as there are no sanctions nor consequences if governments fail to implement the SDGS – unless regional and binding commitments are aligned with the 2030 Agenda. The accountability focus for the 2030 Agenda is on the answerability component for the outcomes and progress, and the strategies in place to reach the outcomes. There is no formal M&E (or accountability) system for the SDGs within the UN as a result of intergovernmental negotiations about global accountability versus national sovereignty (the policy space of national governments)[234],[235].

[232] Nicole Cardinal, 2018. SGD Accountability Handbook: A practical guide for civil society. The Transparency, Accountability & Participation (TAP) Network, 2018. https://secureservercdn.net/166.62.112.219/9bz.99d.myftpupload.com/wp-content/uploads/2019/05/SDG-Accountability-Handbook.pdf?time=1560011655

[233] Spotlight on Sustainable Development 2019 Reshaping governance for sustainability Transforming institutions – shifting power – strengthening rights Global Civil Society Report on the 2030 Agenda and the SDGs https://www.2030spotlight.org/sites/default/files/spot2019/Spotlight_Innenteil_2019_web_gesamt.pdf

[234] UNDESA, 2015

[235] Joy Hyvarinen and Larry MacFaul, 2015. Monitoring progress towards the Sustainable Development Goals - http://www.vertic.org/media/assets/VERTIC%20Brief%2024_Final_RM_.pdf

The involvement of civil society and other key stakeholders in the HLPF remains limited, and there is no official status given to consolidated CSO alternative reports or spotlight reports within the overall HLPF cycle. Challenges to engage all stakeholders (civil society and media for example) in the SDG processes at national and sub-national levels include the need for (more) clear information on the SDGs, translated in local languages.

The reviews indicate that data availability for the global indicators vary among countries which are at the same time exploring M&E solutions to fit their national contexts and aspirations. To avoid parallel data collection processes and stimulate harmonized reporting, existing national structures are being utilized. Most mentioned challenges concern inadequate data disaggregation (Cabo Verde, Namibia, Niger, Senegal and Sudan), limited financial and technical support for M&E, and data collection and management (Benin, Guinea, Mali and Namibia) such as the lack of baseline data for some indicators.

The ACHPR

WHAT IS THE SITUATION?

The primary role of the African Commission on Human and Peoples' Rights (ACHPR) is to promote and protect human rights and peoples' rights (see Article 30 and 45 of the African Charter). To fulfil its mandate the Commission reviews individual complaints of violations of the Maputo Protocol, facilitates norm building and provides guidance towards implementation of these obligations. The ACHPR commissioners conduct promotional country visits which essentially is to encourage states to implement their obligations. In addition cases of human right violations are prepared for submission to the African Court of Human and Peoples' rights (AfCHPR). The commission exists of six special rapporteurs and working committees on specific human rights issues: for example the special rapporteur on rights of women monitoring specifically violations of women's rights[236]. For the countries who ratified the Maputo Protocol the Protocol is binding and their progress is being reviewed by the Commission. To review country progress, the commission meets bi-annually. Each state should submit a progress report after every 2 years and is scheduled for a review by Commission during its Ordinary sessions. During the review meeting, States send their delegations to address questions from the Commission. Recommendations are developed by the Commission and published to the Government. There are no sanctions for countries but the Commission has follow up mechanisms to ensure recommendations are implemented e.g promotional visits by country rapporteurs, and letters of appeal. The commission depend on the political will to implement the recommendations. This often relates to the priority of human rights issues and the leadership on Women's rights issues of the regime.

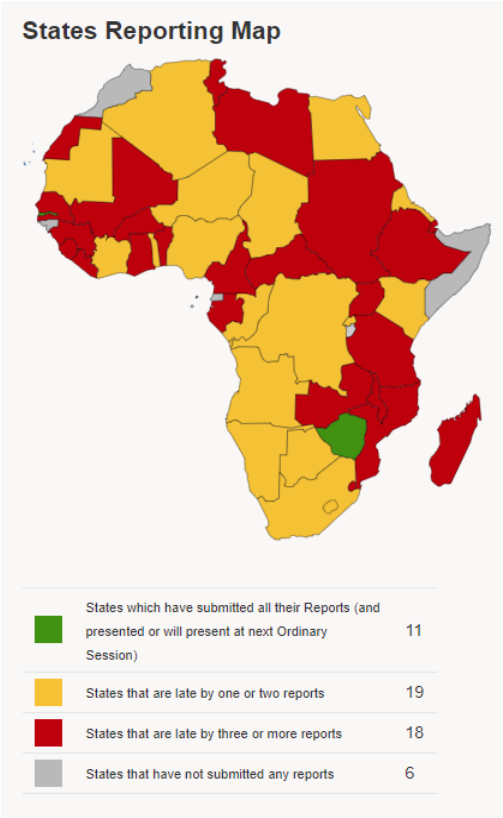


FIGURE 1 STATES REPORTING MAP FROM HTTPS://WWW.ACHPR.ORG/STATEPARTIESTOTHEAFRICANCHARTER. ACCESSED: 4 NOVEMBER 2019

The ACHPR works with a network of CSOs: both with those who have observer status and those without observer status. CSOs with observer status they are officially recognized to participate in activities of

[236]African Commission on Human and Peoples' Right, website – webpage Special Mechanisms accessed December 2019, ACHPR https://www.achpr.org/specialmechanisms

the ACHPR. In practice this means that CSOs can participate in the review of states compliance with regional obligations such as the Maputo Protocol. All CSOs can attend the open public review sessions but also follow the sessions online through streaming. CSOs also have opportunities to contribute to the review by submitting shadow reports either individually or jointly. While the main document is the State report, the Commission also reviews the shadow reports to get a broader perspective of the issues at national level. The questions asked by the Commission include questions submitted by CSO, and the recommendations developed by the Commission are informed by the input submitted by the CSOs. During the review sessions which are open for the public shows that the input from CSO is being integrated by the Commission. There are also other ways for CSO to engage with the Commission (in addition to the shadow reports). For example, through information letters to the specific committees and special rapporteurs[237].

WHAT ARE THE GAPS?

The implementation of the different recommendations provided by the Commission and the compliance with human rights instruments by national governments is identified as a gap by one of the key informants. Progress in terms of SRHR is being hindered by limited efforts of States. While the Commission is framing the SRHR issues well in their recommendations, the translation by governments is inadequate or is taking too long.

Another challenge is that some States try to weaken the accountability mechanisms including the Commission. These States have started to propose retrogressive reviews of the protective mandate of the Commission and close the civic space including through restrictive criteria for Observer status that locks out CSOs, including CSOs working on SRHR. For instance the withdrawal of observer status such as the Coalition of African Lesbians in 2018 following decisions by the African Union Executive Council. If civil society is not engaged, they are not able to highlight gaps at national levels. According to the key informant increased attacks on the Maputo protocol can be observed, both led by governments and CSOs (pro-life movement – especially towards revisions on abortion). In addition, the budget for the Commission is under pressure, and with limited (human) resources it becomes challenging for the Commission and its mandate to protect and promote human and peoples' rights.

CONSIDERATIONS

- The current technology trends provides an new window of opportunity: the power of social media is changing accountability opportunities**.** Both traditional and social media play a major role here. For example, in Kenya the government provided a ban on the Marie Stopes services which was followed by a ban on the post abortion care provided by the Ministry of Health in 2018. A social media campaign was organized on twitter and within 1 day the post abortion care ban was lifted. In this way citizens can put pressure on their governments to comply with human rights issues. The Media also plays an important role in accountability but reflects the challenge of sensationalization and misrepresentation of SRHR issues. A study conducted in Nigeria showed that the role of the Media significantly influenced financial accountability, while the role of donor agencies and CSOs had no significant impact due to limited collaboration with Parliament and executives[238].
- In countries where SRHR are constitutionally protected and citizens are empowered, there are increased campaigns to influence political and financial accountability. It is empowered citizenship capacitated by CSOs using the constitution to hold governments accountable to implement human

[237] African Commission on Human and Peoples' Right, Joint Letter of Appeal to the United Republic of Tanzania, 2017. https://www.achpr.org/news/viewdetail?id=29

[238] Saidu Abubakar, Ambros A. Okwoli, Yohanna G Jugu, 2017. Evaluating the role of media, donor agencies and civil society organisations (CSOs) in promoting public sector accountability. International Journal of Management Science Research, [S.l.], v. 3, n. 1, p. 64, oct. 2017. ISSN 2536 – 605X. Available at: <https://www.ijmsr.net/index.php?

rights decisions. To strengthen accountability Sida could consider to strengthen civil society and work with regional level overarching organisations and especially women's rights organization to create indigenous movements.

Regional Accountability Mechanisms

WHAT IS THE SITUATION?

The New Partnership for Africa's Development (NEPAD), adopted by the AU in 2002, is the strategic framework for socioeconomic development of the continent and mainly implemented at the REC level. Within this framework the AU established the African Peer Review Mechanism (APRM) in 2003. It is a tool where member countries go through a process of self-assessment and peer-review mission with broad consultations (including government, political parties, private sector and CSOs) which results in a publicly available report and a new National Programme of Action with short- medium and long-term goals. It is a mechanism for 'sharing experiences, reinforcing best practices, identifying deficiencies, and assessing capacity-building needs to foster policies, standards and practices that lead to political stability, high economic growth, sustainable development and accelerated sub-regional and continental economic integration'. Membership is voluntary and currently signed by 38 AU countries [239]. While the APRM includes gender indicators, a study[240] undertaken by UNECA in 2016 stated that deficiencies persist and analysed results might be gender-blind or neutral. Therefore, the APRM needs further refinement and rationalization on gender issues. A review of the process and reports in 17 countries indicated an increased focus on gender-empowerment in some of the countries, especially in relation to governance and development initiatives, but it also revealed that critical recommendations for gender equality were abandoned in several country action plans. Other identified gaps or challenges included the lack of credible gender-disaggregated data; the reliance on political will in a voluntary process; the lack of a M&E framework for the mechanism at the continental level; and the need to deploy existing opportunities and synergies with key pan-African institutions. The report contains a large section on recommendations to improve the APRM, especially in relation to support increased gender equality.

The SADC is the only REC that has a Monitoring and Evaluation Framework in place with indicators to monitor on progress in gender equality and a score card to track progress at political level in the implementation of the SRHR strategy against 20 multi-sectoral core indicators[241]. The Score cards were approved and adopted by the ministers in 2018, but need formal approval at the heads of state level and the issue dropped from the agenda of the 2019 SADC summit. This delay in implementation is another example of challenges faced in the implementation of regional or continental commitments.

The EAC is the only REC with an institutionalized social accountability mechanism through its Consultative Dialogue Framework (CDF) for CSO's, the private sector and other interest groups. Regional advocacy networks, such as the Eastern African Sub-Regional Support Initiative for the Advancement of Women (EASSI), and the East African Civil Society Organisations' Forum (EACSOF) were closely involved in the development and monitoring of the Gender Equality and Development Bill and the EAC Gender Equality and Development (GED) Barometer. This Barometer monitors, measures and documents the progress of gender equality in multiple areas, including human rights, GVAW, SRH and HIV & AIDS. Networks, such as the East African Law Society (EALS), the East African Health Platform

[239] African Union, website – webpage African Peer Review Mechanism (APRM), accessed Dec 2019 - https://au.int/en/organs/aprm
[240] United Nations Economic Commission for Africa, 2016. Gender equality and the Africa Peer Review Mechanism https://www.uneca.org/sites/default/files/PublicationFiles/gender_equality_aprm_eng.pdf
[241] Score card for SRHR in the SADC Region; Fast tracking the Strategy for SRHR in the SADC Region 2019-2030 https://genderlinks.org.za/wp-content/uploads/2018/11/SADC-SRHR-Final-Signed-Score-Card-221018.pdf

(EAHP), the Eastern Africa National Networks of AIDS Service Organisations (EANNASO) play a role as advocates on women and girls' rights issues within the CDF. Civil society engagement in other REC's is also considered to be strong in the SADC community and, to a lesser extent, present in ECOWAS.[77]

WHAT ARE THE GAPS?

From the key informant interviews it became clear that while strong continental and regional SRHR policy frameworks and instruments exist, there are gaps in implementation due to limited capacities and commitment of some of the member states. The same applies to existing regional accountability frameworks. Multiple accountability frameworks are there, but it is often unclear how they work, who is responsible, which sanctions apply and who is bringing it forth in order for countries to respect it. For example, SADC declarations are reported by one of the key informant to be more 'expressions of common views' rather than providing a legal binding protocol. When legal binding protocols are in place, enforcement can be questioned. There are limited sanctions and even if these exist these are not enforced. The most reported form of accountability is peer pressure between national governments during the regional reporting meetings. However, the peer pressure is not always used to achieve progress in SRHR as reported by one of the key informants. For example, within Zimbabwe used the SADC forum to get other members to join a day of mass protest against sanctions. The influence of the REC chairs for progress on SRHR is significant.

3.4.2 Social and performance accountability

INTRODUCTION

Social and performance accountability is a process that is applied in many sectors. Lodenstein et al.,[242] described social accountability as actions by 'social actors' (such as citizens and civil society) to demand public officials and politicians to be accountable for their actions. Van Belle et al., described performance accountability as internal systems to support the functioning of health facilities and the objectives of health providers – for governments to demand health care service providers and systems to be accountable. Health facility committees may serve as an extension of service providers and engage in community outreach, the co-management of health centre resources and the facilitation of repairs and fundraising. The review showed that in general when social and performance accountability are used within the SRHR sector it is mainly linked to the (quality of) maternal, neonatal and child health services, while legal and political accountability also addressed HIV, GBV and LGBTI concerns.

WHAT IS THE SITUATION?

Performance accountability is quite prevalent in low-and-middle-income countries and sometimes referred to as inwardly [243]. Social accountability is a more ' bottom up" or outward approach and sees that users' and citizens' voice and community preferences in decision-making in service delivery. Activities include advocating for access to health care ("social leveller") or resources ("advocacy"), the monitoring of the quality of care and the use of funds ("control of quality and management") and the facilitation of feedback mechanisms between health providers and users ("provide accountability

[242] Elsbet Lodenstein, Eric Mafuta, Adolphe C. Kpatchavi, Jean Servais, Marjolein Dieleman, Jacqueline E. W. Broerse Alpha Amadou Bano Barry Thérèse M. N. Mambu, and Jurrien Toonen, 2017. Social accountability in primary health care in West and Central Africa: exploring the role of health facility committees. BMC Health Serv Res. 2017; 17: 403.

[243] McCoy DC, Hall J, Ridge M., 2012. A systematic review of the literature for evidence on health facility committees in low- and middle-income countries. Health Policy Plan. 2012;27:449–466. doi: 10.1093/heapol/czr077

interface")[244]. There are different perspectives which tools in social accountability are useful are not: balance score cards, opinion boxes, audits, health reference groups, engaging communities are all seen as social accountability tools. Some see health committees engaging the communities already a good first step.[245][246]Another vision on social accountability is that it is a basic human rights principle and this means it is always bottom up. The voices of the poorest and the most in need should be heard and services – social and health should be responsive to them. This is also in line with more bottom up approach the health sector but it entails more. Rights are at the centre of this approach and citizens should be given the space and the authority to define their own needs and act upon them. There are several examples of multi-country social accountability programs. One of the well-known examples is described in the 2013 report Lessons from the Mwananchi Programme a social accountability programme in 6 countries. It describes how national coordinating organisations in each country were identified, who then issued calls for proposals from local civil-society and media organisations to implement projects designed to find innovative ways to increase citizen ability to hold their governments to account. Transparency, space to act, incentives and relations between different actors were key, all aimed at transforming citizen-state relationships in favour of the poor. Several studies showed that accountability strategies have the potential to influence equity positively when involving civil society to promote access for marginalized groups (Belle et al., 2017). However, representation of marginalized groups such as the poorest of the poor is not automatically legitimate when CSOs are engaged. For example, Women Right's groups might consist of more educated and wealthy women (Lodenstein et al., 2017). Belle et al. discussed that the success of accountability strategies is influenced by context-specific factors such as power relations and socio-cultural dynamics. A thorough understanding of these local dynamics and incentives is needed, also in order to build relationships based on trust[247]. The tools and strategies to implement these types of programmes are to be found on many websites.[248] Especially in conflict or fragile settings, (rebuilding) trust among and between citizens and providers and state actors plays a key role in social accountability (Lodenstein et al., 2017).

The meaningful participation of civil society actors in SRHR accountability matters depends highly on the general political space for expression and dissent, which varies enormously across sub-Saharan Africa. The democracy advocacy organization Freedom House claims that after much progress in the 1990s and early 2000s the Sub-Saharan Africa region has seen a backsliding in recent years[249]. At present it considers only 9 countries in the region to be 'free': Mauritius, South Africa, Botswana, Namibia, Benin, Ghana, Senegal, Sao Tome and Principe and Cape Verde. Central Africa and the Horn of Africa are dominated by repressive regimes. A number of countries have seen historic openings of political freedom, notably countries that have a long history of repressive rule such as the Gambia, Ethiopia, Angola and Sudan. On the other hand political and civil space is closing in an increasing number

[244] George A, Scott K, Garimella S, Mondal S, Ved R, Sheikh K., 2015. Anchoring contextual analysis in health policy and systems research: a narrative review of contextual factors influencing health committees in low and middle income countries. Soc Sci Med (Elsevier Ltd) 2015;133:159–167. doi: 10.1016/j.socscimed.2015.03.049.

[245] Lodenstein, E., Molenaar, J.M., Ingemann, C. Kondwani Botha, Jenipher Jere Mkandawire, Loan Liem, Jacqueline E. W. Broerse and Marjolein Dieleman., 2019. "We come as friends": approaches to social accountability by health committees in Northern Malawi. BMC Health Serv Res 19, 279 (2019). https://doi.org/10.1186/s12913-019-4069-2

[246] Adweeti Nepal, Santa Kumar Dangol, Anke van der Kwaak, 2020 (unpublished). Improving maternal health services through social accountability interventions in Nepal: An analytical review of existing literature 2020

[247] Fletcher Tembo, 2013. Rethinking social accountability in Africa- Lessons from the Mwananchi Programme https://www.scribd.com/document/174742239/Rethinking-social-accountability-in-Africa-Lessons-from-the-Mwananchi-Programme-pdf

[248]Coady International Institute - Marie Michael Library, Citizen-Led Accountability: Strategies and Tools - https://coady.stfx.ca/course-links/citizen-led-accountability-strategies-and-tools/

[249] Freedom in the World, 2019: https://freedomhouse.org/report/freedom-world/freedom-world-2019/democracy-in-retreat

of countries, such as Tanzania. Around 20 countries across the continent have attempted to introduce or are in the process of introducing legislation or policies that constrain non-governmental organisations (NGOs), particularly those working on human rights, including LGBTQI rights and governance issues[250]. This includes countries where democratic space is not wholly restricted yet such as Zambia, Malawi, Nigeria and Sierra Leone. These restrictions violate global and regional human rights treaties, particularly those relating to freedoms of association, assembly or expression. They are seen as one of the instruments used to prevent challenges to the rule of strongmen or (often long-dominant) ruling parties in addition to counterterrorism, cybersecurity and anti-money laundering laws that are applied selectively to curb NGO freedom. Freedom House points to some evidence of learning and imitation from different countries in ways to restrict NGO-activity and argues they 'may also be finding comfort in the shadow of illiberalism cast by major actors on the global stage'.
The report concludes with recommendations to African civil society, African governments, and the international community and donors. Among several recommendations to civil society, it is proposed that NGOs should challenge anti-NGO measures in court and seek the application of the quantitative limitations test, which affords the groups an opportunity to propose less restrictive measures for achieving identifiable governmental objectives—in this case, accountability in the sector. To complement foreign sources of funding without compromising the resource base and independence of NGOs, African governments should explore incentives that encourage donations from citizens and private entities. Donors, meanwhile, should prioritize flexible funding models, as well as "pooled" and "basket" funds, that take into consideration the strategic nature of the challenge faced by civil society in Africa.[250]

WHAT ARE THE GAPS?

Besides space to act and financial constraints there are gaps in the knowledge how gender, power dynamics and other social hierarchies play out and influences realities as well as (social) accountability initiatives and processes. How do gender and intersecting identities are negotiated among citizens making right claims and or in government responses[226]. Within SRHR the need to address client-provider relations and provider – provider relations is essential.

Social and performance accountability programs but also others like GFF and UHC are mainly linked to maternal and reproductive health, leaving out sexual health and rights. The GFF actively seeks civil society contributions and feedback through its Civil Society Engagement Strategy[251], including CSO representation in the country platforms and Investor's Group as well as youth involvement[252]. However, several case studies on GFF implementation identified insufficient involvement of CSOs to meaningfully contribute to the implementation of the national GFF programme[253]. Existing supporting structures are a global civil society coordination group[254] and a virtual forum launched by PAI for public information on the GFF and support for civil society through capacity building, engagement support grants and

[250] Godfrey M. Musila Freedoms Under Threat: The spread of anti-NGO measures in Africa. Freedom House Special Report, May 2019: https://freedomhouse.org/sites/default/files/05132019_UPDATED_FINAL_Africa_Special_Brief_Freedoms_Under_Threat.pdf
[251] Global Finance Facility, 2017. Civil Society Engagement Strategy. GFF, 2017 - https://www.globalfinancingfacility.org/sites/gff_new/files/documents/GFF-IG5-5%20CS%20Engagement%20Strategy.pdf
[252] Global Finance Facility, 2018. Adolescent and Youth Addendum to the GFF CS Engagement Strategy. GFF, 2018 - https://www.globalfinancingfacility.org/adolescent-and-youth-addendum-gff-cs-engagement-strategy
[253] Wemos, 2019, The Global Financing Facility in Malawi: A brief summary https://www.wemos.nl/wp-content/uploads/2019/09/Wemos_The-Global-Financing-Facility-in-Malawi-2019-1.pdf. See also Wemos' story board at https://readymag.com/pirana/1391999/9/
[254] Global Civil Society Coordinating Group on the Global Financing Facility, 2017. Terms of Reference - https://www.who.int/pmnch/gff_cso_tor.pdf

technical assistance to help the GFF realize effective and sustainable health financing[255]. Multiple resources are available on accountability and the process of CSO involvement. CSOs have developed a GFF scorecard[256] to monitor progress, which is currently used in Kenya[257].

When asking REC's about the role and involvement of civil society it was regularly mentioned that CSO's are invited to join in strategic planning. However, the role of civil society to hold political bodies to account is not so coordinated. Also the mechanisms for REC's to hold country governments accountable for civil society involvement and freedom could be strengthened. Shrinking space for CSOs was seen as an internal affair of countries and not part or the REC's role or mandate. However, it was also mentioned that it is important to show what the contributions of CSO can be and how they can be meaningfully engaged. As one respondent mentioned: 'we need to demystify the work of civil society; now we see them as the police.'

There is a need to engage fully with the interconnections between sexual rights, sexual health and sexual pleasure. Implementation of this so called "triangle approach" to sexual health and rights is more important now than ever with the current political climate, for every individual and especially for those who are most marginalised[258]

CONSIDERATIONS

- Strengthening social accountability mechanisms linked to gender transformative processes in the field of SRHR, not only maternal health
- Strengthening alliance between providers, clients, between different actors and organisations: not as a one off imitative but with follow up meetings.
- Link up to accountability programs but also other movements like GFF and UHC, in order to define the agenda, monitor the accountability mechanisms that are in place, including the involvement of civil society and young people when defining the investment cases, leverage on lessons learned cross-mechanism.
- Assist REC's in clarifying and supporting their accountability role and mandate.
- Prioritize flexible funding models, as well as "pooled" and "basket" funds, that take into consideration the strategic nature of the challenge faced by civil society in Africa

[255] The civil society GFF resource and engagement hub - https://www.csogffhub.org/hub-resources/
[256] Evidence for Action- MamaYe!. GFF Accountability Scorecard scoring System https://www.csogffhub.org/resources/gff-accountability-scorecard-scoring-system/
[257]Health NGOs Network (HENNET), Action for Evidence- MamaYe! 2018. GFF Kenya Scorecard 2018 - https://www.csogffhub.org/resources/gff-civil-society-organisations-accountability-scorecard-kenya-september-2018/
[258] Loue S. 2006. Community health advocacy. Journal of epidemiology and community health, 60(6), 458–463. https://doi.org/10.1136/jech.2004.023044https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2563937/

4. Summary of key findings and considerations

This chapter highlights the key findings on the four outcome areas of the Theory of Change set out against Sida's 5 core perspectives of poverty, human rights, gender equality, conflict and climate change. It also shows where the information gaps are (specifically on climate change and conflict in relation to social norms and accountability). The key-findings can be taken along in reconsiderations on Sida's strategy and Theory of Change.

	Policy Environment	Access to quality SRHR services	Social Norms	Accountability
General	Findings: Relatively strong regional normative frameworks on SRHR are challenged in domestication and implementation and weak in accountability. Decrease in the contraceptive market of the public sector, while deterring regulatory environments are challenging the process to clear and register commodities and organizations. Considerations: REC's expressed need for: 1. technical and financial support for regional accountability mechanisms, 2. strengthening advocacy roles, 3. availability of evidence and data. Consider investments in big data and innovative data collection for development.	Findings: Progress made in many SRHR indicators showing expanded access to SRHR. Not in reproductive cancers and intimate partner violence. Infertility received limited attention. Unmet need for contraception, fertility rates, adolescent pregnancies, unsafe abortions, HIV and STI prevalence, maternal and newborn mortality remain very high in sub-Saharan Africa. Unequal progress between and within countries, especially for adolescent, poorest of the poor, people with disabilities, LGBTQI and displaced people. Considerations: specific suggestion for Theory of Change can be to include access to	Findings: Social norms continue to shape the discourse on gender equality, sexual orientation and gender identity (SOGI), safe abortion, and adolescents' access to SRHR across sub-Saharan Africa. Considerations: Transforming discriminatory social norms requires a solid understanding of the political economy and territorial realities. These efforts must be endogenous. Interventions are needed at regional, national, and grassroots levels and require the involvement of a wide range of stakeholders, including men and boys, to change attitudes on gender roles. For example, nationwide awareness-raising campaigns to	Findings: There are adequate instruments for political accountability and civic engagement; the focus is on answerability and implementation strongly depends on political will and leadership. In political accountability there is limited enforceability. Implementation and compliance with accountability instruments is lacking, partly caused by limited capacity. M&E systems are not in place and quality and availability of data remains challenging;

	Facilitate RECs potential role in regulatory harmonization processes for commodities. Explore joining The African Medicines Registration Harmonization initiative to support WHO in getting registration processes harmonized. Specific suggestion for Theory of Change is to clarify links between the implementation of existing policy frameworks and other focus areas, engaging a multi-sectoral approach.	information in addition to the services. CSE be included under this outcome area as this also corresponds to Guttmacher-Lancet definition of CSRHR	address social stigma, condemn victim shaming and support survivors of gender-based violence have proven efficient. National and regional governments and research institutes need support to generate and manage data on sensitive SRHR topics and present it in a language that can convince policy makers on the need for paradigm shift in those topics. Advocacy remains crucial.	Proposed retrogressive reviews of the protective mandate of the Commission and closing of the civic space. Considerations: To support CSO and Media to influence accountability; To strengthening alliances between providers, clients, between different actors and organisations
Poverty Despite a global decline in poverty, poverty rates in Sub-Saharan Africa remain high and contribute to poor SRHR outcomes. Poverty reinforces poor SRHR, and poor SRHR reinforces poverty. The poorest women tend to have higher unmet need for SRH services, including modern contraceptives. In many countries fertility rate	Findings: Poverty and illiteracy are observed as key challenges in awareness on legal rights and challenge domestication of SRHR frameworks. Lack of focus in policy frameworks on the poorest/most vulnerable populations and strategies to achieve UHC. Consideration: the use of advocacy and (social) media to enhance translation of political commitments and legislations to domestic levels.	Findings: Financial barriers and catastrophic health expenditures (CHE) are a reality for the poorest of the poor. Inequitable access to SRHR services and information for the poorest people and poor people are inadequately protected against CHE Consideration: alternative ways of financing such as vouchers systems.	Findings: Poorer women more likely to experience earlier sexual debut, have multiple sexual partners and partners who are six or more years older and to report having had sex for material or financial support. Education and keeping girls in school increase girls chances of becoming financially secure and independent, lower exposure to intimate partner violence, reduce the risk of HIV infection, expose girls to CSE	Findings: Social accountability can be a mechanism through which services can be responsive to the voices and needs of the poorest of the poor. The accountability strategies have the potential to influence equity positively, as civil society has the potential to promote access for marginalized groups. However, representation of marginalized groups such as the poorest of the poor is

declines when prosperity and development increase.			Consideration: Keeping girls in school by addressing poverty, free education policies, conditional cash transfers that reward parents for keeping their daughters in school has been proven effective. Need for Locally-generated, context-specific data to dispel misbeliefs on CSE. Legal literacy programs to help women, families and communities understand their legal rights.	not automatically legitimate when CSOs are engaged. Consideration: Make sure that in CSO engagement also marginalized groups such as the poorest of the poor are involved
Human Rights The human rights-based approach to health is translated into health services being available, accessible, acceptable and of good quality (3AQ) for all people, without discrimination of any kind. The momentum around Universal Health Coverage (UHC) is an opportunity to advance SRHR and there is growing consensus that UHC cannot be achieved without addressing SRHR.	Findings: Limited attention for *sexual* health and rights in global, regional and national level policies and funding. The link between UHC and SRHR is poorly translated into policies. The role of civil society in advocating and holding states and programs accountable for the integration of comprehensive SRHR, is challenged by the opacity around funding mechanism decision-making approaches and processes, lack of optimal inclusion of key stakeholders	Findings: Human rights-based approach to health is translated into health services being available, accessible, acceptable and of good quality. This concept links both UCH and SRHR. Access for adolescents is hindered by: patriarchal, cultural and social values, norms and (negative or judgmental) attitudes of service providers result in resistance to provide comprehensive SRHR services to adolescents. Limited focus on adolescents boys and men's SRHR.	Findings: Violence and discrimination remain the most concerning legal, social issues facing LGBTIQ persons and communities. None of the East Africa countries have anti-discrimination legislation and hate crime laws to protect persons from bias or discrimination on the grounds of their SOGI, while legislation in West and Southern Africa is diverse.	Findings: Social and performance accountability in SRHR is mostly found to be linked to maternal, neonatal and child health. Some political accountability initiatives also include HIV, GBV and LGBTQI. Social and performance accountability initiatives leave out sexual health and rights. Although civic engagement and CSO participation are presented on paper in

	including CSOs, and the absence of sustainable financing mechanisms for CSOs. Persisting legal barriers for access to safe abortion services Persisting legal barriers for adolescents accessing SRHR without discrimination <u>Considerations:</u> Sida's continued added value on rights approach and the 'sexual components' of the Lancet-Guttmacher SRHR definition. Building alliances with like-wise donors to ensure that sexual rights issues and contentious topics, such as access for adolescents, is addressed. Entry points with Global Financing Mechanisms to be able to define the agenda, including involvement and support of civil society and young people when defining investment cases.	Limited attention for quality of care While there is limited data around LGBTQI, LGBTQI people face marginalization and stigma accessing services and sexual and other types of violence. There are major setbacks in terms of human rights and LBGTQI are reported in sub-Saharan Africa; and homosexual acts are being increasingly criminalized, and violations are underreported. <u>Considerations:</u> To stimulate the inclusion of monitoring and reporting on the quality of care; To promote the access to SRHR information, the establishment of appropriate national curricula for CSE and monitoring and reporting of its implementation should be stimulated; To continue and strengthen focus on marginalized and vulnerable groups such as adolescents, LGBTQI, people with disabilities, poorest of the poor, and displaced people; To consider the role of availability and acceptability (or	Lack of political will to support and respect the rights of LGBT persons. Provider bias to abortion and for adolescents to access services and information. <u>Considerations:</u> Evidence shows that approaching LGBTIQ and abortion issues from a public health perspective allows people to come to the table. Sida can identify national public health associations and work with them to shape the discourse on LGBTIQ persons rights. Fund civil society and women's rights organizations to mount advocacy efforts aimed at removing barriers like parental and spousal consent, which are critical for scaling up services and increasing access for adolescents.	political accountability, there is a lack of real engagement. <u>Considerations:</u> Prioritize flexible funding models, as well as "pooled" and "basket" funds, that take into consideration the strategic nature of the challenge faced by civil society in Africa.

		appropriateness) of services in the Theory of Change.		
Gender equality Gender inequality and restrictive gender norms relate to differences in gendered health behaviours, access to care and gender-biased health systems, in turn reinforcing gender inequalities. The strong link requires gender-transformative programs and policies to achieve progress in SRHR.	Findings: Gender equality quite well integrated in the policy framework. However, discriminatory social norms weaken the implementation and efficiency of gender-sensitive policies, exposing women and girls to ongoing discrimination. Progress in implementation requires addressing social norms. RECs are working to address gender inequality by adopting national gender strategies and implementing legislative reforms, e.g. ECOWAS roadmap on prevention and response to child marriage, but legal loopholes and customary practices often weaken women's rights.	Findings: The intimate partner violence indicator is worsening. CSE can play an important role in addressing gender equality. Unequal access for especially adolescent girls while at the same time there is limited focus on adolescent boys and attention for men's SRHR. Both strengthen gender inequality and limit progress in SRHR for both (young) men and women. Considerations: To stimulate and strengthen gender-transformative policies and programs, especially CSE programs also for out of school youth. To consider the role of power dynamics in the Theory of Change.	Findings: Patriarchal norms, where men are viewed as the norm, and their life experiences are most often used as the basis on which to determine social needs, articulate policy requirements, and assign resources. Discriminatory social and cultural norms are translated into laws that act as barriers to women and girls accessing SRH services (e.g. parental or spousal consent, age-restrictive legal norms), increasing their vulnerability to poor SRH outcomes. RECs working to address gender inequality by adopting national gender strategies and implementing legislative reforms, e.g. ECOWAS roadmap on CM, but legal loopholes and customary practices often weaken women's rights. Considerations: Advocacy remains crucial, identify national and regional	Findings: there is a knowledge gap on how gender, power dynamics and other social hierarchies influence realities and social accountability initiatives and processes Consideration: To stimulate and strengthen social accountability mechanisms linked to gender transformative processes in the field of SRHR.

			level “fight” networks and what they need to sustain their work.	
Conflict Rather than merely *conflict*, this context analysis adopted a definition of *humanitarian crisis* that may either be man-made (e.g. armed conflict) or a natural phenomenon (e.g. drought or floods). The need of people for services and protection increases while at the same time systems break down. Women, adolescents, people with disabilities, ethnic minorities, and people with different Sexual Orientation, Gender Identity and Expression and Sex Characteristics (SOGIESC) are disproportionately affected by crisis and displacement.	<u>Findings:</u> Restrictive policies and misinformation about existing policies in fragile settings prevent implementation of critical comprehensive SRHR services and lead to fragmentation, particular for contraceptive and abortion services. Lingering divide (and lack of synergy) between humanitarian and development actors <u>Considerations:</u> Need for (ongoing) attention for people living in humanitarian crises Need for inter-donor coordination. Consider to link up to IAWG	<u>Findings:</u> Refugees and migrants specifically vulnerable for SRHR related risks, such as Child Marriage, Teenage Pregnancy, STIs, HIV and SGBV. Very limited available, acceptable, accessible and quality SRHR services. Available SRHR services focus on safe motherhood. Specific gap in addressing SRHR needs of vulnerable populations such as LGBTI and adolescents. <u>Considerations:</u> When supporting humanitarian aid to focus on full implementation of MISP and moving towards comprehensive SRHR services. To invest in innovative ways to address equitable financial access for all groups, including marginalized groups – such as voucher programs.	<u>Findings:</u> Legal paradox where countries that criminalize same-sex relations continue to abide by their international obligations to protect LGBTIQ refugees and asylum seekers within their borders but at the same time continue to prosecute and persecute their LGBTIQ citizens. LGBTIQ persons face rights violations and protection challenges during asylum processing. <u>Considerations:</u> Sida can use the UN UPR mechanism to work with national governments and civil society groups to implement policy initiatives and commitments aimed at ending discrimination in education and supporting LGBTI asylum-seekers. Human rights abuses related to SOGI that occurs at the borders require that national governments train their border officials on these issues.	<u>Findings:</u> in (post-)conflict settings, the performance and social accountability is about rebuilding trust among and between citizens and providers and actors of State.

Environment and climate Climate change threatens population health including adverse changes in air pollution, spreading of disease vectors, food insecurity and under-nutrition, displacement and mobility, and mental ill health and subsequently contribute to negative SRHR outcomes. The effects are disproportionately affecting populations and groups that are already struggling the most. Coping mechanisms for scarcity of resources and financial hardship tend to contribute to negative SRHR outcomes: such as migration, transactional sex and Child Marriage, and subsequently to teenage pregnancy. Studies show that met needs for contraception and SRH care are linked to reduced vulnerability and enhanced resilience for climate impacts.	Findings: Limited attention for integration SRHR and climate in policy instruments	Findings: Direct climate change effects such as droughts contribute to displacement of people for example due to the lack of food. Climate impacts such as a lack of food, water and sanitation and increased spread of infectious diseases affect maternal and newborn health. Coping mechanisms related to climate change impacts contribute to negative SRHR outcomes: such as migration, transactional sex and Child Marriage, and subsequently to teenage pregnancy. Unmet need for contraception and SRHR services contribute to vulnerability and limited resilience for climate impacts. Consideration: Integrate FP as mitigation strategy into policies		

Annex 1 Draft Theory of Change Sida SRHR strategy for Sub-Saharan Africa

Vision	SRHR for all			
Impact – contributing to the SDGs	**Goal 3.** Ensure healthy lives and promote well-being for all at all ages; **Goal 4.** Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all; **Goal 5.** Achieve gender equality and empower all women and girls; **Goal 16.** Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels.			
Outcomes *Focus*	Creating an enabling legal and policy environment for SRHR in sub-Saharan African - *Continental and sub-regional SRHR frameworks* - *Continental human rights resolutions* - *Evidence-based decision making* - *Strengthen policy implementation at national level e.g. through technical guidance* - *Interlinking different policy levels/actors* - *Strengthen systems for domestic resource mobilization*	Expanding access to quality assured integrated SRHR services for women, men, adolescents and young people, and LGBTI - *Access to contraceptives, including for adolescents* - *Legal and safe abortion* - *Menstrual hygiene* - *Integration of HIV prevention and SRHR* - *HIV treatment access for adolescents* - *SGBV* - *Health System Effectiveness for SRHR* - *Financial risk protection (UHC)*	Changing social norms around gender equality, sexual orientation and gender identity, safe abortion and adolescents access to SRHR - *CSE* - *Social and behavior change* - *Demand creation* - *Empowerment of rights holders* - *Engaging men and boys, and religious and traditional leaders*	Increasing accountability for policy adoption and implementation, resource allocation, and quality of services - *Political/social accountability* - *Financial accountability* - *Implementation/Social accountability for human rights (3AQ) in services provision* - *Community mobilization* - *Watchdogs* - *Participation in decision making to increase openness, transparency and accountability*
Strategies	**Policy action** Strategic dialogue and high level advocacy for increased political will and commitment, accountability and peer learning, friendly competition and social sanctions/pressure **Knowledge generation and management** Develop service delivery model, increase knowledge sharing and document and disseminate lessons learned to feed into policy cycle at continental and national level **Movement building** Strengthen or build policy communities, networks and alliances, support campaigns, and address politically sensitive issues **Capacity building** Strengthening technical capacity to implement SRHR policy and guidance **Economies of scale** Leverage economies of scale to decrease price of SRHR-commodities thereby expanding access			

Annex 2 Overview Information Needs

result areas, elements and key questions

1. Legal and policy environment

Continental and sub-regional SRHR frameworks, laws and human rights resolutions

- **Domestication of continental and regional policy frameworks**
  - How can the implementation of regional strategies and protocols related to SRHR at country level be strengthened? And how can Sida facilitate domestication of regional policies, protocols and instruments related to SRHR?

Continental and sub-regional regulations and financing mechanisms

- **Regional entry-points and capacity needs**
  - What are the potential entry points for engagement on SRHR with the RECs in West and Central Africa?
  - What kind of support is required from Sida to the regional entities (RECs)? What values could be added, for example technical assistance, capacity building? What are their needs? What can we base our relationships on?
- **Domestic health financing trends**
  - What are domestic health financing trends?
- **General financial aid trends in SRHR**
  - **Financing instruments (GF, Gavi, GFF)**
    - What are main insights into financing instruments, such as GF, Gavi, GFF?
  - **Effects of PLGHA**

Regional political developments and emerging trends

- **Civil Society developments**
- **Initiatives and trends social accountability**
- **Discriminatory laws and policies: young people and women's rights, LGBTQI rights, people with disabilities**
- **SRHR and climate change**
  - What are SRHR and climate change linkages in terms of mitigation and adaptation.
- **SRHR and migration**
  - Furthermore, unpacking migration: access to services in the fragile contexts. How can access to SRHR services be assured or what are good regional initiatives of supporting access to SRHR services? Who are regional actors playing a role in a fragile context and SRHR? What do adolescents in transit need? What model is best suited in these situations? [link with result area 2]
  - How can Sida's regional team best work with emerging trends? [Emerging trends that will be included will depend on the findings]

2. Access to quality services

Access to quality services

- **Regional actors and regional standards**
- **Domestication of regional standards**

- To what extent do collective regionally agreed upon (by RECs) standards and WHO guidelines play a role at country level in terms of service delivering? How are these implemented? For example, provisions of PMTCT services
- How do regional actors use their influence to make sure countries get to domesticate regional standards and improve access to quality services at country level?

- Commodities
  What are opportunities and hurdles at regional level to purchase products or commodities? Also in terms of harmonization among the states with respect to regulatory processes on improving markets.

- Equal access to comprehensive SRHR information and services
- What are successes, barriers and challenges for people with disabilities to access services? What is done at regional level to make sure these people are not missed?
- What are initiatives aiming towards improving equal access to good-quality services for the poor?
- What is the role of the private sector in making SRH information and services accessible and available? What are good private sector initiatives or actors that promote access to SRHR services?

Regional support for Health Systems Strengthening

- Engagement with regional structures
- How to engage with regional structures and entities to support HSS, specifically in relation to SRHR?

UHC and SRHR

- Link UHC and SRHR from different perspectives
- What is the link between UHC and SRHR? What are gatekeepers in UHC/SRHR and how do they interpret UHC and SRHR linkages?
- Driving forces and social actors
- What are driving forces for UHC and SRHR? Who are driving these?
- Regional bodies and regional UHC agenda
- Who are regional bodies and health professional networks/regional professional associations to work with?
- Is there a true vibrant UHC regional environment/agenda in the region and how is/can this be used to increase access to SRHR?

3. Social norms

Prioritized areas of norms:

a) Comprehensive sexuality education
b) Abortion
c) Young people's access to SRHR services
d) LGBTQI+

- Key challenges and gaps
- What are key challenges and gaps in social norms?
- Actors influencing social norms and driving change
- To what extent do the following actors influence social norms and drive actual change: parliamentarians, donors, communities, health workers?
- Linkages changes in legal environment and social norms
- If changes in the legal and policy frameworks are observed, how is this linked to changes in social norms and attitudes of people?

- How are the traditional and legal/policy systems linked in the different countries?

- **Regional strategies working with social norms**

- What is the regional added value of working with social norms, which strategies can be best deployed?

4. Accountability

- **Continental and regional accountability mechanisms under RECs, ACHPR and SDGs**

- How do regional accountability mechanism under the RECs work?
- What are the strengths of the African Commission on Human and People's Rights (ACHPR) and its accountability mechanism?
- How does accountability around SDGs work? How are institutions working with the SDG review process?

- **Accountability mechanisms on access to quality services**

- To what extent do countries hold each other accountable towards the regional standards? What are levels of ambitions?
- How are countries being hold to account for e.g. the Abuja declarations, also in terms of budgetary allocations?
- What are main insights into performance accountability (in relation to services) to improve quality?

Annex 3 Generic Topic guide Key informant Interviews

Below the topic guide for the key informant interviews for the context analysis on SRHR in Sub-Saharan Africa is presented. Currently the guide covers all aspects that will be reflected upon in the analysis. For each key informant interview, specific questions will be selected, based on the background and expertise of the respondent. Therefore, not all questions need to be covered in each interview.

Result area	Topics	Key questions
Enabling legal and policy environment for SRHR		
Creating an enabling legal and policy environment for SRHR	• Continental and sub-regional SRHR frameworks, laws and human rights resolutions • Continental and sub-regional regulations and financing mechanisms • Regional political developments, including anti-choice movements • Interlinking of different policy levels/actors	<u>Continental and sub-regional SRHR frameworks, laws and human rights resolutions</u> i. How can the implementation of regional strategies and protocols related to SRHR at country level be strengthened? i. What are the potential entry points for engagement on SRHR with the RECs and other regional bodies in West and Central Africa? ii. Are there any initiatives towards the merging of the UHC and SRHR agenda? What is your interpretation of UHC and SRHR? What are driving forces for UHC and SRHR? Who is driving this? <u>Continental and sub-regional regulations and financing mechanisms, *including aid architecture*</u> iii. What are the general trends in domestic health financing? iv. What are the general financial aid trends in SRHR- financial priorities v. GF, Gavi, GFF process, linkages and focus- how is it evolving, what is being emphasized in GFF, how are countries responding to it? vi. What is the impact of the global gag rule on the SRHR landscape? Probe for impact on civil society activism, vertical programming by USAID? <u>Regional political developments, including anti-choice movements</u> vii. Impact on (accountability by) civil society - What is your view on the space and funding for CSOs international and regional? viii. What is the impact of the trends in freedom and human rights on the potential for citizen involvement and accountability around SRHR – e.g. exclusion of certain groups, limited or less meaningful citizen engagement, etc. ix. What are trends in and impact of political climate on potential for local/social accountability and vice versa.

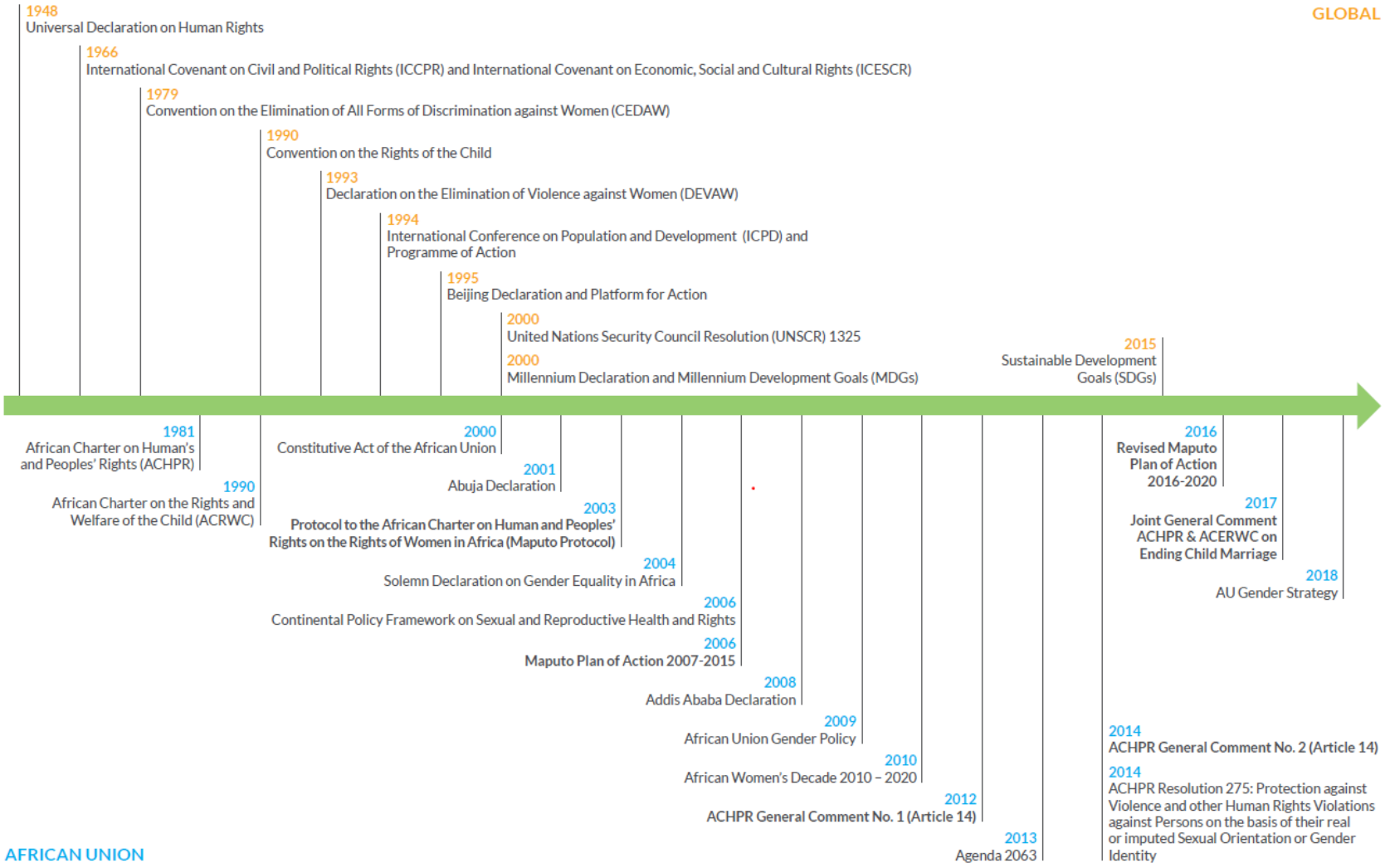
		x. Is there any development in the focus of social accountability initiatives around SRHR across the board? E.g. on quality of care, resource allocation and spending, xi. What are the trends in restrictions or liberalizations on women's rights broadly, LGBTQI rights, abortion, youth-friendly health services, child marriage, CSE. Probe for learnings on barriers and successes. How do key regional accountability mechanisms work - of the RECs including score cards (SADC), Consultative Dialogue Framework (EAC) and Gender Equality and Development Barometer, African Peer Review Mechanism, African Commission on Human and People's Rights? i. In your view, which ones can be considered good practices and why? ii. What are other strengths of the mechanism(s)? iii. What are challenges with these mechanisms or efforts? How does accountability around SDGs work? How are institutions working with the SDG review process? What can be done to support RECs? What are their needs in terms of capacity?
Access to quality SRHR services		
Expanding access to quality assured integrated SRHR services for women, men, adolescents and young people, and LGBTI people – also in fragile and conflict settings	a. Contraceptives b. Abortion c. Menstrual Hygiene d. HIV prevention, treatment and integrated services e. Sexual and Gender-based Violence f. Universal Health Coverage g. Health System Effectiveness h. Health financing i. Antenatal, childbirth and postnatal care, including emergency obstetric and new-born care; j. Reproductive cancers, subfertility and infertility k. Equity and quality of care	What are key regional SRHR challenges in terms of access to and quality of services? How do regional actors use their influence to make sure countries get to domesticate regional standards and improve access to quality services at country level? To what extent do the regional frameworks result in agreed upon minimum standards of service provision? And how is this reflected at country level implementation? What are the ambitions? Social access to services (also specifically for fragile and conflict areas): i. What are the trends in making SRH services available and accessible? What are successes and gaps or challenges in making SRH services accessible to different groups (culturally, geographically), including people with disabilities? What opportunities and hurdles are there at regional level to purchase commodities? Probe harmonization regulations ii. What is the role of the private sector in making SRH information and services accessible and available? What are good private sector initiatives or actors that promote access to SRHR services? Economic access to services (also specifically for fragile and conflict areas)

		i. What are some innovative new mechanisms to strengthen affordability of and in turn access to care? ii. Are you aware of initiatives aiming towards improving equal access to good-quality services for the poor? What are barriers to access to public and private-sector services, such as cost of services (user-fees/cost-sharing), and structural constraints to quality of care (provider training, referral systems, client-provider relations, supplies/logistics, location of service-delivery points) across the region? Quality of care (also specifically for fragile and conflict areas) i. What are successes, gaps or challenges in terms of improving the quality of care in the region? ii. What are mechanism for performance accountability (in relation to services) to improve quality of care? What are linkages between climate changes on SRHR in terms of mitigation and adaptation in the region? How is migration affecting the SRHR situation in the region? How can access to SRHR services be assured? What are good regional initiatives in supporting access to SRHR services in fragile settings? Who are regional actors playing a role in fragile settings and SRHR? What models are best suited in fragile contexts?
Social norms around SRHR and gender		
Changing social norms around gender equality, sexual orientation and gender identity, safe abortion and adolescents' access to SRHR	• Gender equality • Sexual orientation and gender identity • Men's sexual health • Social norms around sensitive SRHR issues (including abortion and adolescents)	What are social norms around SRHR: i. What are trends in terms of social norms around SRHR? For example, CSE, abortion, adolescents, different sexual identifies and LGBTIQ+, marital/extra-marital relationships? ii. What are key challenges or gaps in addressing social norms towards improved SRHR in the region? iii. Are you aware of successful initiatives addressing social norms to improve SRHR? What are trends in terms of gender identities, and gender roles and responsibilities , for example entitlements within marriage/households, decision-making, access to SRH information and services?

		If changes in the legal and policy frameworks are observed, to what extent can this be linked to changes in social norms and attitudes of people? What are linkages between traditional and legal/policy systems?
Accountability		
Increasing accountability for policy adoption and implementation, resource allocation, and quality of services	• Political accountability • Financial accountability • Social accountability • Civil society involvement	*Questions on accountability and CSO involvement are integrated in the policy environment section.*
Any other comments		Is there any SRHR-related issue you would like to discuss we did not yet cover? Any questions for us?

Annex 4 Supplemental documentation with 'Legal and Policy Environment'

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



Adopted from State of African Women report.

TABLE 1 CONTINENTAL POLICY FRAMEWORKS AND COMMITMENTS

Continental Policy Frameworks and commitments	Year	Key highlights
Abuja declaration	2001	AU heads of states commitment to allocate a minimum of 15% of their annual budget to strengthen the health sector.[259]
Solemn declaration on gender equality in Africa	2004	The commitments of AU states to fight HIV and AIDS; enabling women's full participation in peace processes; campaign to end GBV; expanding and promoting gender parity; ensuring the education of girls and literacy of women; promoting and protecting all human rights for women, especially with respect to land, property and inheritance.[260]
Continental Policy Framework on Sexual and Reproductive Health and Rights (CPF)	2006	Endorsed by the AU heads of States, this CPF should offer guidance in policy formulation and strengthen implementation of the Abuja declaration.[261]
Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA)	2009	Launched by the AU to expand the availability and use of universally accessible quality health services, including those related to sexual and reproductive health that are critical for the reduction of maternal mortality, by generating and providing data and increasing political commitment. Scorecards[262] are available for 46 countries that have launched CARMMA and data are available through an online database[263].
Agenda 2063	2013	Africa's strategic framework for inclusive and sustainable development with a vision for gender equality in aspiration 6: "An Africa whose development is people driven, relying on the potential offered by people, especially its women and youth and caring for children".[264]
Addis Ababa Declaration on Population and Development in Africa beyond 2014	2013	The review of the ICPD Plan of Action during the regional conference on population and development in Africa led to the Addis Ababa Declaration, recognizing that 'sexual and reproductive health and rights are not only essential to the realization of social justice, but are central to the achievement of global, regional and national commitments for sustainable development', and continuing to commit to 'enact and enforce laws and policies within national political and legal frameworks to respect and protect sexual and reproductive health and rights of all individuals'[265]
AU Common Position on the AU Campaign to End Child Marriage in Africa	2015	Urging AU member states to act upon 17 commitments in support of ending child marriage.[266]
Africa Health Strategy 2016-2030	2016	Building on a number of continental and global health policy commitments and instruments providing strategic direction to Africa's Member States. It 'advocates for and promotes Member State action to prioritize and invest in specific social determinants of health through better inter-sectorial collaboration, highlights the central importance of health systems strengthening priorities, calls for better leveraging of community strengths, public private and other partnerships as well as recommending a major paradigm

[259] https://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf?ua=1
[260] https://archives.au.int/bitstream/handle/123456789/282/Assembly%20AU%20Decl%2012%20%28III%29%20_E.PDF?sequence=1&isAllowed=y
[261] https://au.int/sites/default/files/documents/30921-doc-srhr_english_0.pdf
[262] http://www.carmma.org/scorecards
[263] https://www.africanhealthstats.org/
[264] https://au.int/en/agenda2063/overview
[265] https://www.unfpa.org/sites/default/files/resource-pdf/addis_declaration_english_final_e1351225_1.pdf
[266] https://au.int/sites/default/files/documents/31010-doc-cap_on_ending_child_marriage_-english_0.pdf

		shift that helps Member States more effectively manage the risks of disasters in a more systematic manner'.[267]
Maputo Plan of Action 2016-2030	2016	Operationalization of the Continental Policy Framework on SRHR (2006).[268] The Maputo Plan of Action guides states towards the implementation of the ICPD Programme of Action (1994) and the Abuja declaration (2001).
AU strategy on Gender Equality And Women's Empowerment (GEWE) 2018-2028	2019	Launched during the AU summit February 2019, with a comprehensive 4 pillar Theory of Change that should guide the implementation of the AU's GEWE commitments.[269]

TABLE 2 SUB-REGIONAL POLICY FRAMEWORKS AND COMMITMENTS RELATED TO SRHR

	Sub-regional policy frameworks and commitments	Year	Key highlights
EAC	EAC SRHR bill	2017	Provides a legal framework for matters relating to sexual and reproductive health, to protect children, adolescents and young persons from sexual abuse and other forms of exploitation, to provide for assisted reproductive technology and to provide for other matters related to those matters[270].
EAC/SADC	ESA commitment on CSE and SRHR for young people	2013	Ministers of Education, Health, Gender, and Youth and Senior Government officials commit to step up efforts to ensure adolescents' and young people's access to good quality CSE and youth-friendly SRH services in the Eastern and Southern Africa (ESA) region, and to work in partnership with young people, parents, civil society, and community and religious leaders to achieve the goals set out in the 2013 ESA Commitment. Adopted by 21 national governments in Eastern and Southern Africa.
SADC	SADC SRHR strategy 2019-2030	2019	Provides a policy and programming framework for SADC Member States to accelerate the attainment of sexual and reproductive health and rights for all people living in the SADC region. Builds upon the Programme of Action of the International Conference on Population and Development (ICPD), the SDGs, the Maputo Plan of Action 2016–2030, and the SADC SRH Strategy 2006–2015, informed by the most current thinking on SRHR as defined by the Lancet-Guttmacher Commission on Accelerating Progress: SRHR for All, and the Manifesto of the global SheDecides movement.[271]
ECOWAS	ECOWAS regional action plan of action for combatting obstetric fistula in West Africa	2015	The regional response to the issue of obstetric fistulas is carried out on the basis of four strategic areas including three principal ones relating to prevention, support to victims and the socio-economic reintegration of affected women. The fourth aspect or axis which is cross-cutting, is defined for the coordination, monitoring and evaluation of activities aimed at controlling obstetric fistula and focusing on operational research[272].
	ECOWAS roadmap on prevention and response to child marriage	2019	The overarching goal of the Road Map is to end Child Marriage in the ECOWAS Region. The roadmap is a programming tool for priority actions on ending child marriage to be implemented over a period of ten years and focuses broadly on: strengthening legal and policy

[267] https://au.int/sites/default/files/documents/30357-doc-final_ahs_strategy_formatted.pdf
[268] https://au.int/sites/default/files/documents/24099-poa_5-_revised_clean.pdf
[269] https://au.int/sites/default/files/documents/36195-doc-au_strategy_for_gender_equality_womens_empowerment_2018-2028_report.pdf
[270] http://www.eala.org/documents/view/the-eac-sexual-and-reproductive-health-rights-bill2017
[271] https://genderlinks.org.za/wp-content/uploads/2018/11/1-Final-signed-SADC-SRHR-Strategy-2019-2030.pdf
[272] https://www.ccdg.ecowas.int/wp-content/uploads/ECOWAS-regional-plan-of-action-for-combating-obstetric-fistula-in-West-Africa.pdf

			frameworks, mobilizing and engaging communities towards social norms change, promote increased access to education, health and other supportive services, ensure effective coordination, reporting, M&E and accountability mechanisms.
IGAD	IGAD regional strategy implementation plan 2016-2020	2016	Pillar 2 programme area 3 'health and development' SP1.2: 1) review country reports on the implementation status of the Maputo protocol, September 2006; 2) review the situation of reproductive health situation in respective countries with a focus on Cross Border and Mobile Populations (CBMP) and 3) integrate RH & RHCS activities with HIV/AIDS for CBMP[273].

TABLE 3. ADDITIONAL REGIONAL POLICY FRAMEWORKS AND COMMITMENTS

Inter-Agency Working Group (IAWG) on reproductive health in crises	1995	Coalition of more than 20 Steering Committee member agencies – representing UN, government, non-governmental, research and donor organizations committed to advancing the sexual and reproductive health of people affected by conflict and natural disasters.
Cotonou Partnership Agreement (CPA)	2000	Agreement between the EU and the African, Caribbean and Pacific Group of States (ACP) for 20 years (till 2020) with commitments regarding family planning, youth, population issues ("in order to improve reproductive health, primary health care, family planning; and prevention of female genital mutilation"), as well as the fight against HIV/AIDS. Currently negotiations take place for a post-Cotonou agreement beyond 2020.[274]
Ouagadougou partnership	2011	Partnership of the governments of nine countries (Benin, Burkina Faso, Côte d'Ivoire, Guinea, Mali, Mauritania, Niger, Senegal and Togo) to address the need for modern contraceptives in West-Africa and to increase progress in the use of family planning services through better coordination between donors and collaboration at national and regional levels.[275]
Kampala declaration	2011	Declaration of the Heads of States and Governments of the Member States of the International Conference on the Great Lakes Region on prevention, survivors support and ending impunity of Gender-based Violence Against Women.[276]
FP2020	2012	By the end of 2019 40 African countries[277] committed to this global partnership to address the policy, financing, delivery and socio-cultural barriers to women accessing contraceptive information, services and supplies.[278]
Sustainable Development Goals	2015	Adopted by all United Nations Member States, including goals on reproductive, maternal, newborn and child health and gender equality.

[273] https://igad.int/documents/6-igad-rs-implementationplan-final-v6/file

[274] Thijssen S, Bossuyt J, Desmidt S. Sexual and reproductive health and rights: opportunities in eu external action beyond 2020. 2019. https://ecdpm.org/wp-content/uploads/Sexual-and-reproductive-health-and-rights-DP-254-Thijssen-Bossuyt-Desmidt-ECDPM-June-2019.pdf

[275] https://partenariatouaga.org/en/

[276] https://www.who.int/workforcealliance/knowledge/resources/kampala_declaration/en/

[277] Egypt, Sudan, Cameroon, CAR, Chad, Congo, DRC, Sao Tome & Principe, Burundi, Comoros, Djibouti, Eritrea, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mozambique, Rwanda, Somalia, South Sudan, Tanzania, Uganda, Zambia, Zimbabwe, Benin, Burkina Faso, Cote d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Togo.

[278] http://www.familyplanning2020.org/

Reservations by country on the Maputo Protocol

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

Adopted from State of African Women report.

Annex 5 Overview of regions used in the analysis and their composition

Regions used in the analysis and their composition			
Regional unit	Countries	Regional Economic Community (REC)	Overlap
Western region	Benin, Burkina Faso, Cape Verde, Côte d'Ivoire, The Gambia, Ghana, Guinea-Bissau, Guinea, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone and Togo (15 countries)	All ECOWAS members	No overlap
Eastern region	Burundi*~^, Djibouti~^, Eritrea~^, Ethiopia~^, Kenya*~^, Rwanda*^, Somalia~, South Sudan*~, Sudan~^, Tanzania* and Uganda*~^ (11 countries)	• EAC members (six, marked with*) • IGAD members (eight, marked with ~) • Seven COMESA members (eight, marked with ^)	• Rwanda and Burundi also in Central region and ECCAS members • Tanzania also in Southern region and SADC member
Central region	Angola, Burundi, Cameroon, CAR, Chad, Congo Republic, DRC, Equatorial Guinea, Gabon, Rwanda and São Tomé & Principe (11 countries)	All ECCAS members	• Rwanda and Burundi also in Eastern region (EAC member) • Angola and DRC also in Southern region and SADC member
Southern region	Angola, Botswana, Comoros^, DRC^, Lesotho, Madagascar^, Malawi^, Mauritius^, Mozambique, Namibia, Seychelles^, South Africa, Swaziland^, Tanzania, Zambia^ and Zimbabwe^ (16 countries)	All SADC members Nine COMESA members (marked with ^)	• Angola and DRC also in Central region and ECCAS members • Tanzania also in Eastern region (EAC member).

In addition:

- The Arab Maghreb Union (AMU) focuses on north-African states
- The Community of Sahel-Saharan States (CEN-SAD) is not highly active