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ENSURING **RIGHTS** MAKE REAL **CHANGE**

SPECIAL EDITION ON SEXUAL AND REPRODUCTIVE HEALTH RIGHTS

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Editorial

Welcome to this special edition of ESR Review on sexual and reproductive health rights in Africa.

Sexual and reproductive health rights remain a significant concern across Africa. They include access to sexual and reproductive health information and services, maternal healthcare, contraception, safe pregnancy and childbirth, protection from harmful practices, and the ability to make informed decisions about sexuality and reproduction. These rights are closely connected to dignity, equality, health, education, bodily autonomy and freedom from violence.

African states have made important commitments to protect and promote sexual and reproductive health rights through constitutions, legislation, policies and regional human rights instruments. However, implementation remains uneven. In many contexts, women, adolescents and children continue to face legal restrictions, stigma, harmful social norms, limited access to services and weak institutional accountability. This gap between legal and policy commitments and the lived realities of rights holders is the central concern of this special issue.

The edition opens with a contribution on male involvement in family planning. Family planning is too often framed as the responsibility of women alone, even where reproductive decisions are shaped by partners, households and wider social expectations. By placing men within the discussion, the contribution challenges narrow approaches to reproductive health and shows that shared responsibility can strengthen both public health outcomes and the enjoyment of rights.

The discussion then turns to child marriage and its impact on sexual and reproductive health rights in Africa. Child marriage remains one of the clearest examples of how legal protection may be displaced by poverty, conflict, bride price, puberty, custom, religious interpretation and family pressure. Where a child is moved into marriage before she can give free, full and informed consent, the consequences extend far beyond the marriage itself. Education is interrupted, childhood is shortened, exposure to early pregnancy increases, and the ability to make meaningful choices about health, sexuality and the future is severely constrained.

The policy analyses in this issue further demonstrate the difficulty of translating rights into practical access. One contribution examines the barriers faced

by adolescents and young people in Seychelles, where constitutional and policy commitments exist alongside legal restrictions, stigma, limited information and uneven access to youth-friendly services. This concern with access is taken further in the analysis of safe and legal abortion in Eswatini and Malawi, where criminalisation, legal uncertainty, weak implementation and social stigma continue to limit reproductive healthcare, even where exceptions exist in law. These contributions remind us that rights cannot be realised through formal guarantees alone. They require clarity, implementation, public education and institutions willing to treat young people as rights holders rather than as passive recipients of moral instruction.

The case review considers the ECOWAS Court's decision on the exclusion of pregnant schoolgirls from mainstream education in Sierra Leone. The decision is significant because it recognises that pregnancy-related exclusion is not merely an education policy issue, but a form of discrimination that affects the rights of adolescent girls to equality, dignity and future opportunities.

This edition concludes with a reflection on an African Commission side event on obstetric violence and maternal health. Obstetric violence remains one of the most serious yet often under-recognised violations within the field of sexual and reproductive health rights. Abuse, neglect, humiliation, coercion and denial of respectful care during pregnancy and childbirth are not merely failures of service delivery. They implicate dignity, equality, bodily integrity, health and, in the most severe cases, the right to life. The reflection highlights the importance of litigation, model laws, interpretive guidance, coalition-building and sustained advocacy in strengthening accountability within the African human rights system.

We hope this Special Edition contributes to ongoing scholarship, advocacy and policy engagement on sexual and reproductive health rights in Africa. More importantly, we hope it encourages continued reflection on how law can move beyond promise and become part of the everyday protection of dignity, equality and reproductive justice.

Favour Funke Akanbi
Co-Editor

FEATURE

Men in the Spotlight: Advancing Family Planning Through Male Inclusion

Airi Nakata

Introduction

Family planning is a cornerstone of public health, one critical for reducing maternal mortality, curbing unsustainable population growth, and fostering economic development. Traditionally, family planning has long been framed as a women's issue, driven by both biological factors and socio-cultural expectations. While this focus has been critical in empowering women, it has also inadvertently sidelined a key stakeholder in the family planning process: men.

Ensuring male involvement in family planning is crucial from the human rights perspective to uphold the principles of non-discrimination and equal access to health services. Further integration of male involvement in national family planning policies can also enhance programme effectiveness.

This article highlights the benefits of such inclusion for improving contraceptive use, dispelling misconceptions, and achieving broader health and social outcomes. By examining policy gaps and emerging strategies, we can advocate for more inclusive approaches that harness the full potential of both partners in family planning efforts and help create an environment in which everyone can enjoy their rights fully.

Background context

Family planning refers to 'the information, means and methods that allow individuals to decide if and when to have children', and involves, among other things,

contraception, fertility treatment, and guidance on pregnancy and infertility (UNFPA 2022). It plays a critical role in saving lives by reducing the maternal mortality ratio, particularly through the prevention of high-risk, high-parity births; for example, the decline in fertility rates in developing countries between 1990 and 2005 averted more than 1 million maternal deaths (Stover & Ross 2010).

Family planning also curbs unsustainable population growth and mitigates its adverse effects on the economy, environment, and development efforts. For instance, in sub-Saharan Africa, family planning and the resulting demographic shifts could boost economic growth and competitiveness, reduce unemployment and underemployment, strengthen national institutions, promote inclusive and equitable development, and enhance resilience (Husain et al. 2016).

Yet despite such broad societal benefits, the burden of responsibility for family planning has disproportionately fallen on women. This emphasis on



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Family planning is both a matter of public health and a fundamental human right.

women is driven by multiple factors. From a biological perspective, it is understandable that women are the centre of focus as they are the ones who face health risks when they become pregnant and give birth. Initiatives targeting women have also been promoted from the empowerment perspective, as family planning empowers women to take charge of their lives and well-being, enabling them to reach their academic, professional, and personal goals (Al Tuwaijri & Saadat 2018).

In addition, socio-cultural factors have placed reproductive responsibilities on women rather than the couple. For instance, a study in Ghana confirmed that traditional gender roles and expectations prevent men from participating in maternal and child health spaces, thus reinforcing rigid definitions of masculinity and discouraging alternative expressions of manhood (Dumbaugh et al. 2014).

Although programmes focused on women are valuable and will continue to play a key role in family planning, the role of men should not be overlooked. Involving men in these initiatives is not only necessary from a human rights perspective, but can also enhance the effectiveness of these initiatives and help achieve broader social benefits.

Family planning as a human right

Family planning is both a matter of public health and a fundamental human right. In 1968, at the United Nations International Conference on Human Rights in Tehran, 157 states affirmed that ‘parents have a basic human right to determine freely and responsibly the number and the spacing of their children’ (United Nations 1968).

International law guarantees individuals access to contraceptive options and information about sexual and reproductive health. For instance, article 12 of

the International Covenant on Economic, Social and Cultural Rights (ICESCR) requires state parties to ‘recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’, a right which has been interpreted to include access to family planning services as essential to health.

More explicitly, the Programme of Action adopted at the International Conference on Population and Development (ICPD) recognised reproductive rights, including the right to ‘make decisions concerning reproduction free of discrimination, coercion and violence’ (United Nations 1994).

In addition, General Comments have been issued to help interpret and implement the ICESCR. The Committee on Economic, Social and Cultural Rights’ General Comment No. 22 (2016) emphasises that access to a full range of contraceptive methods and family planning services is part of the right to health, obliging states to provide services that are accessible, acceptable, and high-quality.

Similarly, the Human Rights Committee’s General Comment No. 36 (2018) extends the right to life to encompass access to sexual and reproductive health services, including family planning, thereby underlining states’ responsibilities to ensure that these services are available as part of their fulfilment of their human rights obligations.

These various instruments affirm the importance of access to family planning and reproductive health services as a fundamental human right. Thus, governments are responsible for ensuring access to contraception, supporting informed decision-making, and maintaining confidentiality for all individuals seeking family planning services.

From this perspective, men should be more actively involved in national family planning policies, both as users of contraception and as key stakeholders in reproductive health initiatives.

Further benefits of male inclusion

Engaging men is a powerful strategy to boost family planning efforts, as men are often the primary decision-makers in family planning decisions within relationships. Although older and context-specific, a Zimbabwean study found that, while women were usually the ones who obtained family planning methods, individual men often had decisive influence over contraceptive use and family-size decisions (Mbizvo & Adamchak 1991). The point is not that decision-making patterns have remained unchanged everywhere, but that male approval and couple communication continue to matter for access, use and continuity.

The use of contraceptives and other family planning methods among married women is also strongly affected by spousal approval. Results from a Tanzanian study showed that women whose husbands approve of family planning were more likely to use contraceptives (36.8 per cent) than those who lacked their husbands' approval (8.8 per cent); women who regularly discussed family planning with their partners had a higher likelihood of using contraceptives (41.0 per cent) than those who discussed it occasionally (27.2 per cent) or not at all (4.3 per cent) (Anasel & Mlinga 2014).

A similar study in Ethiopia revealed that women whose husbands approve of using modern contraceptives are nearly three times more likely to use them (Mohammed et al. 2014). Given the crucial role of spousal approval and communication in family planning, male inclusion is critical in addressing unmet needs in family planning. Male involvement may also help remove social barriers such as misconceptions, lack of knowledge, and cultural values that hinder access to family planning. A study in Nigeria found that misconceptions and inaccurate information were major barriers to men's involvement in family planning; among other things, men's information needs related to concerns about side effects for their partners, fears about their partner's possible infidelity, and worries about the return to fertility after using family planning methods (Akinso & Akinso 2015).

Another study in Ethiopia showed that married men had negative attitudes toward condoms and misconceptions about the effectiveness and acceptance of male sterilisation (Kassa et al. 2014). As such beliefs often stem from patriarchal communities, men are crucial in addressing social barriers and need to be informed of family planning methods and services. Indeed, USAID views men and boys as 'agents of change', as they can leverage their social status and influence to challenge harmful gender norms and inequalities (USAID 2018). Enhancing access to family planning information and services for men, not just as partners but as users, could play a crucial role in dispelling myths and boosting the use of these methods.



A notable gap in male contraceptive options also persists in that no reversible methods are available other than condoms and vasectomy.

Moreover, engaging men is associated with better maternal health outcomes. A study reviewing father-engagement programmes in low- and middle-income countries (LMICs) revealed that father engagement had positive effects, particularly on maternal caregiving for nutrition and health; other maternal outcomes included parenting and psychosocial well-being (Jeong et al. 2023). Another review showed that engaging men in maternal health can benefit both the mother and her family by improving the use of maternity services, enhancing nutrition, and fostering joint decision-making between partners in LMICs (Ladur et al. 2021). Thus, policies to increase male involvement may have positive spillover effects in improving overall maternal health.

Eager men, missing policies

Recent research has shown positive results in male awareness of family planning. For instance, a study found that 99 per cent of men in Nigeria were aware of the concept of family planning and the existence



With men showing a willingness to participate, this is an opportune moment for governments to review and enhance their policies.

of modern contraceptives, while 90 per cent of men in Ethiopia approved of using and choosing family planning methods (Vouking et al. 2014). A study in Nigeria corroborated this, revealing that about 90 per cent of the men surveyed were familiar with at least one family planning method and not only supported their partners' use of contraceptives but also utilised family planning methods themselves (Oyediran et al. 2002).

While these studies are based on a specific sample population and might not be representative, they indicate a notable potential interest among men in being actively engaged in family planning. In a study in Togo, all men were interested in learning more about family planning, especially through information-sharing with community health workers, trusted peers, and individuals with experience in using family planning methods (Koffi et al. 2018). The growing recognition among men of the importance of family planning highlights an important opportunity for their further engagement.

Despite the growing enthusiasm among men to participate in family planning, there remains a significant gap in policies that effectively engage and support their involvement. For instance, past research reviewing 47 interventions, including 13 in sub-Saharan Africa, revealed limited evaluations of programmes aimed at involving men in contraceptive use, with a notable scarcity of direct programming specifically targeting them (Hardee et al. 2016). In recognition of this gap, this article explores the intricacies of family planning policies across sub-Saharan African countries, focusing on how these policies incorporate male involvement.

The policy landscape in Sub-Saharan Africa

An analysis was undertaken of national family planning

policies in 17 sub-Saharan countries (Benin, Burkina Faso, Côte d'Ivoire, the Democratic Republic of Congo (DRC), Ethiopia, Ghana, Guinea, Kenya, Madagascar, Mali, Niger, Nigeria, Rwanda, Tanzania, Uganda, Zambia, and Zimbabwe). These countries were selected on the basis of the online availability of their national family planning or reproductive health policies for 2023, as well as their high commitment to the development of family planning policies. All 17 governments are commitment-makers to both FP2020 and FP2030 and have taken measures to provide citizens with the resources and support necessary to make informed decisions about their sexual and reproductive health.

It was found that three countries - the DRC, Nigeria, and Zambia - had no policies at all targeting men. While Kenya mentioned promoting community awareness of male infertility, it lacked policies to encourage male inclusion in contraceptive use or other family planning services. Only Mali, Uganda, and Zimbabwe explicitly identified men as key targets in their main strategies. In most other countries, male involvement was either mentioned in sub-strategies or included as part of detailed action plans, but was seldom emphasised within the primary policy frameworks.

Among the countries with male inclusion strategies, the most prevalent policies highlighted men's roles as key change agents or supportive partners in family planning efforts.

Policies engaging men as leaders of change included collaboration with religious and traditional leaders (Benin, Burkina Faso, Mali, Niger, Rwanda, and Zimbabwe) and empowering male 'champions' or 'influencers' to advocate for family planning within communities (Côte d'Ivoire, Niger, Rwanda, Tanzania, and Zimbabwe).

Policies targeting men as supportive partners included discussion workshops to encourage parents to discuss sexuality and family planning with their children (Benin), partner initiatives aimed at empowering men



Adequate funding could help accelerate the development of new male contraceptive methods and foster inclusive family planning strategies.

and women in the management of birth issues (Niger), and increasing the effective use of couples counselling (Rwanda).

In addition, francophone countries such as Burkina Faso, Guinea, and Niger promoted the l'Ecole des Maris ('schools for husbands') initiative, one which supports the idea that both partners should be equally involved in decision-making and encourages men to take a more active role in family planning.

At the same time, there was a widespread lack of concrete policies targeting men as users of family planning services. While many countries expressed support for boys and men as clients, most of them did not have specific measures to address their needs and promote male usage of contraceptives or other methods.

In this regard, Uganda and Zimbabwe stood out for their comprehensive approaches. Uganda supported efforts to motivate men to use modern contraception by addressing men's myths, misinformation, and health concerns. It also facilitated the dissemination of comprehensive family planning information targeting men as one of the key user groups. Similarly, Zimbabwe promoted target-specific capacity-building for service providers that included men as one of the target populations and aimed to introduce innovative ways of reaching men with messages, such as 'moonlight dialogues', to engage them and address myths about family planning, sexuality, and health.

Zimbabwe also showed its commitment to integrating male involvement in family planning in school curricula, generating data through surveys and research to understand male perspectives, and transforming gender norms through a broad range of interventions and advocacy. This comprehensive approach to male engagement distinguishes Zimbabwe from other countries. It may also be noteworthy that Madagascar's policy uniquely included awareness-raising activities

on comprehensive sexuality education, even though the overall plan lacked detail.

Are male-engagement strategies effective?

It is difficult to assess if the existence of such comprehensive male inclusion policies at the national level contributes to better family planning outcomes. In Uganda and Zimbabwe, male involvement was not discussed extensively in previous strategies and was added as a new element in current plans. A simple comparison shows that, in both countries, the average annual growth rate in the number of users of modern methods of contraception among unmarried women was higher during the period of the current plan than in that of the older plan.

However, both of them simultaneously introduced other innovative policies that added to the previous strategies, confounding the potential association. For instance, Uganda's 2020-2025 costed information plan introduced innovations in technology, financing, and service delivery; Zimbabwe's 2022-2026 strategy introduced digital health, sustainability efforts, enhanced M&E frameworks, and a stronger focus on integrating family planning with broader health services.

While such concurrent policy innovations make it challenging to isolate the impact of male-involvement policies, these preliminary observations may suggest a promising direction for further research that could reveal a positive causal relationship between national policy and outcomes.

On a smaller scale, however, more rigorously designed research certainly does demonstrate the effectiveness of male-inclusion interventions. For instance, a study that used experimental and quasi-experimental

designs to examine behavioural and service-level interventions involving men to increase the use of family planning methods in LMICs found that these interventions significantly increased the likelihood of improved contraceptive use compared to control groups, although there were considerable differences in the effect sizes across the studies (Aventin et al. 2023).

Male involvement is associated with an increased uptake of family planning services.

Evidence supporting this can also be found in the context of sub-Saharan Africa. A scoping review that assessed 18 reproductive health interventions in eight sub-Saharan countries between 2007 and 2018 found that male involvement is associated with an increased uptake of family planning services and HIV counselling and testing, a reduction in risk behaviours, and improved maternal health and spousal communication (Nkwonta & Messias 2019).

These findings suggest that engaging men in family planning and reproductive health initiatives can be an effective strategy for enhancing health outcomes in diverse settings, including sub-Saharan Africa.

Conclusion: Addressing challenges and advancing policy

Increasing male involvement in family planning strategies presents several challenges. One major issue is the limited systematic data collection on men's fertility and relationships, which restricts the ability to provide effective services for men. Additionally, existing programmes that promote male contraceptive methods have not been thoroughly evaluated, and funding for this research and implementation is often insufficient.

A notable gap in male contraceptive options also persists in that no reversible methods are available

other than condoms and vasectomy. While research into new hormonal and non-hormonal male contraceptives is ongoing, progress has slowed down due to a lack of investment by pharmaceutical companies, leaving non-profits and foundations to fill the void. Adequate funding could help accelerate the development of new male contraceptive methods and foster inclusive family planning strategies.

Despite these challenges, governments have a compelling case for implementing or strengthening male inclusion policies in their national family planning strategies. This presents a way for governments to fulfil their international human rights obligations by promoting more inclusive and effective public health strategies that recognise the rights of all individuals to make informed decisions about their reproductive lives. Doing so could also address the diverse needs of their populations and promote healthier, more equitable societies. With men showing a willingness to participate, this is an opportune moment for governments to review and enhance their policies for achieving more inclusive, effective strategies for family planning.

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FEATURE

After Twelve is Lunch: Child Marriage and Sexual and Reproductive Rights in Africa

Sifiso Arthur Madi and Favour Funke Akanbi

Introduction

The saying “after twelve is lunch” captures a troubling social logic: that once a girl reaches puberty, she becomes available for sexual access, marriage and motherhood. In some communities, menstruation is treated not as a stage of childhood development, but as evidence that a girl is ready for marriage. This article challenges that assumption by examining child marriage through a sexual and reproductive rights lens. It argues that child marriage is not only a question of age or family formation. It is a practice through which a girl’s body, sexuality, education and reproductive future may be controlled before she is able to give free, full and informed consent. Child marriage therefore raises urgent concerns about bodily integrity, protection from violence, access to education, reproductive decision-making and the right of children to grow into adulthood free from coercion.

Background

Sexuality and reproduction are often governed by silence, shame and unequal power. In many communities, conversations about sex are permitted only when they concern marriage, morality or reproduction. Girls are then expected to be sexually innocent, obedient and protected, while the same communities may treat male sexuality as natural or inevitable. This double standard matters because it can turn control over girls’ bodies into something that appears normal, respectable or even protective.

Child marriage sits within that broader pattern. It is sometimes defended as custom, family decision-making, moral protection, religious duty or economic necessity. Yet the effect is often the same: a child is moved into an adult marital and reproductive role before she has the maturity, legal capacity or social power to consent in any meaningful sense. Her schooling may be interrupted. Her sexual life may be decided by others. Pregnancy may be expected

soon after marriage. Her ability to refuse sex, delay childbirth, use contraception or leave an abusive relationship may be extremely limited.

This should not be read as a claim that African cultures are uniform or inherently harmful. The point is narrower and more precise. Certain practices, when combined with patriarchy, poverty, bride price, family pressure and weak legal protection, can expose children to forced or early marriage. The language of culture or tradition cannot be used to hide coercion, sexual exploitation or the denial of sexual and reproductive rights.



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SRHR cannot be reduced to health services alone. It also includes bodily integrity, privacy, equality, information, consent and freedom from harmful practices.

Sexual and reproductive health rights

Sexual and reproductive health rights concern the ability of people, within applicable legal frameworks and with respect for children's evolving capacities, to make informed, voluntary and dignified decisions about sexuality, relationships and reproduction. These rights include access to reproductive health care, contraception, maternal health care, sexuality education, protection from sexual and gender-based violence, and the ability to decide whether and when to have children (WHO n.d.; OHCHR n.d.; Centre for Reproductive Rights 2025).

Viewed in this way, SRHR cannot be reduced to health services alone. It also includes bodily integrity, privacy, equality, information, consent and freedom from harmful practices. These rights are especially important in relation to children because children require protection from exploitation while also needing age-appropriate information and support as they mature. The language of "evolving capacities" is important here: it recognises that adolescents develop decision-making ability over time, but it does not permit adults to impose marriage, sexual relations or pregnancy on a child.

Child marriage directly undermines these protections. It may place a child in a household where sex is expected, pregnancy is encouraged and obedience is demanded. Bride price may be interpreted as giving the husband or his family authority over the child's body. In such circumstances, consent becomes almost impossible to separate from pressure, dependence and fear. The problem is not only that the child is married too early. It is that marriage becomes the setting through which control over her body and future is made socially acceptable.

International and African human rights standards

International human rights law protects sexual and reproductive autonomy through several connected rights. The Universal Declaration of Human Rights protects privacy and recognises that marriage must be entered into only with the free and full consent of the intending spouses. The International Covenant on Civil and Political Rights protects life, liberty, security of the person and privacy, and also requires free and full consent to marriage. The International Covenant on Economic, Social and Cultural Rights protects the right to the highest attainable standard of health, which includes sexual and reproductive health. These protections are reinforced by the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child. Article 16 of CEDAW is particularly important because it requires equality between women and men in marriage and family relations. It also recognises the same rights to decide freely and responsibly on the number and spacing of children and to have access to the information, education and means necessary to exercise those rights. Article 16(2) goes further by providing that the betrothal and marriage of a child shall have no legal effect and that states must specify a minimum age for marriage.

The CRC strengthens this position by requiring the best interests of the child to be treated as a primary consideration and by requiring protection from harmful traditional practices. The CEDAW and CRC Committees have explained that child marriage is a form of forced marriage because a child cannot give full, free and informed consent to such a life-altering arrangement (CEDAW Committee and CRC Committee 2014).

African regional standards are even more direct. The African Charter on the Rights and Welfare of the Child prohibits child marriage and the betrothal of



Child marriage is not only a question of age or family formation; it is a practice through which a girl's body and future may be controlled.

girls and boys, and requires states to set 18 as the minimum age of marriage. The Maputo Protocol also requires marriage to take place only with the free and full consent of both parties and provides that the minimum age of marriage for women shall be 18 years. These provisions leave little room for arguments that puberty, parental approval, bride price or custom can replace the child's own consent.

The South African position illustrates the difficulty that arises when domestic law is not as clear as African regional standards. The Recognition of Customary Marriages Act 120 of 1998 generally requires prospective spouses to be over 18 and to consent to the marriage, but it also contains exceptions through ministerial permission. The Marriage Act 25 of 1961 has also historically permitted minors to marry with prescribed consent. Such exceptions are problematic because they weaken the message that childhood should not be converted into marriage through parental or official approval.

Examples of forced marriage and child marriage

Forced marriage in South Africa

Ukuthwala

Ukuthwala is an indigenous practice in South Africa that has been described as involving the taking of a girl or young woman in order to initiate marriage negotiations (Eniola & Aremo 2020: 32). It is not described in the same way in every community or text. In some accounts, the young woman may know of the plan. In abusive forms, however, she is taken without meaningful consent and the practice becomes a vehicle for coercion, abduction and sexual exploitation.

The legal concern is clearest where a child is taken by an adult man and the language of custom is

used to pressure her family into accepting marriage negotiations. In that situation, parental approval or bride price may be treated as more important than the child's own wishes. This directly conflicts with the requirement of free and full consent. It also affects sexual and reproductive rights because the child does not choose whether, when or with whom sexual relations will occur. Another person's decision is imposed on her.

South African courts have treated abusive forms of this practice as serious rights violations. In *Jezile v S*, the Western Cape High Court made it clear that ukuthwala could not be relied on to justify conduct amounting to trafficking, rape or other serious violations of a child's rights (*Jezile v S and Others* 2015). The judgment is important because it separates culture from coercion. It does not condemn custom as such. It rejects the use of custom as a shield for abduction, rape, trafficking and child marriage.

Ukuganisela

Ukuganisela is different from ukuthwala, but it may also operate as a form of forced or child marriage. It has been discussed in relation to some Zulu communities in South Africa and refers to a situation in which parents or guardians decide to marry off a child, sometimes after being approached by a prospective husband or his family (Mtshali 2014: 52). The child's view may be ignored, or treated as less important than the family's decision.

The problem is that parental consent is treated as if it can replace the child's own free and full consent. This is especially troubling where the family is experiencing poverty and bride price is seen as a source of relief. In such circumstances, marrying off a daughter may be framed as economic survival. The girl, however, bears the consequences. She may leave school, move into a household where she has little power, begin sexual relations before she is ready and face pressure to become pregnant.

The concern is not that families facing poverty are careless. It is that poverty, gender inequality and weak protection systems can make harmful choices appear economically rational. A rights-based approach must therefore address both the practice itself and the conditions that make child marriage appear acceptable or necessary.

Forced marriage in Tanzania

Nyumba Ntobhu

Another practice that raises concerns in the East African region is nyumba ntobhu, a woman-to-woman customary marriage associated especially with the Kurya community in the Mara region of northern Tanzania and neighbouring parts of Kenya. The expression is often translated as a “house without a man” or “house of women”. In its traditional form, it allows an older woman, often a widow or a woman without male heirs, to marry a younger woman so that the younger woman may bear children for the older woman’s household (Sikira, Chingonikaya & Ringo 2012: 116-129; Nahamya 2017: 115-116).

Nyumba ntobhu is not usually understood as a sexual relationship between the two women. Rather, the younger woman may be expected to have children through a male partner, with the children then treated as belonging to the older woman’s family line. The practice is sometimes explained as a way for older women to secure heirs, protect property, obtain household support or avoid dependence on male relatives. It is also sometimes described as giving some younger women an alternative to violent marriages with men.

Those explanations do not remove the sexual and reproductive rights concern where the younger woman is a child, or where poverty, family pressure or bride price leaves her with little real choice. The legal problem is that the girl or young woman may be placed in a reproductive role chosen by others. If she cannot decide freely whether to enter the arrangement, who the male partner will be, whether to have sexual relations, whether to become pregnant or whether to raise children in that household, the practice becomes a form of reproductive control. Even where it is presented as protection from male violence, it can

still deny the girl control over her own body, sexuality and future.

If she cannot decide freely whether to enter the arrangement, the practice becomes a form of reproductive control.

Forced marriage in Uganda, the DRC, CAR and South Sudan

Forced marriage can also occur in conflict settings. The Lord’s Resistance Army (LRA), which originated in Uganda and operated in parts of the Democratic Republic of Congo, the Central African Republic and South Sudan, used forced marriage as part of its internal social and political order. Baines explains that the LRA regulated sexual conduct and punished conduct it considered sexually immoral, while at the same time assigning women and girls to male combatants as “wives” (Baines 2014: 405-417).

This example shows how marriage may be used to make coerced sexual relationships appear legitimate within a particular social order. The contradiction is stark. Sexual activity outside marriage may be punished, while forced marriage is used to authorise sexual access, pregnancy, domestic labour and control over women and girls. In such situations, sexual and reproductive rights are almost entirely displaced by the authority of the armed group.

Marital rape and child marriage

Marital rape occurs where one spouse forces sexual intercourse on another without consent. It violates bodily autonomy, dignity and sexual self-determination. In child marriage, the harm is intensified because the child did not meaningfully consent to the marriage in the first place, yet the marriage may then be used to presume continuing sexual consent. The child may be expected to begin sexual relations immediately, often with a much older spouse and within a relationship marked by economic, social and physical inequality.

Mtshali refers to a report in Ilanga newspaper concerning a 41-year-old man who was to be married to a 13-year-old girl in a Zulu cultural wedding (Mtshali 2014: 56). The example shows the severe power imbalance that child marriage can create. A 13-year-old cannot be treated as having given meaningful consent simply because the arrangement is described as cultural or because adults approve it. The phrase “after twelve is lunch” captures this harmful logic: puberty is treated as sexual and marital readiness, even though the girl remains a child.

This is why child marriage must be understood as a sexual and reproductive rights issue, not only as a family-law or cultural-practice issue. It affects whether a girl can refuse sex, delay pregnancy, use contraception, remain in school, seek health care, report violence and imagine a future beyond marriage. It also shows why marital rape and child marriage must be addressed together. A legal system that permits or tolerates child marriage creates the conditions in which sexual violence may be hidden inside marriage.



Keeping girls in school is itself a sexual and reproductive rights intervention

The role of education in protecting SRHR

Education plays a protective role in at least two ways. First, girls need general education because schooling expands their choices, strengthens their economic prospects and delays entry into marriage. Secondly, children and adolescents need age-appropriate sexuality education because they require accurate information about their bodies, consent, contraception, pregnancy, violence and where to seek help.

For a girl at risk of child marriage, school may be one of the few institutions that keeps her visible. It may connect her to teachers, peers, social services and information. When she is removed from school and placed in marriage, she may lose not only education but also access to people and systems that could identify abuse or support her to resist it. This is why education should not be treated as separate from SRHR. Keeping

girls in school is itself a sexual and reproductive rights intervention.

Comprehensive sexuality education is equally important. It can help children understand consent, recognise coercion and know that pregnancy, sexual relations and marriage should not be imposed on them. It can also help adolescents understand contraception, pregnancy spacing and available health services. However, education must not be directed only at girls. Teaching girls about their rights while leaving husbands, parents, traditional leaders, religious leaders and communities unchanged may expose girls to backlash and leave them responsible for resisting systems they did not create.

A broader approach is therefore required. Boys, men, parents, community leaders, teachers, health workers, police officials, prosecutors and social workers all need to understand that child marriage is not a private family arrangement but a rights violation. Community education should take place in schools, clinics, churches, mosques, traditional forums, taxi ranks and other public spaces where social attitudes are shaped. Legal practitioners and civil society organisations also have an important role in translating legal protections into language that communities understand.

Conclusion

Child marriage remains a serious sexual and reproductive rights concern in Africa. It exposes children, especially girls, to early sexual activity, early pregnancy, interrupted education and unequal marital power before they are able to give meaningful consent. It also shows how law, custom, poverty and gender inequality can work together to control a child's body and future.

Treaties and statutes are necessary, but they are not enough. States should harmonise marriage laws around 18 as the minimum age, remove exceptions that allow parental or official consent to validate child marriage, ensure access to adolescent-friendly sexual and reproductive health services, protect girls from marital rape and domestic violence, and invest in education that reaches both children and the adults who make decisions around them. Without these

measures, sexual and reproductive rights will remain a formal promise rather than a lived reality for many children.

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POLICY ANALYSIS

Young People's Barriers to Accessing SRHR in Seychelles

Sindiso N. Nkomo

Introduction

The stage of being a youth, which also encompasses the period of adolescence, is an important one, especially in the context of sexual and reproductive health and rights (SRHR). This is the stage when people experience psychosocial and physiological changes, along with increased associated health risks that include vulnerability to pregnancy, HIV, sexually transmitted infections (STIs), alcohol and drug abuse, and gender-based violence (Wilkins et al. 2022: 541).

Generally, young people encounter many challenges when accessing sexual and reproductive health (SRH) services, especially contraceptive services. Those from African countries, which include Seychelles, are not exempt from such challenges, as they have unmet needs in relation to contraception (Pleaner et al. 2022: 3). Key barriers faced by young people in accessing SRH services include fear of stigma, embarrassment, lack of privacy, provider attitudes, lack of knowledge about services, and cultural and legal barriers (Pleaner et al. 2022: 3).

SRHR are protected under several regional and international human rights instruments to which Seychelles is a party. These include the Convention on the Elimination of Discrimination Against Women (CEDAW), International Covenant on Economic, Social and Cultural Rights (ICESCR), International Covenant on Civil and Political Rights (ICCPR), African Charter on Human and Peoples' Rights (ACHPR/African Charter), and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol).

To show its commitment to these instruments, Seychelles has domesticated their provisions in some

of its legislation, such as the Constitution. However, certain pieces of legislation hinder access to SRHR services by criminalising abortion and placing age restrictions on access to contraceptives. Due to these legal barriers, young people's enjoyment of SRHR is negatively impacted.

This review examines the barriers that young people in Seychelles face in accessing SRHR. It will do so by looking at the SRHR situation of young people in the country and the protection afforded to them under human rights law as well as Seychelles' law.

The review adopts the definition of 'young persons' provided by the African Youth Charter: 'youth or young people shall refer to every person between the ages of fifteen and thirty-five years'. This means the adolescent stage is also covered by the definition, as adolescence is described by the World Health Organization as 'the phase of life between childhood and adulthood, from ages ten to nineteen' (World Health Organization n.d.). Since the review covers people under the age of 18, reference will be made to child-specific human rights instruments when discussing the protection of the SRHR of young people.



Certain pieces of legislation hinder access to SRHR services by criminalising abortion and placing age restrictions on access to contraceptives.

Overview of the SRHR situation of young people

Statistics reveal that teenage pregnancies and abortion, whether safe or unsafe, are increasing at an alarming rate in Seychelles (National Assembly of Seychelles 2022), all of which highlights adolescent vulnerability. Unsafe and illegal terminations thus persist. Some of these abortions are procured in other countries such as Mauritius, often by way of potentially unsafe procedures that later lead to complications and affect the fertility of the young women involved (Republic of Seychelles 2013).

In addition, young people in Seychelles, especially males, grapple with alcohol and drug abuse. In 2023, Seychelles reported the highest rate of alcohol (46.5 per cent) and marijuana use (6.6 per cent) among school going adolescents in sub-Saharan Africa (Kugbey 2023: 1). Drug use is also closely linked to Seychelles' HIV and hepatitis epidemics; UNAIDS reported that injecting drug use continued to drive both epidemics (UNAIDS 2020: 44). Alcohol consumption is common at social and family events in Seychelles, and its prevalence among adolescents is high (Farnia et al. 2024). Drug and alcohol abuse affects both male and female young people, and has negative effects such as causing hormonal imbalance, impacting fertility, and causing sexual dysfunction (American Addiction Centers 2024). In the case of young women, it can affect their fertility and pregnancy, especially in instances where young women consume drugs and alcohol during pregnancy (Sebastiani et al. 2018: 3).

Furthermore, most young people who identify as sexual minorities remain closeted about their sexuality (Bru 2015: 247). This stems from limited information and religious or cultural norms.

The protection of young people's SRHR under human rights law

This section looks at the different rights that are most relevant to the SRHR of young people, namely the rights to health, life, and access to information.

Right to health

The right to health is enshrined in article 12 of the ICESCR, which is the most comprehensive provision in human rights instruments. This right is also protected in article 24 of the Convention on the Rights of the Child (CRC) and article 12 of CEDAW.

The Committee on Economic, Social and Cultural Rights (CESCR/Committee), which is responsible for the implementation of the ICESCR, clarified in General Comment No. 14 that the right to health includes freedoms and entitlements. Freedom entails that no medical treatment can take place without the consent of an individual (para 8); entitlements include access to health services that ensure the highest attainable level of health (para 8). This includes access to SRHR services, such as contraception and maternal health care, without legal, religious, cultural, or knowledge barriers (para 11).

As such, for SRHR to be enjoyed by young people, they must consent to any SRH-related services, which might include contraceptive methods. The enjoyment of this right by young people in Seychelles also entails that their access to SRH services should not be hindered by factors such as lack of knowledge or legal, religious and cultural barriers.

In Africa at the regional level, the right to health finds protection in article 16 of the African Charter, which obligates states to guarantee the right to health to every individual. Article 16 obligates states to come up with adequate measures necessary for protecting the health of their people. The African Commission on Human and Peoples' Rights (African Commission/Commission) has emphasised that access to SRH services is central to the right to health. In its Principles and Guidelines for the Realisation of Economic, Social and Cultural Rights in the African Charter, the Commission notes that health care services, including SRH services, must be available, accessible, acceptable, and of good quality (African Commission 2011: paras 61–64, 67(p)).



Young people need comprehensive information to be able to exercise their SRHR.

Article 14 of the Maputo Protocol is comprehensive in protecting different elements of SRHR. It enjoins states to realise the different SRHR of women, such as the prevention and treatment of STIs and the right to abortion where a pregnancy could endanger the life of the woman or is a result of incest or rape. Article 14 also recognises women's right to decide whether to have children, how many children to have, and the spacing between them.

Unfortunately, in Seychelles, women may terminate pregnancies only on limited grounds similar to those provided in the Maputo Protocol. They thus do not have the right to decide whether to carry a pregnancy to term in circumstances where they are not emotionally or financially ready to do so, which undermines their right to reproductive autonomy recognised in article 14 of the Maputo Protocol. This shortcoming plays a role in forcing women, especially adolescents, to undergo illegal and unsafe abortions, which are detrimental to their health.

The right to health is provided for in article 29 of the Constitution of Seychelles. This provision obliges the state, among other things, to take steps to provide free primary health care in state institutions, reduce infant mortality and promote the healthy development of the child. To fulfil this, the government funds health services, including SRH and information, for all citizens, including young people and persons with disabilities (Kamga 2022: 200).

Right to life

The right to life was first mentioned in article 3 of the UDHR, which provides that 'everyone has the right to life, liberty, and security of person'. The right is also entrenched in article 6 (1) of the ICCPR: 'Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.' The expression 'inherent right to life' cannot be comprehended properly in a restrictive manner, as the realisation of this right mandates state parties to adopt positive measures. CEDAW does not contain a stand-alone right to life provision, but article 12 remains relevant because it requires non-discriminatory access to health care, including family planning services.

The right to life applies to SRHR, especially in instances where abortion laws are restrictive or where abortion on non-therapeutic grounds is illegal. The right is also threatened where abortion on non-therapeutic grounds is illegal and women end up opting for the illegal and unsafe route to procure abortions. This has been witnessed in Seychelles, where young women procure unsafe and illegal abortions that have the potential to take away their lives.

Article 15 of the Constitution of Seychelles entrenches the right to life. Importantly, however, this provision is silent on the regulation of abortion, and thus the Penal Code and Termination of Pregnancy Act (TOPA) are the chief frameworks when it comes to abortion. This adversely impacts the protection of women because the absence of a specific regulation in the Constitution has left abortion laws subject to change through ordinary legislation depending on the prevailing social, political or religious views in Seychelles at any given time. A lack of constitutional clarity on abortion is thus highly problematic, as it can lead to conflicting interpretations or sudden changes in the law - which in turn can affect the access to safe and legal abortion services that young people require.

Access to information

The right to information is provided in article 19(2) of the ICCPR, article 10(h) of CEDAW, and article 24(2)(f) of the CRC. It supports the right to health, including SRHR, because health-related information is fundamental to the realisation of the right to health. That is to say, if young people in Seychelles can access information related to preventing and treating different sicknesses and diseases, they are motivated to make sound decisions about their health; likewise, they need comprehensive information to be able to exercise their SRHR. Conversely, the delivery of SRHR services, such as family planning services, without full and unbiased information can deprive young women of the ability to choose the number and spacing of their children (Coliver 1995: 1285).

At the regional level, the right to access information is entrenched in article 9(1) of the African Charter, which guarantees 'the right to receive information'. This right can be invoked when young people in Seychelles

claim access to health-related information. The African Commission has interpreted the right to family planning education as implying that states have a duty 'to provide complete and accurate information which is necessary for the respect, protection, promotion and enjoyment of health, including the choice of contraceptive methods' (African Commission 2014: para 28). Accordingly, Seychelles has a duty to put in place measures that include training health personnel on the importance of providing complete information to clients, including young people, and guaranteeing that information about family planning or contraception is disseminated to them in accessible languages.

The right to access information is entrenched in article 28 of the Constitution and afforded to every Seychellois. Article 28 guarantees everyone the right to access information relating to themselves and held by a public authority. This implies that everyone in Seychelles, including young people, has a right to access information relating to their health, including their SRHR - even from public entities such as the Ministry of Health, which has custody of SRHR information in Seychelles. The right also implies that people must be educated about their right to health, including their SRHR. As such, the Ministry of Health and Ministry of Education have the role of ensuring that young people are capacitated in regard to their SRHR, to which end these ministries need to come up with strategies to make this a reality.

Factors affecting access to SRHR

Legal barriers

Certain laws are a barrier to the full enjoyment of SRHR. For instance, although some of the legal requirements outlined in the TOPA for procuring an abortion in Seychelles comply with the requirements laid down in the Maputo Protocol, they do not cater for abortions for non-therapeutic reasons. According to article 3 of the TOPA, abortion is allowed in a few cases such as if the pregnancy endangers the life of the woman, if it is a result of rape or incest, or if there is a significant risk that the child would suffer from severe physical or mental abnormalities. Moreover, with regard to young people under the age of 18, their parents' consent is

required before a pregnancy is terminated.

The TOPA requirements thus force young people who are not emotionally and financially ready to carry a pregnancy to full term to carry such pregnancies since abortion for non-therapeutic reasons is illegal in terms of this law. As a result, young people resort to procuring abortions in other countries, and often such abortions are obtained under potentially unsafe procedures that later lead to complications and affect the fertility of the young women involved (Republic of Seychelles 2013).

Religious and cultural barriers

Teenage pregnancy has become rampant in Seychelles despite the inclusion of comprehensive sexuality education (CSE) in the school curriculum under the Personal, Social and Citizenship Education (PSE) and the Citizenship Education (CE) programmes. Recent World Bank Gender Data Portal figures indicate that 55 out of every 1,000 girls aged 15 to 19 gave birth in Seychelles in 2023 (World Bank 2023).



Health-related information is fundamental to the realisation of the right to health.

The inclusion of CSE in the school curriculum has not been effective owing to religious and cultural beliefs as well as negative attitudes by teachers, who overlook sexuality and topics related to sex and gender because they consider them culturally and religiously inappropriate (Pillay 2019: 1). Although attempts have been made to capacitate teachers in these areas, many of them shun this subject; even those who are willing to teach it are affected by how parents will react, given that some parents might not agree with having their children taught sexuality topics at school.

The failure to teach, or talk to children about, sex or issues surrounding sexuality and reproduction at school and home has led to problems, as young people of school-going age end up making erroneous assumptions about sex. Another factor that contributes to the increase in teenage pregnancies is the prohibition of the distribution of condoms to young

people in educational institutions, despite the fact that young people in such institutions are sexually active (Bru 2015: 247).

Limited access to information

Limited information is shared among young people regarding sexuality. As a result, many young people who might identify as lesbian, gay, bisexual, transgender or queer (LGBTQ+) remain closeted about their sexuality (Bru 2015: 247). Pressure from culture and religion also contributes to the failure of young people to express their sexual identities. Despite the inclusion of CSE in the school curriculum, most teachers avoid discussions or topics on homosexuality as a variation of human sexuality. As a result, LGBTQ+ teenagers remain closeted for fear of being discriminated against by their peers and teachers due to their sexual orientation (Bru 2015: 247).

Recommendations

“ Religious and cultural beliefs and a lack of adequate knowledge and information are further barriers to the enjoyment of SRHR.

Ministry of Health

The Ministry of Health (MoH) should ensure that SRHR services are accessible, confidential, and youth-friendly. This includes training health-care personnel to communicate effectively with young people and provide non-judgemental care.

The MoH should launch awareness campaigns to educate young people about their SRHR. The MoH could adopt a variety of strategies, such as using social media and community events.

Peer education programmes: Establish peer education initiatives where trained young people can share information and support with their peers to help them make informed choices about their SRH.

Ministry of Education

There is a need for the Ministry of Education to put measures in place for monitoring and ensuring that age-appropriate CSE is provided in all schools and that teachers do not deprive children of this right because of personal or religious beliefs.

Policy-makers in parliament

The TOPA should be amended to expand the grounds for termination of pregnancy to include non-therapeutic reasons.

There is a need to amend policies and ensure that they allow sexually active young people below the age of 18 years to access contraceptives without parental consent since the age of sexual consent is below 18 years for both girls and boys.

Conclusion

Although Seychelles is a signatory to a plethora of human rights instruments relevant to the SRHR of young people, young people still face challenges in enjoying these rights. The country has also enacted different pieces of legislation and policies that could benefit young people in enjoying their SRHR, but certain of the laws pose barriers to the full enjoyment of SRHR. Some are discriminatory on the grounds of age, while others are restrictive. Religious and cultural beliefs and a lack of adequate knowledge and information are further barriers to the enjoyment of SRHR.

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“ Legal protection is only meaningful where services are accessible, confidential and youth-friendly.

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POLICY ANALYSIS

Young People and Access to Safe and Legal Abortion in Eswatini and Malawi

Godfrey Kangaude

Introduction

Access to safe abortion remains a significant challenge for adolescent girls and young women in Africa. Seventy per cent of hospitalisations due to unsafe abortion in the developing world are among girls below 20 years of age (Atuhaire 2019). Across the continent, abortion laws are often restrictive, inconsistent, and influenced by colonial legal legacies, religious beliefs, and political dynamics (Bankole et al. 2020). This is particularly evident in Eswatini and Malawi, where unclear legal and policy frameworks create barriers to access, especially for young people facing unintended pregnancies, sexual violence, or socio-economic hardship.

In Malawi, an estimated 141,000 abortions occur annually, with 18 per cent of maternal deaths linked to unsafe procedures, disproportionately affecting young women under 24 years old (Levandowski et al. 2013). In Eswatini, abortion-related complications account for 23 per cent of maternal deaths, although there is limited data on the specific impact on young women (Macleod et al. 2023). However, qualitative research suggests that abortion is common among young people and that most procedures occur in unsafe conditions (Eswatini Ministry of Health 2023).

Both Malawi and Eswatini have ratified international and regional treaties, including the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), which recognises abortion as a reproductive right. However, compliance with these standards requires effective implementation at the national level, particularly through legal and policy instruments.

This article compares the legal and policy frameworks governing abortion in Eswatini and Malawi, assessing the extent to which they align with international

human rights standards to ensure young people's access to safe and legal abortion. It then offers recommendations for strengthening legal and policy protections to enhance young people's reproductive rights.

Legal frameworks on abortion

Eswatini: Abortion is prohibited but allowed on specified grounds

The Constitution of Eswatini, 2005, is the primary legal instrument governing access to safe and legal abortion. According to section 15(5) on the right to life, abortion is unlawful, but exceptions are permissible in certain circumstances. It is permitted on medical or therapeutic grounds, including cases where a doctor certifies that continuing the pregnancy would endanger the woman's life or pose a serious risk to her physical or mental health (section 15(5)(a)(i) and (ii)). Abortion is also allowed when there is a serious risk



Access to safe abortion remains a significant challenge for adolescent girls and young women in Africa.

that the child would be born with severe physical or mental impairments (section 15(5)(a)(iii)). In addition, it is permitted in cases of rape, incest, or unlawful sexual intercourse with a woman who is mentally disabled (section 15(5)(b)). The Constitution also grants Parliament the authority to expand the grounds for legal abortion, providing room for future legislative reform (section 15(5)(c)).

However, challenges exist both in the legal framework and its implementation. First, the law remains highly restrictive, as it prohibits abortion on all grounds except those explicitly permitted under section 15(5) of the Constitution. This means that young people seeking an abortion for reasons that are not recognised in the law are denied access. Furthermore, any abortion performed outside of these legal grounds is a criminal offence, one carrying penalties of up to life imprisonment. Anecdotal evidence suggests that health-care providers who assist with abortions, as well as women who undergo the procedure, have faced arrest (Anonymous 2018).

Apart from the law, there are other challenges, such as the criminalisation of abortion, the nature of the social and cultural context, and the existence of stigma. The social and cultural context is negative regarding abortion. A strategic assessment found that in Eswatini culture, abortion is considered an act that angers ancestors, and anyone who considers abortion is stigmatised (Eswatini Ministry of Health 2023). Furthermore, because Eswatini is predominantly Christian, abortion is considered immoral and a sin and thus discouraged.

The influence of culture and religion shapes knowledge, information and practices around abortion, with the result that even though the law permits abortion on certain grounds, girls and women are generally unaware of this (Mavundla & Ngweni 2014). Negative cultural attitudes combined with the criminalisation of abortion create an environment that perpetuates inaccurate and inadequate information about abortion. This contributes to the inability of girls and women to access services due to fear of criminalisation or stigma and has a chilling effect on service providers (Macleod et al. 2023).

Another challenge is that there are no policies and guidelines to support the operationalisation of the law

and ensure that people are well informed about access to safe abortion. Thus, although there are clearly articulated grounds for abortion, in practice getting a safe and legal abortion is difficult, especially for young people.

Malawi: Abortion is restricted, but with an uncertain exception

Malawi's abortion law is complex to navigate because it requires an interpretation of multiple legal instruments, primarily the Gender Equality Act of 2013 and several provisions of the colonial-era Penal Code of 1930. Section 19 of the Gender Equality Act recognises the right to access sexual and reproductive health (SRH) services, which implicitly includes safe and legal abortion. Section 19(2) explicitly states that every individual has the right to decide whether to have a child, implying a potential right to terminate a pregnancy if one chooses to not have the child when already pregnant. However, this right is subject to other written laws, including the Penal Code, which significantly restricts abortion access.

Restrictive abortion laws create barriers that disproportionately affect young people.

Sections 149 to 151 of the Penal Code criminalise unlawful abortion, prohibiting a woman from procuring her own miscarriage and third parties from assisting her in doing so. However, section 243 provides a narrow exception, stating that a person is not criminally liable if he or she unintentionally harms the foetus while attempting to save the life of the pregnant woman. This exception is typically interpreted to apply to medical emergencies, such as eclampsia, where a skilled provider may terminate a pregnancy to prevent catastrophic health consequences for the woman.

However, the law remains ambiguous, leaving room for interpretations that vary from the highly restrictive to the more liberal, not unlike what the situation was in the United Kingdom in the 1900s before the case of *R v Bourne* brought some clarity. In the absence of an authoritative legal interpretation, health-care providers, policy-makers, and law enforcement

agencies apply their own subjective understandings, leading to inconsistent implementation (Kangaude & Mhango 2018). Due to this uncertainty, young girls impregnated through rape are often denied abortion services because some health providers believe such cases are not legally permitted.

The main legal barrier to safe abortion access in Malawi remains its criminalisation under the Penal Code. Compounding this is the uncertainty about the scope of legal abortion, for example the question of whether the law covers girls and women who become pregnant due to rape. Then there are the social and cultural factors that create an environment deeply hostile to abortion (Jackson et al. 2011). Discussions of abortion are often framed in moral and religious terms rather than legal principles, reinforcing stigma and misinformation.

Furthermore, the criminalisation of abortion deters women from seeking services at hospitals, even when they might qualify for legal abortion, and creates a chilling effect among health-care providers, who fear legal repercussions due to the law's lack of clarity (Kangaude & Mhango 2018).

Discussion

Young people, particularly adolescent girls and young women, are among those most affected by restrictive abortion laws in Malawi and Eswatini. Both countries impose strict legal limitations on abortion, but their frameworks differ in scope, clarity, and degree of implementation. The restrictive nature of these laws creates barriers that disproportionately impact on young people, who often have less access to information, financial resources, and health-care services than others.

In Malawi, abortion is highly restricted under the Penal Code, which criminalises abortion except when necessary to save the life of the pregnant woman. However, the Gender Equality Act of 2013 guarantees SRHR, which implicitly includes legal abortion. The contradiction between these legal instruments creates confusion for both young people and health-care providers, preventing access even in cases of rape, incest, or serious health risks.

Eswatini's Constitution (in section 15(5)) prohibits abortion but allows exceptions for rape, incest, severe foetal anomalies, and life-threatening pregnancies. Nevertheless, a lack of clear implementation guidelines combined with health-provider fears of prosecution means that even when abortion is legally permitted, young people often face barriers to access safe services. In both countries, social stigma and moral opposition to abortion compound the legal barriers, discouraging young people from seeking services even when they may be legally eligible for them.

Fear of prosecution prevents health-care providers from offering safe abortion; young people lack comprehensive sexuality education and information on legal services; and criminalisation deters women from seeking post-abortion care, increasing the risk of complications from unsafe procedures. Religious and cultural opposition dominates policy discussions, making legal reform politically difficult despite evidence of the harm caused by unsafe abortion and despite recommendations by treaty-monitoring bodies advising legal and policy reform (United Nations Committee on Economic, Social and Cultural Rights 2024).

Both Malawi and Eswatini have ratified international and regional human rights treaties, including the Maputo Protocol, which recognises abortion as a reproductive right in cases of rape, incest, health risks, and severe foetal anomalies. However, neither country has fully implemented these commitments, leading to contradictions between international obligations and domestic legal frameworks.

In Malawi, the challenge is the criminalisation of abortion and lack of clarity about safe and legal abortion; in Eswatini, the law is aligned to the Maputo Protocol, but the absence of clear legal procedures and provider guidance limits access in practice. Furthermore, Eswatini still criminalises abortion in cases that fall outside the indications stated under the Constitution.



Legal provisions alone do not guarantee access to safe abortion.



Without these reforms, young people will continue to bear the brunt of restrictive abortion laws.

Addressing the impact of restrictive abortion laws on young people in Malawi and Eswatini requires legal clarity, policy alignment with international human rights standards, and improved access to safe and legal abortion, especially for young people.

Recommendations

The World Health Organization (WHO) (2022) has made several legal and policy recommendations on abortion that emphasise the need for full decriminalisation, expanded access, and improved implementation.

First, the WHO urges states to fully decriminalise abortion and ensure that no one faces legal sanctions for providing abortion services or information. Criminalisation reinforces stigma by legitimising mistreatment of and discrimination against women and girls seeking abortion, making it harder for them to access care. In Malawi, decriminalisation would require amending or repealing the Penal Code provisions on abortion (sections 149-151). In Eswatini, it would require an amendment to section 15(5) of the Constitution. However, an alternative approach in Eswatini is for Parliament to enact enabling legislation under section 15(5)(c) of the Constitution.

Secondly, the WHO recommends that abortion should not be restricted to specific grounds but should be available upon request to ensure that pregnant women and girls have full autonomy over their reproductive choices. Restricting abortion to certain legal conditions forces individuals to seek approval from third parties who may deny services based on personal or institutional biases. By removing these restrictions, both Malawi and Eswatini would ensure that decisions about pregnancy remain solely in the hands of those who are pregnant rather than make them subject to rigid legal frameworks that often fail to consider individual circumstances.

While these reforms represent long-term legal and policy changes, immediate action is also necessary. Civil society organisations can play a key role in disseminating accurate information about safe and legal abortion to counter widespread misinformation and support government efforts to clarify pathways for accessing abortion services. This is especially important for young people, who often lack information about where to go and how to seek legal abortion services.

Civil society can also mount advocacy efforts to push for legal and policy reforms that align with international and regional human rights commitments, including those under the Maputo Protocol, which already provides a minimum standard for Eswatini's legal framework.

In Malawi, an ideal reform would involve repealing sections 149 to 151 of the Penal Code. Even without additional legal reforms beyond repealing the Penal Code provisions, sections 19 and 20 of the Gender Equality Act could provide sufficient legal backing for the provision of safe abortion services in Malawi.

In Eswatini, civil society could either advocate for a constitutional amendment or push for Parliament to create enabling legislation under section 15(5)(c) of the Constitution to expand access within the existing framework.

Finally, both countries need to improve the implementation of their existing laws, as legal provisions alone do not guarantee access to safe abortion (Favier et al. 2018). This includes training health-care providers to ensure clarity on the legal framework, improving service delivery mechanisms, and tackling the stigma around abortion. Without these critical steps, liberal legal reforms are likely to fail to translate into meaningful access for those who need them most, including girls and young women.

Conclusion

The abortion laws in both Eswatini and Malawi fail to fully protect young people's reproductive rights, although Eswatini's legal framework provides more exceptions than Malawi's. In both countries, restrictive laws, legal uncertainty, and weak policy implementation create significant barriers to access, forcing many young people into unsafe abortions that contribute to high maternal mortality rates. The criminalisation of

abortion and social stigma further deters young people from seeking comprehensive sexual and reproductive health services, thus deepening health inequalities and exacerbating the risks associated with unsafe procedures.

Ensuring young people's access to safe abortion depends on urgent legal and policy reforms. Both countries must work towards decriminalising abortion, clarifying the legal framework, and aligning their laws with international human rights commitments such as the Maputo Protocol. However, expanding the legal grounds for abortion alone is not enough: it must be accompanied by improved implementation strategies, provider training, and community engagement to combat stigma and misinformation.

Immediate action is also necessary while long-term reforms are being pursued. Civil society organisations can play a critical role in raising awareness, providing accurate information, supporting legal and policy advocacy, and ensuring that young people know how to access available services. Addressing the legal, institutional, and social barriers to abortion would not only protect young people's rights but also improve public health outcomes, reduce maternal mortality, and advance gender equality in both Eswatini and Malawi.

Without these reforms, young people will continue to bear the brunt of restrictive abortion laws, facing harm to their health and, with that, life-threatening consequences. The need for change is urgent, and the responsibility lies with governments, policy-makers, civil society, and international partners to ensure that reproductive justice becomes a reality for all young people in Eswatini and Malawi.

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CASE REVIEW

The ECOWAS Court's Decision on the Right to Education for Pregnant Schoolgirls in Sierra Leone

Usang Maria Assim

Introduction

The case of Women Against Violence and Exploitation in Society (WAVES) & Child Welfare Society, Sierra Leone (CWS-SL) (on behalf of pregnant adolescent schoolgirls in Sierra Leone) v The Republic of Sierra Leone (ECOWAS Court of Justice, 12 December 2019) highlights critical issues concerning pregnant adolescent girls' rights to non-discrimination and education.

WAVES and CWS-SL, two non-governmental organisations (NGOs), filed the suit on behalf of young girls excluded from mainstream schooling due to pregnancy. At the applicants' request, the Court later struck CWS-SL out, leaving WAVES as the sole applicant. They brought the case on behalf of pregnant adolescent schoolgirls in Sierra Leone, aiming to challenge the discriminatory policies affecting the right to education of the girls in this matter.

Case background

This case addresses long-standing socio-economic and educational barriers in Sierra Leone that restrict access to education for girls, especially for pregnant adolescents. Following Sierra Leone's civil war (1991–2002), which saw a rise in gender-based violence and teenage pregnancies, the Truth and Reconciliation Commission recommended steps to promote gender equality. In 2013, the government launched a National

Strategy for the Reduction of Teenage Pregnancy to support young mothers in continuing their education. However, the 2014 Ebola outbreak interrupted this plan, leading to a spike in teenage pregnancies. When schools reopened, the government issued a policy barring visibly pregnant girls from mainstream schools. The policy effectively required pregnant girls to attend alternative schooling, which offered a reduced curriculum of core subjects and operated part-time. This approach, while intending to address social concerns, has since been criticised for reinforcing stigma, limiting educational opportunities, and perpetuating socio-economic challenges for adolescent mothers.

The case brought before the ECOWAS Court centres on these policies, asserting that this exclusion infringes on the right to education and equality. The contention was that the exclusionary policy harms young mothers by limiting their academic and professional prospects, trapping them in cycles of poverty and undermining their right to a non-discriminatory education.



This case addresses long-standing socio-economic and educational barriers in Sierra Leone that restrict access to education for girls, especially for pregnant adolescents.

Applicant's case

The applicants contended that Sierra Leone's policy barring pregnant schoolgirls from attending mainstream schools violated their rights to education and was inherently discriminatory. In presenting their case, the applicants highlighted several specific ways in which this discrimination was manifested. First, they pointed out that the policy led to a denial of access to mainstream education for pregnant girls. By preventing them from attending regular schools, the policy significantly limited their educational opportunities compared to their non-pregnant peers, who continued to receive full access to schooling.

Secondly, the applicants criticised the inferior quality of alternative education offered to these girls. While alternative schools were established as a response to the policy, these schools operated only three days per week and offered a limited curriculum covering just four subjects. The applicants argued that this alternative education was both inadequate and inaccessible as well as to the disadvantage of pregnant girls in that it deprived them of equal educational opportunities.

Additionally, the applicants argued that the policy fostered stigmatisation and segregation of pregnant girls, creating social stigma that marked them as undeserving of the same educational rights as others. This stigma, coupled with the lack of parental and community support due to societal attitudes toward teenage pregnancy, discouraged many girls from returning to school, effectively isolating them and reinforcing their exclusion.

Finally, the applicants argued that there was no reasonable justification for the differential treatment imposed on pregnant girls. They noted that male students, including those who may have been involved in the pregnancies, continued to enjoy full access to mainstream education without any disruption. This unequal treatment underscored the discriminatory nature of the policy, as it singled out pregnant girls for punishment while allowing male students to continue their education unimpeded.

Respondent's defence

The Republic of Sierra Leone initiated its defence by

contesting the ECOWAS Court's jurisdiction to hear the case and focusing on the applicants' lack of legal standing. It argued that the second applicant lacked legal recognition as it was not registered in Sierra Leone and thus could not be a valid party. Furthermore, the respondent claimed that the applicants had no legal basis to represent 'pregnant adolescent school girls', as this group was not formally recognised as a legal entity and there were no identifiable victims directly linked to the case. Sierra Leone urged the court to dismiss the case on these procedural grounds.

Pregnancy-related exclusion from school is a matter of equality, non-discrimination and the right to education.

In defending its position on the exclusion of pregnant girls from mainstream schools, Sierra Leone asserted that the alleged 'ban' was not a formal, state-sanctioned policy.

According to the respondent, the exclusionary practice stemmed from a single statement made by a former Minister of Education, Dr Minkailu Bah, who publicly declared that visibly pregnant girls would be prohibited from attending school. Sierra Leone claimed that the statement was subsequently retracted and should be understood as an isolated incident rather than an ongoing government-endorsed policy. The respondent further argued that the statement did not reflect the government's commitment to supporting the welfare of all students, including pregnant girls.

In that light, Sierra Leone aimed to demonstrate that no formalised policy exists that deliberately excludes pregnant girls from mainstream education. This line of defence was intended to discredit the applicants' claim that the exclusionary policy represented an entrenched and systematic practice sanctioned by the government.

The respondent's defence also centred on its provision of alternative educational opportunities for pregnant students. Sierra Leone argued that it had created separate schools specifically to address the needs

of pregnant girls, enabling them to continue their education in an environment tailored to their unique circumstances.

These alternative schools, according to the respondent, offered a focused curriculum that covered core subjects such as Mathematics, English, Integrated Science, and Social Studies, although they operated on a reduced schedule of three days per week. While the applicants criticised these alternative schools for their limited accessibility, narrow curriculum, and lack of parity with mainstream institutions, the respondent defended these limitations as practical measures that considered the specific challenges faced by pregnant students.

Legal analysis

The ECOWAS Court of Justice accepted jurisdiction over this case based on its mandate to adjudicate human rights violations within ECOWAS member states under article 9(4) of the 2005 Supplementary Protocol. This provision grants the court the authority to address cases where member states may have failed to uphold rights enshrined in international treaties they have ratified, including the African Charter on Human and Peoples' Rights, Convention on the Rights of the Child and Convention on the Elimination of All Forms of Discrimination Against Women, all of which Sierra Leone is bound to observe.

Thus, the court affirmed its competence to examine the allegations of discrimination and rights denial facing pregnant schoolgirls under these international obligations. To support its jurisdiction, it highlighted its broad authority in human rights cases, one extending beyond state-to-state disputes to encompass cases brought by individuals and NGOs.

Furthermore, the court recognised the standing of the applicant, WAVES, because it is a legally recognised NGO and had brought the action on behalf of a section of the community in Sierra Leone whose rights to education had been significantly violated; it was thus bringing the action in the public interest. The court further recognised that WAVES had sufficient interest to bring the case due to the serious concerns the policy raised about systemic discrimination and the broader public importance of ensuring educational access for all girls, including pregnant ones. It noted that the

alleged violation, if left unaddressed, could have future implications for other pregnant girls, making the case one of significant public concern.

Moreover, with regard to state responsibility and human rights violations, the court's finding of state responsibility was pivotal. Under international law, a state is accountable for the actions of its officials when those actions breach international obligations, regardless of whether they reflect formal or isolated policies. In this case, the Minister of Education made the statement while performing his official duties, meaning Sierra Leone could not evade liability under state responsibility rules.

The court found that, based on the facts presented, discrimination indeed exists against pregnant schoolgirls in Sierra Leone. The applicant detailed how pregnant girls, rather than being allowed to stay in mainstream schools, were relegated to alternative schools with limited resources and a reduced curriculum. These alternative schools were less accessible and offered an inferior education compared to mainstream schools, which affected the quality of education available to pregnant girls. In contrast, their male counterparts, including those who may have been involved in these pregnancies, continued to attend mainstream schools, benefiting from a full curriculum and standard educational facilities.



The decision offers a model for inclusive education policies across the region.

While the court acknowledged that alternative schooling could be acceptable if it met equal standards and provided additional support for pregnant students, the arrangement in Sierra Leone fell far short of this. This form of segregation and inferior treatment breached the state's obligations to ensure non-discriminatory access to education.

Court findings and judgment

After examining the arguments and evidence presented by both sides, the ECOWAS Court ruled that the exclusion policy, whether officially or informally

implemented, constituted a violation of the rights to education and non-discrimination under international and regional human rights law. The court noted that the statement by the Minister of Education, regardless of the government's later attempts to provide alternative schooling, effectively barred pregnant girls from accessing the same quality of education as their non-pregnant peers. This practice was found to be discriminatory, as it restricted educational access based solely on pregnancy status, which is a factor specific to young girls and, therefore, inherently gender-based.

As such, the court ordered the government of Sierra Leone to revoke the exclusion policy and take measures to reintegrate pregnant girls into mainstream schools. Additionally, it mandated that the government develop nationwide programmes to combat stigma against adolescent mothers, improve access to comprehensive sexual and reproductive health education, and address the underlying factors contributing to teenage pregnancies.

Analysis of the court's impact

The ECOWAS Court's judgment in the WAVES case sets a significant precedent for human rights protections in the region, and particularly in regard to educational access and gender equality. By declaring the exclusion of pregnant girls from mainstream schools discriminatory, the court reinforced the fundamental right to education without gender-based restrictions.

This case serves as a critical example of regional courts using human rights frameworks to hold member states accountable for policies that marginalise vulnerable groups. The decision highlights the court's role in advancing social justice by addressing the intersection of educational rights, gender equality, and social inclusion.

The judgment also has broader implications for educational policy across Africa. By emphasising the inadequacy of alternative schooling and calling for

reintegration programmes, the court highlighted that separate educational provisions for marginalised groups are often insufficient to meet the standards of equality. This finding urges other ECOWAS member states to examine their own policies to ensure compliance with international and regional human rights obligations.

Additionally, the court's order for nationwide campaigns to reduce stigma and promote reproductive health awareness signals a move toward more holistic interventions that address root causes of discrimination. By mandating proactive measures, this ruling emphasises the need for member states to adopt policies that empower young women and promote the achievement of the sustainable development goals, with a focus on inclusive and equitable quality education (Goal 4) and gender equality (Goal 5).

Conclusion

The WAVES case underscores the importance of regional human rights mechanisms in protecting educational rights and addressing gender-based discrimination. Through this ruling, the ECOWAS Court highlighted the critical role of inclusive education policies in advancing social equity and supporting the welfare of vulnerable populations, particularly adolescent mothers.

The case not only requires Sierra Leone to change its policies, but also offers a model for other African nations, promoting a future where education is accessible to all, irrespective of gender or pregnancy status. The judgment's emphasis on structural reform and stigma reduction reflects a progressive approach to human rights that aligns with Africa's broader commitment to gender equality, marking a meaningful step forward in the quest for inclusive educational opportunities.

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The WAVES case underscores the importance of regional human rights mechanisms in protecting educational rights and addressing gender-based discrimination.

EVENT

Reflections from the ACHPR Side Event on Obstetric Violence and Maternal Health

Favour Funke Akanbi

Introduction

The Roundtable on Obstetric Violence was held on 14 October 2024 at the Jawara International Conference Centre in Banjul. It was organised by the Bridging the Gap Coalition under the Women's Platform, with the Initiative for Strategic Litigation in Africa, the Kenya Legal and Ethical Issues Network on HIV and AIDS, and the Dullah Omar Institute forming part of the coalition. The side event created a space for lawyers, advocates, researchers and civil society actors to reflect on how regional human rights mechanisms can be used more effectively to address obstetric violence and strengthen accountability for violations of maternal health rights.

The discussion built on earlier conversations from the 78th Ordinary Session of the African Commission on Human and Peoples' Rights. Its central concern was how the African Commission can be used to strengthen advocacy, develop clearer standards and hold states accountable for their obligations to protect women from obstetric violence. The roundtable was therefore not simply a technical discussion about litigation. It was also a reflection on how the African human rights system can respond to harm experienced by women in reproductive health-care settings.

Understanding obstetric violence

The discussion took place against a growing recognition that mistreatment during pregnancy, childbirth and the postnatal period is not merely a matter of poor

service delivery. It is also a human rights concern. Obstetric violence may include verbal abuse, physical mistreatment, denial of informed consent, coercive procedures, neglect, discrimination, detention after childbirth and other forms of degrading or disrespectful treatment within reproductive health-care settings. These experiences often affect women who already face intersecting forms of vulnerability, including poverty, youth, disability, migration status, rural exclusion and other forms of social marginalisation.

The roundtable was important because it moved the discussion beyond the clinical setting. It asked how regional human rights law can respond when harm occurs in places that should provide care, safety and dignity. It also asked how the African human rights system can better recognise the relationship between obstetric violence, gender-based violence, reproductive autonomy, equality and the right to health.



A central issue was the absence of a consistent legal understanding of obstetric violence in many African contexts.

A central issue was the absence of a consistent legal understanding of obstetric violence in many African contexts. Although the harm experienced by women during childbirth may be severe, it is not always named or treated as a distinct rights violation. This makes litigation and advocacy difficult because courts, commissions and national institutions may struggle to place the harm within existing categories of gender-based violence, reproductive rights, health rights or dignity.

“ Obstetric violence forces us to think carefully about the meaning of care within human rights law.

Participants also reflected on the evidentiary difficulties that arise in obstetric violence cases. Physical injury may sometimes be visible, but many forms of harm are less easily documented. Psychological trauma, humiliation, denial of consent, coercion, abandonment and loss of dignity may be central to a woman's experience, yet difficult to prove within formal legal processes. This creates a gap between lived experience and legal recognition. The roundtable therefore highlighted the need for advocacy that does not reduce obstetric violence only to physical injury, but takes seriously the full range of harm that women experience in reproductive health-care settings.

Lessons from Communication 564/15

The discussion then turned to the African Commission's decision in *Community Law Centre and Others v Nigeria*, Communication 564/15, which concerned maternal mortality and failures in Nigeria's health-care system. The communication was submitted against the Federal Republic of Nigeria on behalf of women who suffered serious maternal health harms, including injuries and deaths linked to pregnancy and childbirth. The case was significant because it required the Commission

to consider state responsibility for maternal health within the African human rights framework.

For many participants, the decision was disappointing. The Commission did not use the case to develop a strong and gender-sensitive approach to maternal health accountability. Instead, its reasoning was seen as cautious and formalistic. Participants were particularly concerned that the Commission did not sufficiently recognise the seriousness of preventable maternal harm as a rights issue, nor did it fully engage with how systemic neglect in health-care settings can undermine women's dignity, autonomy and equality.

The case also raised broader questions about how regional human rights bodies approach socio-economic rights. Maternal health is often affected by limited resources, weak infrastructure and underfunded public health systems. However, participants stressed that resource constraints should not become a general explanation that allows states to avoid accountability. Even where resources are limited, states still have duties to take reasonable, deliberate and concrete steps to improve access to maternal health care and to prevent avoidable harm.

The roundtable therefore treated Communication 564/15 as more than a single case. It was discussed as a missed opportunity for the African Commission to clarify the content of state obligations in relation to maternal health and obstetric violence. It also showed the need for stronger normative guidance within the African human rights system. Without clearer standards, women who experience mistreatment in childbirth may continue to face serious barriers when seeking recognition, remedies and accountability.

Strategic use of regional mechanisms

Participants considered several possible pathways for strengthening the African Commission's response to obstetric violence. One proposal was the development of a model law that could guide African states in recognising and prohibiting obstetric violence. Such

a model law could set out minimum standards for respectful maternity care, informed consent, non-discrimination, accountability and remedies. It could also assist states that do not yet have specific legal protection against obstetric violence.

Another possible pathway was the development of a general comment or other interpretive guidance by the African Commission. This would help clarify how the African Charter and the Maputo Protocol apply to obstetric violence and maternal health. Such guidance could explain how rights to dignity, health, equality, life and freedom from cruel, inhuman or degrading treatment are implicated when women are abused or neglected during pregnancy and childbirth. It could also assist advocates, courts and policymakers in understanding obstetric violence as a structural issue rather than as isolated acts of individual misconduct.

Regional mechanisms matter, even when they are slow or imperfect.

The discussion also considered the use of resolutions, communications and special mechanisms within the African Commission. While participants recognised the limitations of these mechanisms, they also acknowledged their strategic value. Communications can bring specific cases before the Commission and create opportunities for legal development. Resolutions can help build political and normative pressure. Special rapporteurs and working groups can support research, advocacy and standard-setting. The challenge is to use these mechanisms in a coordinated way, while also being realistic about the procedural delays and institutional constraints that affect the African Commission.

Procedural concerns and collaboration

Participants acknowledged several procedural obstacles in the African Commission system that could hinder these initiatives. These include slow processing of cases, limited transparency in decision-making

and resource constraints that often delay responses. To address these barriers, the coalition proposed continued engagement with the Commission and its mechanisms, particularly in cases relating to women's rights and health care.

A recurring concern was the opacity of the Commission's communication procedure. Article 59 of the African Charter requires measures taken under the relevant chapter to remain confidential unless otherwise decided. However, the discussion also highlighted the need for greater transparency within the limits of the Charter. When case progress, procedural status and outcomes are difficult to follow, civil society actors face challenges in monitoring implementation and sustaining advocacy. Greater clarity would strengthen trust in the system and assist advocates who rely on regional mechanisms to advance accountability.

The roundtable ended with a strong emphasis on collaboration. Obstetric violence cannot be addressed through litigation alone. It requires coordinated advocacy, research, documentation, community engagement and legal reform. It also requires partnerships between women's rights organisations, health rights advocates, regional institutions, lawyers and affected communities. Participants recognised that many organisations are already working on maternal health and reproductive justice, and that regional advocacy should build on existing efforts rather than duplicate them.

Reflection

One of the most important reflections from the roundtable was that obstetric violence forces us to think carefully about the meaning of care within human rights law. A health system may appear to provide services, but if women are humiliated, coerced, ignored or denied meaningful consent, then the service itself becomes a site of harm. Maternal health care must therefore be understood not only in terms of availability, but also in terms of dignity, autonomy, equality and accountability.

The roundtable was also a reminder that regional mechanisms matter, even when they are slow or

imperfect. The African Commission remains an important site for shaping standards, naming violations and pushing states toward stronger protection. However, its usefulness depends on how boldly it is willing to interpret rights in light of women's lived experiences. Obstetric violence requires a legal response that is attentive to the everyday forms of abuse and neglect that women experience when seeking reproductive health care.

The side event therefore created an important space for reflection and strategy. It showed both the limits and

possibilities of the African human rights system. It also made clear that the recognition of obstetric violence as a human rights issue is a necessary step toward ensuring that women are treated with dignity, respect and autonomy before, during and after childbirth.

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