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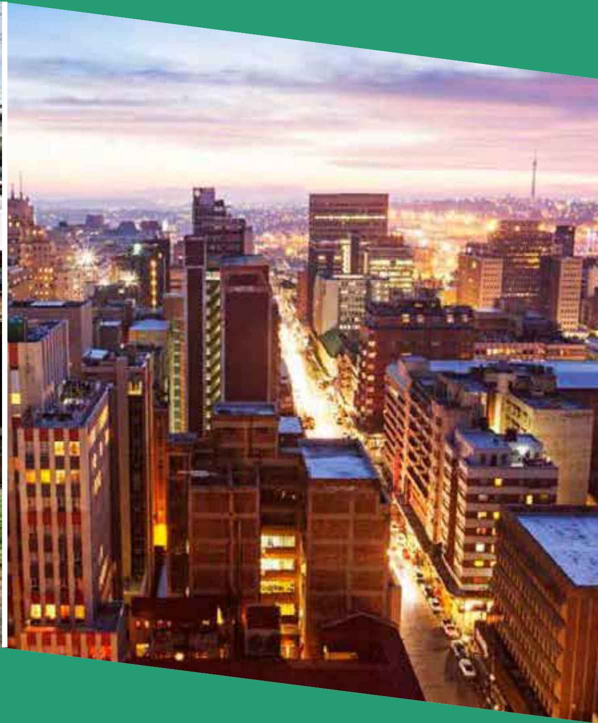

ESR REVIEW

Economic & Social Rights Review in Africa

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

SPECIAL EDITION ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

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Editorial

Welcome to this special edition of *ESR Review*, which puts the spotlight on advancing sexual and reproductive health rights (SRHR) in Africa. Although SRHR is fundamental to human dignity and well-being, in Africa the SRHR landscape is characterised by a complex interplay of cultural, political, and economic factors that shape access to services and information. This special edition sheds light both on issues that impact the enjoyment of SRHR and on opportunities to advance these rights.

Our first feature article delves into the right of birthing persons to respectful maternity care and the role of regional human rights mechanisms in advancing this right and eliminating obstetric violence in Africa. The second article examines period poverty in Uganda and its impact on access to education for school-going girls. It also proposes solutions as to how the government and other stakeholders could address this problem. The third article highlights barriers to realising SRHR in Cameroon, such as legal restrictions, cultural and religious resistance, corruption and other governance issues, and humanitarian crises.

This edition includes a policy review that questions the adequacy of Zimbabwe's legal and policy framework on women's access to family-planning services and information during humanitarian emergencies. Also featured is a review of ***The Book of WOMB (Who Owns My Body)***, which documents the SRHR experiences and challenges of women in a rural community in KwaZulu-Natal, South Africa.

As the continent strives for sustainable development and social justice, prioritising SRHR is not only a health issue but a vital human rights concern. Here, fostering collaboration between governments, civil society, and international organisations is essential. By prioritising SRHR, we can create a healthier, more equitable future for all Africans. Embracing this vision requires commitment, advocacy, and a willingness to challenge the status quo. We hope this special edition of *ESR Review* contributes to precisely that endeavour.

Aisosa Jennifer Omoruyi
Guest Editor

FEATURE

Enhancing Respectful Maternity Care and Eliminating Obstetric Violence: The African Union's Human Rights Framework

Kerigo Odada, Satang Nabaneh and Mai Aman

Introduction

The discourse on the elimination of obstetric violence during facility-based childbirth and the realisation of respectful maternity care (RMC) is rapidly gaining momentum in Africa and globally. Individuals and organisations alike are increasingly raising awareness of obstetric violence as a form of structural and interpersonal violence. These discussions focus on establishing access to respectful maternity care as a human right that embodies various other rights provided for in national, regional, and international human rights instruments.

Unfortunately, however, there is still a dearth of jurisprudence on RMC and obstetric violence in Africa. Unlike the case with the inter-American and European systems, the African human rights system has been little explored as an avenue for redress. This article thus briefly examines the role of African human rights mechanisms in protecting the right of birthing persons to receive respectful maternity care which is free from violence.

The concept of respectful maternity care

The World Health Organization (WHO) defines quality health care as safe, effective, timely, efficient, equitable, people-centred services that deliver the health outcomes communities want. This is reflected in its conceptualisation of RMC, which it defines as care provided to birthing persons in a way that maintains the dignity, privacy, and confidentiality of pregnant and birthing women, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and birth.

This type of care centres on the rights of a birthing person during pregnancy, birth, and the postpartum period, and seeks to ensure that the person's autonomy is safeguarded by medical service providers and hospital staff at all times. RMC is a universal human right of every childbearing woman in every health system.

As a human rights-centred approach to pregnancy and birth, RMC anchors itself on, among others, the right to dignity, the right to equality and non-discrimination, and the right of every person to the highest attainable standards of physical and mental health. RMC as a crucial component of the right to health in particular guarantees all pregnant persons the right to receive reproductive health care services throughout the cycle of pregnancy, birth, and the postpartum period in a dignified manner free from all forms of violence.

Pregnancy, childbirth, and the postpartum period are some of the most important reproductive experiences of childbearing persons. Besides being experiences

that usher in new life, they represent points in one's reproductive experiences where multiple systems of power and oppression intersect due to the socio-political position occupied by the birthing phenomenon. This position occupied by pregnancy and childbirth is, in many societies, a subject of great social, economic and political interest, resulting in the policing of the birthing bodies.

In sub-Saharan Africa (SSA), the conversation around health care has focused on the reduction of maternal mortality and morbidity. In many states, maternal mortality and morbidity remain a major challenge, one which is attributable to, among other things, the poor quality of care that characterises many maternal health systems in the region.

Presently, unsafe care in general is considered to be one of the 10 leading causes of death and disability worldwide, with low- and middle-income countries accounting for approximately 5.7 to 8.4 million of these deaths annually. With regard to maternal health care, as of 2017, it was estimated that 94 per cent of the 295,000 global maternal deaths occurred in low-income countries, with two-thirds of these deaths occurring in SSA.

The concept of obstetric violence

The term 'obstetric violence', albeit controversial terminology, comprehensively captures the systematic violence perpetrated against women during and after facility-based childbirth. This term has been instrumental in highlighting issues around quality of care in obstetric care. It conveys the pervasive power imbalance between medical practitioners and women and how these factors, put together, are a manifestation of deep-rooted systemic and structural forms of violence against women (VAW).

This nomenclature embodies the essential features of acts that amount to VAW, which perpetuates structural gender inequality, systematically devalues the lives of women and girls, and consequently disempowers them.

The term 'obstetric violence' has its roots in Latin America, where it is formally recognised in Argentina, Venezuela, Uruguay, Panama and Mexico. It was coined to refer to the mistreatment of all persons capable of getting pregnant by medical service providers and hospital staff during facility-based childbirth. Venezuela was the first country to legally prohibit obstetric violence through its Organic Law on the Right of Women to a Life Free of Violence. Under this law, obstetric violence is legislated as one of 19 types of VAW that are punishable by law.

Whereas the conversation on obstetric violence in Africa is not as advanced as in Latin America, reports have documented different forms of abuse that pregnant persons are subjected to during facility-based care.

The term 'obstetric violence' has been instrumental in highlighting issues around the quality of care in obstetric care.

Some of these human rights violations include physical abuse; humiliation and verbal abuse; coercive or unconsented medical procedures (including sterilisation); lack of confidentiality; failure to get fully informed consent; refusal to give pain medication; gross violations of privacy; refusal of admission to health facilities; neglecting women during childbirth to suffer life-threatening, avoidable complications; and postpartum detention of pregnant persons and their newborns in facilities after childbirth due to an inability to pay. These violations are structural and interpersonal, with the state culpable for the former and medical service providers and hospital staff, for the latter.

Moreover, pregnant persons' experience of obstetric violence is not uniform. Different persons experience different forms of obstetric violence differently, and this depends on individual identity and social location – in other words, on factors such as class, gender, age, education, marital status, and disability. Quite often,

multiple systems of oppression work together to predispose certain groups of people to rights violations more than others. Evidence demonstrates that one's social location and how that location intersects with systems of power and oppression determines one's experience of obstetric violence.

Thus, the term 'obstetric violence' is essential in addressing the structural dimensions through which this type of violence, which has an explicit connection with gender-based violence and social inequalities, manifests itself.

Indeed, obstetric violence was conceptualised as a form of VAW in a recent decision of the Committee on Convention on the Elimination of All Forms of Discrimination against Women in 2022, in the case of N.A.E v Spain, which established it as a particular type of violence against women during facility-based childbirth which is widespread, systematic, and ingrained in health systems.

VAW, according to the CEDAW Committee, in its General Recommendation No. 19 on Violence against Women, includes gender-based violence, be it 'physical, mental or sexual harm or suffering, threats of such acts, coercion, and other deprivations of liberty'. The recommendation obligates states to ensure that third parties, through private actions, do not violate the rights of other citizens. If states cannot fulfil this obligation, they may be held responsible.

The human rights framework for RMC in Africa

Regional human rights systems monitor governments' compliance with human rights obligations. RMC and obstetric violence are human rights issues that intersect with several rights enshrined in treaties and expanded on in resolutions and general comments. In this section, we briefly discuss some avenues through which the African human rights framework could help advance the discourse on RMC and the elimination of obstetric violence.

Equality and non-discrimination

The right to equality and non-discrimination is enshrined in article 2 of the African Charter on Human and Peoples' Rights ('African Charter'). Additionally, article 3(1) and (2) underscore that every individual shall be equal before the law and entitled to equal protection of the law. The Charter, under article 18, mandates all states to eliminate all forms of discrimination against women and ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions.

The right to non-discrimination is also provided under article 2 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa ('Maputo Protocol'). This article calls upon state parties to adopt measures that, among other things, prohibit or curb harmful practices that endanger the health and general well-being of women.

Furthermore, it obligates African governments to take corrective measures to address persistent discriminatory practices against women, including adopting legislation to eliminate discriminatory practices against women; undertaking measures to address the social and cultural patterns that perpetuate discrimination against women and girls; and embarking on education and awareness campaigns to change people's attitudes.

The right to health

Persons capable of getting pregnant have higher health-system utilisation needs than those who do not. Unfortunately, however, as evidenced by the high rates

> **"...obstetric violence has an explicit connection with gender-based violence and social inequalities**

of maternal mortality and morbidity in sub-Saharan Africa, health-system inefficiencies disproportionately impact birthing persons. As postulated by the WHO, this disparity within the health system indicates the persistent inequity between genders. It paints a picture of the subservient position occupied by persons capable of getting pregnant in society, as multiple systems of oppression intersect to increase adverse reproductive health outcomes for this social group.

The right to health within the African Union human rights framework is enshrined in article 16 of the African Charter. This is the cornerstone of health as a human right on the continent. The Maputo Protocol, on the other hand, strengthens this right by explicitly addressing women's health, including sexual and reproductive health. State parties are called upon to respect and promote the rights in the Protocol, ensuring access to essential health-care services.

The Maputo Protocol emphasises the importance of adequate resources for realising sexual and reproductive rights. It mandates states to allocate sufficient funds for health care and implement initiatives to prevent and eradicate violence against women. The Protocol requires states to provide accessible and affordable health services for women, particularly those in rural areas, and to establish robust prenatal, delivery, and postnatal care systems.

To achieve this, appropriate policy reforms to address health financing concerns that affect the availability, accessibility, and quality of services people receive in maternal health services are necessary. These structural reforms to increase the allocation of human and capital resources must include curriculum reforms to change how medicine is practised. All of this, unfortunately, depends on political will because allocating resources for health is a political decision ultimately brought to life by policies developed and subsequently implemented to facilitate the distribution of money, power, and resources.

The African Commission on Human and Peoples' Rights (ACHPR) has established mechanisms and standards to promote women's rights. It has adopted two general comments on article 14 related to women's health. In General Comment No. 1 on article 14(1)(d) and (e) of the Protocol, paragraph 22, the Commission states that the obligation to protect in relation to article 14(1)(d) and (e) requires states to take measures that prevent third parties from interfering with the rights in the Protocol. The same general comment in paragraph 23 provides that the obligation to promote in relation to article 14(1)(d) and (e) requires states to create legal, social and economic conditions that enable women to exercise their rights in relation to sexual and reproductive health. This involves engaging in sensitisation activities, in community mobilisation, and in training health-care workers and religious, traditional and political leaders on the importance of the right to protection and of being informed about one's health status and that of one's partner.

In General Comment No. 2 on article 14(1)(a), (b), (c) and (f) and 14(2)(a) and (c), the Commission, in paragraph 43, underscores that states' obligation to protect requires state parties to take the necessary measures to prevent third parties from interfering with the enjoyment of women's sexual and reproductive rights. Particular attention must be given to prevention as regards the interference of third parties in the rights of vulnerable groups such as adolescent girls, women living with disabilities, women living with HIV, and women in situations of conflict. The obligation entails formulating standards and guidelines for access to sexual and reproductive services.

This is particularly relevant in light of reports from various countries on non-consented forms of care, including forced and/or coerced sterilisation, forced contraception, and other routine procedures. The African Commission, in Resolution 260 on involuntary sterilisation as a violation of human rights, condemns all forms of involuntary sterilisation targeted at vulnerable groups, such as women living with HIV, as a violation of the rights to dignity, health, non-discrimination and freedom from cruel, inhuman and degrading treatment.

Lastly, the African Youth Charter, a unique instrument addressing youth rights, includes significant health provisions. It recognises the challenges young people face and calls for youth-friendly healthcare services. Article 16 guarantees the right to health, encompassing access to health care, determinants of health, and addressing non-communicable diseases.

The right to dignity and freedom from torture, cruel, inhuman, and degrading treatment

Another important right and freedom relating to RMC and the elimination of obstetric violence is the right to dignity and the freedom from torture, cruel, inhuman and degrading treatment. Both the African Charter and Maputo Protocol explicitly recognise these rights and prohibit all forms of such treatment.

The right to dignity is provided in article 5 of the African Charter and is integral to human rights, including the right to autonomy and control over reproduction and sexuality. Article 3 of the Maputo Protocol guarantees women's rights to dignity. In terms of article 4 of the Protocol, every woman has the right to dignity inherent in a human being, a right to respect as a person and a right to the full development of her personality.

The right to dignity has been underscored in *Legal and Human Rights Centre and Centre for Reproductive Rights (on behalf of Tanzanian girls) v United Republic of Tanzania*. In this communication, the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) found that forced or mandatory pregnancy testing to access education was a violation of children's right to dignity, privacy, and freedom from torture.

Article 5 of the Charter also acknowledges the interdependent relationship between the right to dignity and the absolute prohibition of torture and other forms of ill-treatment. Additionally, in *Purohit and Moore v The Gambia*, the Commission held that 'exposing victims to 'personal suffering and indignity' violates the right to human dignity.

Lastly, General Comment No. 4, which focuses on the right to redress for victims of torture and other ill-treatment, addresses sexual and gender-based violence, which amounts to a form of torture and other ill-treatment in view of its specific, traumatic and gendered impact on victims, including the individual, the family, and the collective.

Control of reproduction and sexuality is an essential element of human dignity, both as a precondition for women to exercise their other rights and fulfil basic needs and as an end in itself. The right to dignity also forms the basis for the right to autonomy in making decisions regarding one's health, especially sexual and reproductive health. Therefore, it is argued that the Protocol affirms women's autonomy as a human right.

Autonomy revolutionises the provision of reproductive health care services by shifting service provision from being physician-centred to being patient-centred.

Liberty and security of the person

In many parts of Africa, the unaffordability of health care remains a significant barrier to accessing health care services, including SRH services. Evidence has shown that the extent to which states and other stakeholders invest resources in healthcare services directly affects the availability and accessibility of these services and the quality of care people receive.

The financial accessibility of maternal health care services remains a huge barrier in the quest to realise RMC. In many parts of the continent, access depends on individual purchasing power, as out-of-pocket (OOP) expenditure on health is the main way one can access care. OOP in the context of maternal health care not only limits access, but also predisposes pregnant persons to other forms of violations, including postpartum detention.

Postpartum detention healthcare facilities involve the arbitrary deprivation of liberty for non-payment of user fees and is one of the many forms of obstetric violence documented in Kenya, Democratic Republic of Congo (DRC), Burundi, Nigeria and Tanzania, among others. Article 6 of the African Charter provides that 'every individual shall have the right to liberty and security of their person respected'. No one may be deprived of their freedom without cause, except as provided for by law. In particular, no one may be arbitrarily arrested or detained. Furthermore, the Maputo Protocol calls upon member states to take legislative and administrative measures to eliminate VAW in all its forms, both private and public.

Beyond including the prohibition of arbitrary deprivation of liberty, the right to freedom and security of the person has also been interpreted to include the right to informed consent and decision-making, or the right to make autonomous decisions, regarding one's health and related procedural interventions and treatment. This interpretation means that no person shall be subjected to any form of forcible treatment or intrusion upon their bodily integrity.
Together, the right to bodily integrity, the right to informed consent, and the right to self-determination ground the principle of bodily autonomy, which entails respecting the capacity of persons to think for themselves and make judgments about what they deem to be good for themselves. Autonomy revolutionises the provision of reproductive health care services by shifting service provision from being physician-centred to being patient-centred. Health-care providers are expected to obtain informed consent from their patients before performing any medical intervention.

The role of the African Court and Commission

Obstetric violence, as a rights-centred framing conceptualised to capture various forms of human rights violations that occur during pregnancy and facility-based childbirth, is progressively taking root across the globe. Increasingly, various human rights bodies have used this terminology to highlight the gendered nature of the human rights violations experienced by pregnant persons during facility-based childbirth.

Although obstetric violence is yet to be formally recognised within the African human rights framework, cases involving related human rights concerns have been adjudicated upon or reported on at the regional human rights mechanisms since as early as 2003. *In Purohit and Moore v The Gambia,* for example, the African Commission, apart from demonstrating the nexus between discrimination and health, underscored the need for states to provide quality health-care services and not just focus on physical access.

Lessons from regional human rights mechanisms

The Inter-American Commission of Human Rights (IACHR) was the first international human rights body to hear and rectify a case relating to obstetric violence: *María Mamérita Mestanza Chávez v Perú* in 2003. This case, in which an indigenous woman was coerced into a tubal ligation and died from the procedure, resulted in a 'friendly settlement' in which Peru recognised its failure to fulfil its responsibilities under the various treaties to which it is party.

The IACHR also published a human rights report condemning reports of forced sterilisation in Mexico. Similarly, in 2021, the Inter-American Court of Human Rights (IACtHR) ruled in *Manuela et al. v El Salvador* that the state was responsible for the detention, conviction, and death of a woman who suffered an obstetric emergency. The court deemed El Salvador responsible for the death of Manuela, who in 2008 was unjustly sentenced to 30 years in prison for aggravated homicide after suffering an obstetric emergency that resulted in her pregnancy loss. The state was found to have violated Manuela's rights, inter alia, to life, health, judicial protections and guarantees, and freedom from discrimination and gender violence.

In November 2022, the IACtHR declared Argentina responsible for violating the rights to life, integrity, and health in *Britez Arce et al. v Argentina*, which marks

the first time the court applied the concept of obstetric violence. In September 2023, in Rodríguez Pacheco v Venezuela, the IACtHR reiterated the definition of obstetric violence and emphasised that states must regulate and supervise all health care provided under their jurisdiction, in both public and private settings, to prevent acts of obstetric violence and violations of the right to health and personal integrity. They must also take measures to investigate, punish, and remedy such violations when they occur.

Within the European human rights framework, obstetric violence cases, particularly non-consented care, were adjudicated as early as 2011 in *VC v SLOVAKIA*, where the Roma applicant was coerced into a tubal ligation. The European Court of Human Rights ruled that forced sterilisation is a violation of the European Convention on Human Rights (specifically article 3, which prohibits torture or inhuman and degrading treatment, and article 8, which protects the right to private and family life). However, in its judgments, the ECtHR has failed to recognise coerced sterilisation and hospital treatment as discrimination.

Conclusion

The African Court and Commission hold significant potential to advance the cause of RMC and eliminate obstetric violence in Africa. Through their respective mandates, these institutions can develop binding jurisprudence and influential standards that promote women's rights and hold states accountable for their obligations in this regard.

While the Commission has yet to directly address cases of maternal mortality, its jurisprudence on related human rights issues, such as the right to health and the prohibition of torture, can provide invaluable guidance and precedents. The African Commission, with its focus on the promotion and protection of human rights, can play a crucial role in raising awareness, advocating for policy reforms, and fostering regional cooperation to address the challenges of RMC. It would be timely for the Commission to adopt a resolution to conduct a continent-wide study on RMC and subsequently draft and adopt a general comment on the subject that provides further guidance and promotes accountability. The African human rights system has a major role to play in contributing to a just and more equitable healthcare system that ensures the safety and dignity of pregnant persons and newborns across the continent.

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FEATURE

Do We Really Care if We Don't Invest Our Resources? Period Poverty and the Right to Education of Female Children in Uganda

Kansiime Mukama Taremwa

Introduction

Uganda ratified the United Nations Convention on the Rights of the Child (CRC) in 1990. To meet the commitments under the CRC, Uganda's Constitution in Article 34 provides for children's rights, including the right to basic education. Several laws operationalise the enjoyment of children's right to education, among them the Children's Act of 2016 and the Education (Pre-Primary, Primary and Post-Primary) Act of 2008. In 1997 and 2007, respectively, Uganda also rolled out the Universal Primary Education (UPE) and Universal Secondary Education (USE) policies as part of its steps to progressively realise the right to education under international human rights law, particularly the CRC.

The state's obligations regarding the CRC must be fulfilled in the context of the fundamental principles in the CRC, which are non-discrimination, the best interests of the child, the right to life, survival, and development, and considering the child's views.

It is impossible to discuss the right to education without contextualising the unique place of girls in the education ecosystem. There are challenges that girls face within the cycle of education that make access to education difficult. In this paper, we shall cast light on the issue of menstrual health and how it impacts the right to education for female children in Uganda.

Obligations under article 28 of the CRC

Article 28 of the CRC recognises the right to education and enjoins the state to progressively realise it by making primary education compulsory and freely available to all. Article 28 also seeks to ensure that the state encourages different forms of secondary education, including vocational education. Finally, it enjoins the state to take measures to encourage regular attendance at school and reduce drop-out rates.

When girls are on their period, the rate of absenteeism is at 28 per cent compared to 7 per cent when not on their period.

Rights under article 28 of the CRC mirror the content of the right to education as captured under article 13 of the International Covenant in Economic, Social, and Cultural Rights (CESCR). The CRC expands the scope of article 13 of the ICESCR by adding obligations to encourage school attendance. In terms of the CESCR, the state is required to take specific, targeted and measured legislative, policy and administrative steps to ensure that the rights under the CESCR are progressively realised.

While the right to education is to be realised progressively, the Committee on Economic, Social and Cultural Rights has indicated in its General Comment No. 13 that the state has minimum core obligations that are of an immediate nature. Generally, the overarching obligations are to ensure that the right to education is enjoyed in a non-discriminatory manner and that the state take steps to progressively realise the right.

For a state to sustain the justification that it has not been able to meet even its minimum core obligations, it must demonstrate that every effort has been made to use all resources that are at its disposal to satisfy, as a matter of priority, those minimum obligations. As for article 28 of the CRC, the minimum core obligations of the state are to ensure non-discrimination in access to education and the availability of free compulsory primary education. The state should demonstrate that budget allocations are sufficiently directed to the performance of the said obligations.

Uganda has undertaken legislative and policy interventions to progressively realise the right to education as enshrined under article 28 of the CRC. The Constitution of Uganda in article 30 provides for the right to education for all persons. Article 34(2) of the right to education provides for the right of every child to basic education. This right to basic education is implicit too in section 3 of the Children's Act, which requires that, in ascertaining the best interests of the child, regard must be had to, among other things, the child's educational needs. Section 4 of the Children's Act also provides that children have the right to access basic social services. Basic education is considered refers to primary education and lower secondary education.

In Uganda, the emphasis has been on providing universal primary and secondary education. According to Tamusuza (2011: 12), this has allowed many children to go to school, as the UPE programme underscores gender equality. Under the Education Act, the government has been charged primarily with ensuring that trained teachers are deployed, paying salaries and allowances to teachers, and providing educational materials and other capital development inputs.

Uganda has made considerable gains, increasing school enrolment by 100 per cent. However, no evidence exists that this has necessarily led to greater educational attainment. This finding is more prevalent amongst girls since 'being male corresponds to greater years of primary school' (Kan & Klasen 2019: 17). Despite the growing enrolment, girls are still exposed to higher chances of not completing their primary school years. A deeper analysis of the situation reveals that there are impediments to achieving gender parity, which would significantly improve educational attainment. One of the impediments is the period-poverty crisis.

The period-poverty crisis in Uganda's education system

Period poverty is a lack of access to a safe means of managing menstruation. A quarter of girls between the age of 12–18 years drop out of school when they begin menstruation. When girls are on their period, the rate of absenteeism is at 28 per cent compared to 7 per cent when not on their period. Worse still, a package of pads in Uganda costs at least $2 and above, yet there is no initiative by the government to significantly subsidise this or make it free for school-going children.

Uganda is not qualitatively eradicating gender inequalities associated with period poverty in the context of compulsory free education. This has exacerbated inequalities based on gender because school-going girls end up missing school due to menstruation, a situation that boys do not encounter. It has also amplified inequalities based on economic standing, as a majority of school-going girls who suffer the scourge of period poverty are from rural areas.

Legislative and budgetary initiatives are linked to increased accessibility to menstrual products and, consequently, access to education.

The right to education entails that education should be available, accessible, acceptable and adaptable. If period poverty due to poor or absent sanitation facilities affects the menstrual health of school-going girls, thus impeding their ability to attend school, it cannot be said that education is available or accessible to them. These trends perpetuate inequality as they amplify pre-existing structural differentiating factors that reek of discrimination.

While the government may argue that it is severely constrained, it has not demonstrated that it has its priorities straight. For instance, in the 2024/25 budget cycle, it allocated a total of 10.204 trillion Uganda shillings to sectors such as education, health, and water, sanitation and hygiene. By contrast, governance and security, which constitute the coercive state machinery that maintains President Yoweri Museveni's hold on power, were allocated 9.107 trillion Uganda shillings. For closer context, the Ministry of Defence was allocated a total of 3.880 trillion Uganda shillings ($1.029 billion) as opposed to 975.534 billion Uganda shillings ($258.9 million) (Kidamba 2024). Nothing in the budget even remotely addresses the issue of funding for menstrual health programmes.

In previous years, matters such as water, sanitation, and hygiene (WASH), which play a major role in combating period poverty, have received less than 5 per cent of the national budget (UNICEF & WHO 2024: 8). In the 2023/24 budget cycle, UNICEF found that while education remained among the top four priorities of the budget, the proportion of the budget allotted to the pre-primary and primary education sub-sector declined from 51 per cent to 34 per cent between 2017/18 and 2021/22 (UNICEF 2023: 4).

Commendably, Uganda has, through its policy directions, succeeded in bringing the conversation on menstruation out of the realm of secrecy and shame. In 2020, the Ministry of Education came up with a Menstrual Health Management manual in conjunction with Plan International. In the same initiative, training was conducted in teacher-training institutions and within local communities to curb the stigma surrounding menstruation.

Uganda, nevertheless, continues to avoid taking bold budgetary and tax actions. Budget allocations to the education sub-sector remain way below the expected international standard of 20 per cent of the total budget. Uganda still allocates merely a paltry 8.4 per cent to the education sector.

Legislative and budgetary initiatives are linked to increased accessibility to menstrual products and, consequently, access to education. In 2021, Scotland passed a law, the Period Products (Free Provision) (Scotland) Act 2021, in which it made provision for access to free menstrual products in schools. This law was based on a survey which found that 84 per cent of people who had access to free menstrual products were able to go on with their day-to-day activities, including school attendance (UNICEF & WHO 2024: 67).

Uganda, by contrast, has been preoccupied with sectors such as governance, security, energy, and transport. While these sectors, especially energy and transport, are direct enablers of access to education, interventions in these sectors usually come from foreign debt. Increased public debt strains the budget to the extent of having an adverse effect on other social sectors (Muhawe 2019: 6, 8). Worse still, most of these debts are financed by Chinese loans, the agreements for which remain shrouded in mystery and opaque to accountability to citizens.

The government, for some unknown reason, maintains a tax on sanitary pads, even though senior officials have been mentioning since 2017, and again most recently in March 2024, that there are plans to scrap it. This lack of decisive commitment does not lend credence to any

notions that the government is interested in the plight of school-going girls.

Indeed, efforts to combat period poverty have been abandoned to global and domestic civil society and the goodwill of a few individuals. That is no way to assure the future of the country's women. Moreover, as a result, the state becomes complicit in the country's massive levels of school drop-out, as it does in the associated consequences such as child marriages, teenage pregnancies, and the entrenchment of inequality.

Uganda can do more – a lot more

Nothing shows that we believe in the dreams of our young people like investing our resources in these dreams. The Ugandan government must take decisive budgetary action. Period poverty is a budget issue, and Uganda needs to pay attention to gender-responsive budgeting.

The United Nations Educational, Scientific and Cultural Organisation (UNESCO) defines gender-responsive budgeting as a means of integrating a gender perspective in all steps of the budget process — planning, drafting, implementing, and evaluating — to ensure that budget policies take into consideration the gender issues in society.

A good example of this close to home is Kenya, which removed taxes on sanitary pads and raw materials used in their manufacture. Uganda may benefit from benchmarking with Kenya on this issue, as well as with other countries, such as Scotland, which have made bold moves in this direction.

Another budgeting issue is spending resources on combating stigma around menstruation. Governments must invest in cost-effective information campaigns that raise awareness of the normal nature of menstruation in society, especially in the context of schools. Efforts to remove the stigma around menstruation must be bold, deliberate and financially supported.

These information campaigns should include training public officials on addressing menstrual health issues. In the past, high-level government officials have clashed with activists involved in providing reusable menstrual pads rather than supporting their initiatives. Part of the state's minimum core obligations is the obligation to respect, which entails not interfering with the rights of people. Misinformed views on re-usable pads reinforce stigma associated with menstruation and detract from the initiatives of those doing what the state has failed to do for so many years. The state should not fight those who are doing the job despite their modest means.

The integration of menstrual health management into the mainstream curriculum should be done by the Ministry of Education. It should not just do this as an extracurricular item; moreover, these lessons should not only focus on the biology of menstruation but integrate lived experiences. These lessons should include boys so as to enable them to be agents of change against menstrual-related stigma.

Efforts to remove the stigma around menstruation must be bold, deliberate and financially supported.

Uganda needs to innovate around its budgeting priorities and provide solutions for school-going girls when it comes to period poverty. For instance, one of the country's priorities is infrastructural projects. Public-private partnerships can be used to set up sanitation facilities for communities where large infrastructural projects are being conducted as part of the corporate social responsibility required of corporate entities. The partnerships can also be used to allocate portions of money meant for these projects into locally championed initiatives focused on combating period poverty in the host communities of large infrastructural projects.

The government could also tag certain funds in security and defence budgets to anti-stigma campaigns targeting period poverty. The security forces could support community initiatives through corporate social responsibility initiatives targeted at combating period poverty as part of their large budgets. Menstrual health needs to be mainstreamed even within defence and security planning, for instance by making targeted investments in military families as well as in educational facilities for the school going children of military servicemen and -women.
Some militaries in the world take centre-stage in averting crises that are premised on stigma, such as mental health stigma. However, these interventions are usually restricted to those within the military and their families. Compelling evidence suggests that militaries can be used in a transformative manner. This is why militaries are usually enlisted to assist in times of crisis and emergency. In this case, the military would be required not only to provide its human resources but also to commit part of its large budget to corporate social responsibility efforts to combat menstrual stigma.

We must caution, however, that in Uganda's case, there is a need to be cautious about the military's involvement in public affairs, as it is often used to assert the interests of the ruling regime and not necessarily to provide community transformation. There is the danger of normalising militarisation. The antidote would be to bring in the military as an entity subordinate to civilian authority. This might be a stretch, but we should leave no stone unturned in finding opportunities to better the fortunes of school-going girls in Uganda.

Uganda also needs to adopt policies and laws that integrate efforts to combat period poverty. Policies and laws that make schools, workplaces, and public institutions supportive of managing menstruation with comfort and dignity must be prioritised. These would have a ripple-effect on society – it is not in doubt that the opinions of elites in society shape the trajectory of societal opinion through literature and the arts.

For example, it would have a positive effect if workplaces granted menstrual leave to employees on request. It would send a strong message to children if they saw that their parents can have leave days due to their period and thus not hide the fact of menstruation but enjoy comfort and dignity.
Likewise, the government and other stakeholders should invest in campaigns in which the nation's icons in the arts and entertainment show support for combating period poverty. Uganda has always done well with these when it comes to drawing attention to public health concerns. Such campaigns have been used to rally citizen cooperation on issues such as HIV/AIDS prevention and the use of antiretrovirals, as well as vaccinations against hepatitis, COVID-19, and others. Nothing in the literature seems to speak to the existence of campaigns championed by a country's top talents on issues of menstrual health in the context of school-going girls. However, leveraging the arts has the potential to normalise what is wrongly perceived as a culturally abnormal conversation and give it a place of importance in national discourse.

Conclusion

While Uganda must be commended for its efforts to make basic education universally available and free, its efforts are undermined by the scourge of period poverty. Unless and until the government centres this conversation as part of its budgetary and tax planning, education will never be fully accessible to all school-going girls. Education will become a psychosocial burden for them if they cannot attend school because of a natural phenomenon; it will be a burden for them if they cannot access water and sanitation facilities in school because there is no gender-responsiveness in budgeting for such.

Free education thus remains a myth if school-going girls cannot access safe means to manage menstruation. If we treasure the future of our nation, a future which is impossible without the future of our girls, we must put our money where our dreams are. Period poverty is a budget issue, and if the government cares, it will reevaluate its budget priorities.

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FEATURE

Barriers to Sexual and Reproductive Health Rights and Education in Cameroon: What Way Forward?

Wazeh Nicoline Nwenushi Tumasang

Introduction

Sexual and reproductive health and rights (SRHR) are aspects of human rights recognised globally as essential for individual autonomy and the well-being of communities. In Cameroon, these rights face significant challenges, with numerous obstacles limiting access to SRHR services and quality education. The country's diverse socio-political landscape – marked by deeply rooted patriarchal norms, humanitarian challenges, and weak governance structures – creates a difficult environment for SRHR advancement.

Cameroon is bound by a range of international, regional, and national commitments that aim to enhance SRHR, including the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Maputo Protocol, the UNSCR 1325 on Women, Peace and Security (2000), and the Sustainable Development Goals (SDGs). However, implementing these frameworks has been slow and fragmentary, primarily due to cultural resistance, legal barriers, corruption, and a lack of political will.

This article explores the legal, cultural, and socio-political barriers to SRHR and education in Cameroon. It assesses the role of civil society organisations (CSOs), faith-based organisations, and funding institutions in overcoming these challenges and how the latter are compounded by humanitarian factors such as climate change, armed conflict, and forced displacement. In analysing these issues, the article proposes strategies for improving SRHR outcomes.

Legal and policy frameworks for SRHR in Cameroon

International and regional instruments

Cameroon is a signatory to several international and regional treaties that promote SRHR and gender equality.

- Notably, it ratified CEDAW in 1994, which obligates the government to eliminate gender-based discrimination and ensure women's access to health services, including reproductive health care.

- The UNSCR 1325 on Women, Peace and Security highlights the importance of considering women and girls' special needs and human rights in conflict situations, including sexual and reproductive health services.

Corruption exacerbates already severe funding shortages in the health sector, leaving many health facilities without the resources needed to provide SRHR services.

- The Maputo Protocol, ratified by Cameroon in 2009, recognises the importance of reproductive rights, including the right to safe abortion in cases of sexual assault, rape, incest, or when the health of the mother or foetus is at risk (article 14(2)(c) XIV 2, C).

The instruments also call for increased access to comprehensive sexuality education (CSE) and family planning services.

However, despite these commitments, the United Nations Population Fund (UNFPA) (2024) has reported that the implementation of these frameworks remains weak, with SRHR services often inaccessible in rural and conflict-affected regions. Cameroon's legal environment also remains restrictive concerning abortion and access to contraception is limited by cultural and religious opposition.

National policies

At the national level, Cameroon has adopted policies for improving access to SRH services. The Cameroon Health Sector Strategy 2016–2027 emphasises the importance of reproductive health and the need to reduce maternal and child mortality. This policy also highlights the importance of addressing gender-based violence and harmful traditional practices such as female genital mutilation (FGM), which is still prevalent in parts of the country.

The Penal Code in Cameroon includes provisions criminalising harmful practices such as FGM, yet enforcement of these laws remains inconsistent. The Cameroon Health Sector Strategy 2016–2027 sets ambitious targets for improving health infrastructure and expanding access to reproductive health services, but funding constraints and corruption undermine its implementation. The government has made some progress in improving maternal health outcomes, but significant gaps remain, particularly in rural areas where access to health care is severely limited due to poor infrastructure and security concerns.

Key barriers to SRHR and education

Legal restrictions

One of the most significant barriers to SRHR in Cameroon is the restrictive legal framework on reproductive rights. Under Cameroon's Penal Code, abortion is criminalised except in cases of rape or when the mother's life is in danger (sections 337 and 339). Even in these circumstances, accessing safe abortion services is often difficult due to bureaucratic delays, stigma, and the reluctance of health-care providers to perform the procedure.

A report by the Guttmacher Institute (2019) found that unsafe abortions are a major contributor to maternal mortality in Cameroon, accounting for more than 36 per cent of maternal deaths. The report highlighted that restrictive laws push many women to seek unsafe abortion services, often provided by untrained practitioners in unsanitary conditions. This contributes to high rates of complications such as sepsis, haemorrhage, and infertility.

In addition to restrictive abortion laws, access to contraception is limited, particularly for unmarried women and adolescents. Cultural and religious opposition to contraception, combined with a lack of education on reproductive health, means that many women do not have the information or means to prevent unintended pregnancies. According to the Cameroon Demographic and Health Survey (2018), only 23 per cent of married women use modern contraceptive methods, while the unmet need for family planning stands at 20 per cent. These legal restrictions also compound the unique challenges faced by LGBTQIA+ individuals and organisations in advocating for their rights.

Cameroon's legal environment also remains restrictive concerning abortion and access to contraception is limited by cultural and religious opposition.

Cultural and religious barriers

One of the most significant barriers to SRHR in Cameroon is the restrictive legal framework on reproductive rights. Under Cameroon's Penal Code, abortion is criminalised except in cases of rape or when the mother's life is in danger (sections 337 and 339). Even in these circumstances, accessing safe abortion services is often difficult due to bureaucratic delays, stigma, and the reluctance of heal

Cultural and religious norms play a significant role in shaping attitudes toward SRHR in Cameroon. The country is deeply influenced by religious institutions, particularly Christianity and Islam, which often hold conservative views on reproductive rights. Religious leaders influence public opinion, particularly in rural areas, where traditional values are strongly upheld.

In some regions, particularly in the Far North, Imams discourage the use of contraceptives, citing religious doctrine that promotes large families. Similarly, some Christian denominations, particularly Catholic and evangelical churches, oppose contraception and CSE. This religious resistance poses significant challenges to implementing SRHR policies and programmes.

A 2017 study by the Centre for Reproductive Rights found that more than 50 per cent of religious leaders in Cameroon opposed the introduction of CSE in schools, arguing that it would promote immorality and promiscuity among young people. As a result, many schools do not offer CSE, leaving young people uninformed about their reproductive health and rights.

At the same time, cultural norms that value large families and male dominance in decision-making further limit women's ability to access SRHR services. In many communities, women have to seek permission from their husbands or male relatives before accessing health care, including contraception and maternal health services. This patriarchal system restricts women's autonomy and reinforces harmful gender stereotypes that devalue women's health and well-being.

> **These legal restrictions also compound the unique challenges faced by LGBTQIA+ individuals and organisations in advocating for their rights.**

Corruption and governance

Corruption remains a significant challenge in Cameroon's health and education sectors. Transparency International ranked Cameroon 142nd out of 180 countries in its 2022 Corruption Perceptions Index, indicating a high level of perceived corruption. Funds allocated for health care and SRHR services are often siphoned off by corrupt officials, leaving health facilities under-resourced and unable to provide adequate care.

In the health sector, corruption manifests in various forms, including the misappropriation of funds meant for maternal and child health programmes, the illegal sale of medication meant to be free for patients, and the diversion of medical supplies to the black market. Such corruption exacerbates already severe funding shortages in the health sector, leaving many health facilities without the resources needed to provide SRHR services.

Corruption also affects education, with reports of bribery in school admissions and diversion of funds meant for educational infrastructure. As a result, many schools, particularly in rural and conflict-affected regions, are severely underfunded. This lack of resources compromises the quality of education, limits the availability of teachers, and prevents the effective implementation of CSE programmes. Moreover, the mismanagement of resources allocated for SRHR services undermines efforts to improve healthcare infrastructure and access to essential reproductive health services.

Humanitarian challenges: Armed conflict, climate change, and forced displacement

The interconnected crises of armed conflict, climate change, and forced displacement represent significant humanitarian challenges to realising SRHR in Cameroon.

The Boko Haram insurgency in the northern regions and the anglophone crisis in the northwest and southwest regions have led to large-scale displacement, with more than 800,000 internally displaced persons (IDPs) as of 2022. These crises destabilise health-care systems, reducing access to essential services, including reproductive health care, maternal health, and contraception.

Women and girls are particularly vulnerable, facing heightened risks of sexual and gender-based violence, unintended pregnancies, and unsafe abortions in displacement camps and conflict zones, where health infrastructure is either destroyed, disrupted or inaccessible.

Additionally, climate change exacerbates these challenges, particularly in northern Cameroon, where droughts, erratic rainfall, and the shrinking size of Lake Chad force communities to migrate, further straining limited resources. Women in these regions often suffer disproportionately, with restricted access to SRHR services in overcrowded, under-resourced camps and health centres, leading to poor maternal outcomes and increased rates of sexually transmitted infections.

Addressing these humanitarian challenges requires an integrated approach that builds climate-resilient health systems, prioritises SRHR in humanitarian aid, and ensures that reproductive health services are accessible to displaced populations.

Climate change, as noted, has emerged as a significant challenge in Cameroon, exacerbating vulnerabilities and displacing communities, particularly in the northern regions. The Lake Chad Basin, which includes northern Cameroon, has been heavily impacted by climate change, with rising temperatures, erratic rainfall patterns, and the shrinking of Lake Chad affecting livelihoods, particularly of those dependent on agriculture and fishing.

As communities lose their sources of income due to climate-induced changes, women and girls are disproportionately affected. Many are forced to migrate to urban areas or refugee camps, where access to healthcare services, including SRHR, is severely limited. According to the International Organization for Migration (IOM), more than 60,000 people are displaced annually due to climate-related disasters in northern Cameroon. These displaced populations face additional challenges, such as food insecurity, limited access to clean water, and overcrowded living conditions, negatively impacting SRHR outcomes.

Women and girls in displacement camps are particularly vulnerable to sexual and gender-based violence, with limited access to health services, including maternal care and contraception. The disruption of health services in these regions further limits access to reproductive health care, exacerbating the risks of maternal mortality, unintended pregnancies, and sexually transmitted infections. Addressing these issues requires a concerted effort to build climate-resilient health systems and ensure that SRHR services are available to displaced populations.

> **“Strengthening partnerships between the government, civil society, and faith-based institutions will also be crucial to changing harmful cultural norms and expanding access to SRHR services.**

The role of civil society organisations

Addressing SRHR gaps

CSOs have been instrumental in filling gaps left by the government and addressing the challenges to SRHR and education in Cameroon. Organisations such as Pathways for Women's Empowerment and Development (PaWED-IATC), Hopes Advocate Africa (HADA), and Network of Aunties for the Empowerment of Adolescent Mothers (RENATA) have been at the forefront of advocacy efforts to improve access to SRHR services, particularly for women and girls in marginalised communities and conflict-affected areas. In addition to conducting advocacy, CSOs play a critical role in service delivery. Many provide direct health-care services, including contraception, maternal care, and post-abortion care, in regions where government services are limited or non-existent. They also work to raise awareness about SRHR issues, educate communities about reproductive health, and challenge harmful cultural norms that limit women's autonomy.

Funding institutions

Several international funding institutions support SRHR and educational initiatives in Cameroon. The UNFPA has been a key player in promoting reproductive health services in the country, particularly in conflict-affected regions. The Global Fund for Women provides flexible and equitable funding to CSOs engaged in SRHR, especially advocacy for free and safe abortion; it has also been pivotal in funding health programmes in Cameroon, particularly in the areas of HIV/AIDS, malaria, and tuberculosis.

Other organisations such as Amplify Change, Open Society, and Her Voice Fund have also been instrumental. Likewise, the World Bank has provided financial and technical support for education initiatives in Cameroon, particularly those aimed at improving access to education for girls. Through its Global Partnership for Education, it has funded programmes that aim to reduce gender disparities in education and increase the enrolment and retention of girls in school. This support is critical, as education is a key factor in improving SRHR outcomes, with educated women more likely than others to access reproductive health services and make informed decisions about their health.

The role of faith-based and cultural institutions

Resistance to SRHR

Faith-based institutions in Cameroon wield significant influence, particularly in rural areas, where religious leaders play a central role in community life. However, many of these institutions have been resistant to SRHR initiatives, particularly those related to contraception and CSE.

The Catholic Church, which is the dominant religious institution in many parts of Cameroon, opposes the use of contraception and views abortion as morally unacceptable under any circumstances. This stance has had a significant impact on public policy and the availability of reproductive health services, particularly in regions where the Church wields considerable influence.

In the Far North, some Islamic leaders oppose certain SRH services, particularly contraception, which they argue contradicts religious teachings that promote large families. This resistance complicates efforts to promote family planning and reduce maternal and child mortality in these regions. According to a 2017 study by the Centre for Reproductive Rights, many faith-based leaders in Cameroon believe that promoting CSE in schools encourages promiscuity, which has further limited the implementation of SRHR programmes targeting young people.

Positive contributions

Despite this resistance, some religious institutions have begun to engage with SRHR issues in a more constructive way. For instance, the Catholic Church has been active in providing maternal care services through its network of health centres, particularly in rural areas. In some cases, religious leaders have

partnered with CSOs to promote maternal health, particularly around issues like birth spacing, which can help reduce maternal mortality rates.

Moreover, certain religious groups have been receptive to programmes aimed at reducing gender-based violence and child marriage. By engaging with faith-based institutions and incorporating religious perspectives into SRHR programming, there is potential to shift attitudes and promote a more supportive environment for reproductive health rights in Cameroon.

Challenges and the way forward

Strengthening legal reforms

Legal reforms are critical to advancing SRHR in Cameroon. The current legal framework, particularly around abortion and contraception, needs to be harmonised with international and regional commitments, such as the Maputo Protocol. Advocacy groups, CSOs, and international bodies like the African Commission on Human and Peoples' Rights, and United Nations Human Rights Council (UNHRC) during Universal Periodic Reviews (UPR) have called on the government to expand access to reproductive health services, including safe abortion, and remove legal barriers that restrict access to contraception, particularly for adolescents and unmarried women.

These legal reforms should also address issues of gender-based violence, ensuring that survivors have access to justice and healthcare services, including post-rape care and psychological support. While some progress has been made in criminalising harmful practices such as FGM, enforcement remains weak, and more needs to be done to hold perpetrators accountable and protect women and girls from violence.

Conflict resolution and humanitarian aid

Efforts to resolve the ongoing conflicts in the northern and anglophone regions must prioritise the health and education of women and girls. International organisations, including the United Nations, the African Union, and the Economic Community of Central African States (ECCAS), should continue to pressure the Cameroonian government to engage in dialogue and seek a peaceful resolution to the anglophone crisis.
In the meantime, humanitarian aid should focus on rebuilding health and education infrastructure in conflict-affected areas. Programmes that provide mobile health clinics, reproductive health services, and education in displacement camps can help mitigate the impact of conflict on SRHR outcomes.

Enhancing SRHR education

CSE is a key component of improving SRHR outcomes, yet it remains controversial in Cameroon due to cultural and religious opposition. However, evidence from other countries shows that CSE can help reduce rates of unintended pregnancy, HIV transmission, and gender-based violence, particularly among adolescents.
To enhance SRHR education, the government should work with CSOs, educators, and religious leaders to develop culturally sensitive CSE programmes that respect local values while providing young people with the information they need in order to make informed decisions about their health.

Climate-resilient health systems

Given the impact of climate change on health systems in northern Cameroon, there is a need for climate-resilient health infrastructure. This includes building health facilities that can withstand extreme weather conditions, training healthcare workers to respond to the unique needs of displaced populations and ensuring that SRHR services are integrated into emergency response programmes.

> **CSE is a key component of improving SRHR outcomes, yet it remains controversial in Cameroon due to cultural and religious opposition.**

Conclusion

The realisation of SRHR and education in Cameroon remains a significant challenge, hindered by legal restrictions, armed conflict, cultural and religious opposition, corruption, and climate change. While international and regional frameworks provide a strong foundation, their implementation has been inconsistent, and significant gaps remain in access to services.

Women and girls, in particular, thus face substantial barriers, including restrictive abortion laws, limited access to contraception, gender-based violence, and a lack of CSE. Armed conflicts, particularly in the northern and anglophone regions, have exacerbated these challenges, displacing hundreds of thousands of people and further weakening health and education systems.

Despite these obstacles, there are opportunities for progress. CSOs have played a critical role in filling gaps left by the government, providing vital services and advocating for the rights of women and girls. Funding institutions, including UNFPA, Global Fund for Women, Amplify Change, the Global Fund, the World Bank and others, have provided essential resources to improve health and education infrastructure, though corruption and governance issues continue to undermine these efforts.

Moving forward, a multi-pronged approach is necessary to overcome the barriers to SRHR in Cameroon. Legal reforms should be prioritised to expand access to reproductive health services, while efforts to resolve the ongoing conflicts must address the health and education needs of women and girls. Strengthening partnerships between the government, civil society, and faith-based institutions will also be crucial to changing harmful cultural norms and expanding access to SRHR services. Furthermore, building climate-resilient health systems will be essential in addressing the challenges posed by climate change and forced displacement.
By addressing these issues holistically, Cameroon can make significant strides toward ensuring universal access to SRHR and education for all.

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POLICY REVIEW

Zimbabwe's Legal and Policy Framework on Women's Access to Family Planning Information During Emergencies

Patience Ndlovu

Introduction

Zimbabwe has been inundated over the years by diseases like cholera, dysentery and typhoid, natural disasters like Cyclone Idai (2019), and, in 2020, the Covid-19 pandemic. During these and other humanitarian emergencies, women's ability to access family-planning information and services has been impaired – and a contributing factor is the country's legal and policy framework.

Zimbabwe is taking too long to enact a legal and policy framework whose gender dimensions are responsive to women's needs to access to family-planning information, thus jeopardising access to a broader range of sexual and reproductive health rights (SRHR) at the most critical of times.

The right to family planning

The right to family planning entails that individuals and couples have the information and latitude necessary to choose their desired number of children and the spacing and timing of these births (WHO 2009). Family planning information should be provided in a manner consistent with the needs of the individual and the community, considering age, gender, language ability, educational level, disability, sexual orientation, gender identity, and intersex status. It follows, then, that access to reproductive information and services is crucial, especially during emergencies, which are times when social structures are broken (Chatiza 2019).

International and Regional norms and standards on the right to family planning

Accordingly, an enabling legal and policy framework should be in place to ensure that women and adolescents in particular, the main groups disproportionately affected by disasters, are able to access family-planning information as a tool crucial for self-determination and economic empowerment. This is so because agency and autonomy are connected to women's health, well-being and dignity.

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa ('African Women's Protocol') in article 12(2) enjoins states to promote literacy among women and girls, a provision which one can interpret to include reproductive rights education. Article 14(f) of the African Women's Protocol provides for women's right to family-planning education.

Similarly, CESCR General Comment No. 22 enjoins states to provide complete and accurate information which is vital for the respect, promotion, protection and enjoyment of health. States are required to ensure that service providers receive training so that they are capacitated with full, accurate family-planning information. Furthermore, there is a need to ensure the availability, accessibility, acceptability, and reliability of the said family information and services. Competent institutions should be mandated to provide reproductive health information and services to different population groups, including women and girls with disabilities.

General Comment No. 22 describes the right to reproductive information as a bedrock needed for the enjoyment of other rights since when women are well informed about their reproductive health, they are likely to be able to make better choices about other aspects of their lives.

Furthermore, the African Commission on Human and Peoples' Rights (ACHPR) stresses the importance of family-planning information and education – this should encompass knowledge about one's HIV status as well as that of one's partner. Family planning information for women in humanitarian contexts must be dispensed in line with the guidance in the Maputo Plan of Action and articles 2 and 5 of the African Women's Protocol. SDGs Target 3:7 on health requires that, by 2030, governments should have ensured universal access to sexual and reproductive healthcare services, including family-planning information and education.

Humanitarian emergencies and Zimbabwe's legal and policy framework on family planning, information and services

The Constitution of Zimbabwe provides for the right to basic healthcare services, including reproductive health care. Section 62(1) of the Constitution guarantees the right to information from anyone (including the state) to exercise or protect a right, thereby providing the basis for access to family-planning information.

Women's access to family-planning information on an equal basis with men is enunciated by CEDAW Committee General Recommendation No. 21, article 16(e). Furthermore, in the case of adolescents, article 13(1) of the Convention on the Rights of the Child (CRC) guarantees young people the right to seek, receive and impart information of all kinds, implying that SRHR information falls within the scope of this right. Adolescents, therefore, have the same right to control their bodies as adults do and need to receive reproductive information, counselling and a full range of goods and services. Access to family-planning education and services is also echoed in article 24(1)(f) of the CRC.

The key disaster-response statute in Zimbabwe is the Civil Protection Act (CPA) Chapter (10:06) of 1989 whose usefulness may have been long overtaken by many developments and the upsurge of humanitarian emergencies in the country. The CPA provides civil protection services and establishes funds and operational structures, but it is silent on the apportionment of resources to ensure that women can access family planning or other reproductive health goods and services during disasters.

Commendably, the CPA mandates the civil protection officer to maintain specified stocks of water, fuel, food or medical supplies for use during the state of disaster, thereby recognising the importance of the social determinants of SRHR. The interconnectedness of social determinants and family planning is also recognised in obligations on the state to respect, protect, promote and fulfil human rights. It is the state's obligation to ensure that during disasters, underlying and social determinants such as access to safe and potable water, adequate sanitation, adequate food and nutrition, adequate housing, and health-related education and information are availed to the affected populations.

The margin by which the poorest population of a country can access the right to sexual and reproductive health is likely to inform us about the prevailing societal

inequalities in that country. Societal inequalities are reflected through unequal power distribution, income inequalities, poverty among other issues. Zimbabwe's population is largely rural (more than half of it (52 percent are female and 68 percent of the population live in rural areas) (ZIMSTAT,2017). Although rural women make up a substantial part of Zimbabwe's population, they are disproportionately affected by lack of access to family planning information and services due to poor service delivery in rural areas, underdevelopment, discrimination and pressure to submit to harmful social norms and cultural practices which exacerbate violation of their rights (NDLOVU 2024).

Recommendations on improving women's access to family planning information and services

There is a need for the law to recognise the multiple layers of discrimination that present obstacles to women's quest to access family-planning information during emergencies. The Centre for Reproductive Rights has elaborated on barriers that inhibit access to reproductive health information and services for rural women – barriers that are intensified in emergency situations. Reproductive health, as a cornerstone of other rights, must be given prominence in the laws that govern disaster risk management. Furthermore, the law should specify how the state and its agents should ensure the availability, accessibility, acceptability and quality of family-planning information and services dispensed during disasters.

In this regard, the Committee on the Elimination of Discrimination Against Women (CEDAW) in its concluding observations on Zimbabwe's sixth periodic report pointed out the silence on gender components in climate-related policies given the disproportionately adverse impacts of cyclones and floods on women and girls. A gender perspective in laws and policies would entail that laws and policies spell out women and girls' participation in decision-making during the making of laws as well as in structures of disaster response. Chatiza, 2019) notes that in the case of Cyclone Idai in Zimbabwe, key structures in the disaster management continuum were male-dominated and thus risked overlooking and failing to respond effectively to women and girls' issues, in particular reproductive health issues.

Furthermore, Zimbabwe has been urged by the CEDAW's concluding observations on the 6th periodic review to strengthen efforts to adopt comprehensive gender-responsive and disability-inclusive approaches to developing and implementing climate change and disaster risk reduction policies. These recommendations arise mainly because current legislation is inadequate for enabling women's access to reproductive information and other services during humanitarian emergencies. While Zimbabwe's Public Health Act Chapter (15:17) provides for basic, accessible, and adequate health services, respect for fundamental human rights and freedoms, and the right to health care, as per the Constitution, it omits the gender dimensions of access to health during humanitarian emergencies called for by General Recommendation No. 37.

Country-level disaster preparedness and response plans should reflect recognition of specific reproductive needs for population groups affected by disasters.

In terms of CESCR General Comment No. 22, essential elements of SRHR family-planning information must be delivered in an acceptable format and in understandable languages to women, adolescents, persons with disabilities, and persons living with HIV. UNICEF Zimbabwe's adolescence and youth strategy 2023–2026 seeks, as one of its outputs, to meet adolescents and youth's need for comprehensive knowledge on HIV prevention, substance abuse, SRHR,

and pregnancy and its prevention, thereby recognising the pivotal value that reproductive information has for different population groups such as adolescent girls, young women, those with disabilities, and the most vulnerable. Comprehensive sexuality education is one of the strategy's interventions. Yet, while the strategy prescribes that humanitarian preparedness should integrate adolescent programming in response plans, it lacks specificity about adolescents' access to reproductive health information, especially in humanitarian emergency contexts.

The United Nations Office for Disaster Risk Reduction (UNDRR) has stated that Zimbabwe has engaged in a process to review its disaster risk-reduction legislation since 1995. Although the UNDRR reports that the processes were meant to culminate in an Emergency Preparedness and Disaster Management Act, this legislation did not come into effect. In 2023, ActionAid Zimbabwe, a local non-governmental organisation, was still calling for Zimbabwe to come up with robust disaster risk-reduction legislation. Although the Emergency Preparedness and Disaster Management Bill was tabled in Parliament, at the time of writing (2024) there has been very slow movement in enacting this legislation. Unjustifiably long delays in ensuring an enabling legal and policy environment that advances women's access to family-planning information and services during emergencies are in themselves a violation of women's rights.

The National Health Strategy of Zimbabwe (2021–2025) acknowledges the recurrence of public health emergencies and cites the attendant pressure on old and dilapidated infrastructure. Humanitarian emergencies due to climate change, cholera, typhoid and pandemics such as COVID-19 have seen a surge in demand for health services. The National Health Strategy states that dispensation of health-related information to disaster-affected populations is generalised. Thus, it may not be clear if this Strategic document informs access to family planning information and services by disaster-affected populations.

While the National Development Strategy 1 (2020–2025) entrenches disaster risk management, it does not acknowledge gender dimensions and how the government and its responsible ministries will ensure access to family planning or other reproductive services for disaster-affected populations.

The Zimbabwe National HIV and AIDS Strategic Plan (2021–2025) provides for the continued delivery of lifesaving HIV and AIDs interventions during humanitarian emergencies. Commendably, this National HIV and AIDS strategic Plan recognises the effects of floods and displacement caused by Cyclone Idai in Eastern Zimbabwe and the curtailment of the abilities of affected persons on Anti-retroviral therapy (ART) to access services under such disaster conditions. It also elaborates on how drought affects PLHIV's access to services and how economic collapse encourages risky behaviours. In such instances, it is paramount for the policy document to provide guidelines on the provision of tailored family-planning information and services as well as on how national capacity can be strengthened to cope during disasters.

There is a need for the law to recognise the multiple layers of discrimination that present obstacles to women's quest to access family-planning information during emergencies

Zimbabwe's National Family Planning Strategy (2022–2026) acknowledges the effect of humanitarian emergencies on women and children and the adverse effects on their abilities to access health care and family-planning services. The policy contains strategies for enhancing access to family-planning information and services and for improving attitudes, practices and knowledge to facilitate increased uptake of family-planning and reproductive services.

While there have been strides in incorporating family-planning information and service in some policies, there is room for further improvement. It is important for the laws and policies governing humanitarian emergencies to spell out a minimum initial service package of family-planning information and services to be provided to disaster-affected populations as informed by international standards and guidelines.

Improving the coverage of access to family-planning information by paying attention to the budgetary needs of rural populations in health and disaster-related policies would ensure that women can access lifesaving reproductive health services during times of disaster. Ensuring the availability, accessibility, acceptability and quality of reproductive information and services is paramount and should not be compromised even during disasters.

Laws and policies must be updated timeously to address the current gaps in disaster risk management in Zimbabwe. Country-level disaster preparedness and response plans should reflect recognition of specific reproductive needs for population groups affected by disasters. Thus, the possibility of conducting a country disaster risk assessment incorporating all human rights needs during disasters should be explored. Integrating the various components of SRHR in humanitarian response is advisable.

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The margin by which the poorest population of a country can access the right to sexual and reproductive health is likely to inform us about the prevailing societal inequalities.

BOOK REVIEW

The Book of WOMB

Jane Quin

Introduction

For many years in the past two decades, an organisation called Justice and Women (JAW) ran a programme on sexual rights and reproductive health with women in the deep rural area of the Mthonjaneni Local Municipality surrounding Melmoth, in the King Cetshwayo District of KwaZulu-Natal in South Africa. In 2017, women involved in this programme produced a book entitled The Book of WOMB that documents their work. 'WOMB' is an acronym for 'who owns my body'.

The Book of WOMB reports on a collective self-reflexive research project commissioned by the Joint Gender Fund of HIVOS and seeking to 'increase the knowledge base of what makes community-based locally developed gender-based violence programmes in South Africa work'. The main work of the project was based on the existing WOMB programme of JAW.

Although written primarily for themselves, the producers of the book also wanted to share what they learnt so that others could benefit from it. The construction of the book aims to supports both these functions.

The Book of WOMB is a rainbow book, meaning that the sections or chapters are presented in different colours, each with its own particular purpose. The 'green chapter' was written by the WOMB project coordinator. It focuses on the work of the WOMB programme and responds to the question, 'What has the WOMB project been doing (in response to GBV)?' The project coordinator explains as follows:

> The work of the WOMB Programme is about planning activities to be run in the community and the debriefing of the Community-Based Facilitators (CBFs) after running each of the activities about Sexual Reproductive Health and Rights ... that directly intersect[] with GBV.
> Through this project, JAW sought to disrupt cultural beliefs and practices internalised by rural women which perpetuate their vulnerability to sexual abuse. These beliefs and practices also disconnect women from their own bodies in such a way that they do not timeously access health services when they are ill.

The chapter provides detail on the programme's process, purpose and topics, and reflects on interactive mutual learning:

> We have become aware of the deep levels of mistrust amongst women as this is a community which still practices polygamy. Where women have internalised oppression and become complicit in perpetrating it. Distrust of each other deepens women's vulnerability as they cannot access sufficient support from one another to challenge issues which impact on all.

"Where women have internalised oppression and become complicit in perpetrating it.

The 'yellow chapter' was produced by the WOMB project facilitators. The introduction of this illustrated chapter gives a clear picture of the nature of the work:

> Community-based facilitators (CBFs) mobilise women in different areas with support of JAW staff. They are running modules to the community. The modules were about 'who owns my body' (WOMB) as women, and gender-based violence (GBV). They run the process in deep rural areas. Most people are uneducated and believe cultural practices and some of them are in polygamy marriages. They are under traditional leadership.
>
> Also JAW staff are based in the community and we have almost 10 years work with them about different projects. That makes it easy for the community to work with us and introduce our CBFs to them. We and the CBFs know some experiences and cultural practices that women faced.

The stories of the community-based facilitators in the 'orange chapter' provide detail on the work and learning in practice. The chapter responds to the question, 'How do we see community members' experience of GBV through the WOMB programme?' The wide range of topics deal with issues of health and sexuality from menstruation to menopause, the raising of boys and girls, gender-based violence, traditional affairs, protests, and more.

The stories are written and presented in their original language and handwriting. They are reproduced in typed text in the alternative language of English or isiZulu. They speak from the heart of the experience, as seen in these excerpts:

> The community does not believe modern health prevention methods, but they believe traditional prevention such as that if you are not ready to have a child, you must take a snail's shell and then you put what you used while you were on period and then you bury it where you will be able to find it when you are ready to have a child. What I learned here is that this community needs education.
>
> I was able to talk with women and they also listened and I see myself as a person who can be listened. If I speak more, I will be more powerful because I used to be shy and now I am not. The women were trying to prevent pregnancy but some of the methods were dangerous and not effective.
>
> When we facilitated, people heard us well and they received the message. For some, this incited sadness, one woman mentioned that she was even chased away because she would not bear children and when she had left, she met another man and they had a baby. After several years, they brought her back to the wedded household, they told her to pay a fine (culturally), and she went back. This act shows that a woman is treated as a tool that makes children and if she does not do this, she is charged, or blamed. What is painful for this woman is that her husband married another woman after she was chased away [...]

The 'blue chapter' is about the research methodology and shares the thinking behind some of the mechanisms used in the processes. There are also white- and pink-paged 'book ends' on either side of the book. While the white pages introduce the book, the pink pages contain some inspiring final reflections – for instance, 'we all own the research process, we are motivated; and I'm pleased that this documentary could be seen by my grand-grandchildren'. The pink pages also contain analytical conclusions, including the maxim that informed this project: 'Trust; Opening; Taking risks carefully'. There was also an emphasis on the 'need to keep practising this culture in the community' – pun intended.

JAW itself no longer exists in the same form as it did at the time of the making of *The Book of WOMB*. A new iteration emerged, though, a fully community-based organisation called Kwehlukile. Kwehlukile continues to offer support to women in the area, including through developing food sovereignty.

The Book of WOMB may be ordered from Ntombi Ngobese at the email address Ntombi.sanec@gmail.com on a gift-economy basis (in other words, you pay what you can and feel). All contributions of any amount help to fund Kwehlukile.

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