MONITORING REPORT
APRIL 2013

RECLAIMING & REDEFINING RIGHTS

ICPD +20:

STATUS OF SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN AFRICA

by World YWCA

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GLOSSARY

AFNET	Anti Female Genital Mutilation Network
AIDS	Acquired Immune Deficiency Syndrome
AMMD	Averting Maternal Death and Disability Programme
ANC	Antenatal Care
ARROW	Asian-Pacific Resource and Research Centre for Women
ART	Anti-Retroviral Therapy
ARV	Anti-Retrovirus
ARV/NVP	Anti-Retroviral Prophylaxis
AU	African Union
BPFA	Beijing Platform for Action
BSS	Behavioural Surveillance Surveys
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organisations
CTC	Care and Treatment Centres
DHS	Demographic Health Surveys
EmOC	Emergency Obstetric Care
FBO	Faith Based Organisations
FSW	Female Sex Workers
GBS	General Budget Support
GDI	Gender Development Index
GDP	Gross Domestic Product
GF	Global Fund
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GII	Gender Inequality Index
GRZ	Government of the Republic of Zambia
HAART	Highly Active Anti-Retroviral Therapy
HCT	HIV Care and Treatment
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HTC	HIV Testing and Counselling
IARC	International Agency for Research on Cancer
IBBSS	Integrated Biological and Behavioural Survelillance Survey
ICASA	International Conference on AIDS & STIS in Africa
ICCPR	International Covenant on Civil and Political Rights
ICPD	International Conference on Population and Development
IDU	Injecting Drug Users
IHDI	Inequality Adjusted Human Development Index-Value
IMF	International Monetary Fund
IUD	Intra-Uterine Device
KDHS	Kenya Demographic Health Survey
LGBTI	Lesbian, Gay, Bisexual and Transgender
LGBTIQ	Lesbian, Gay, Bisexual, Trans and Intersex and Questioning
MARP	Most At Risk Persons
MDGS	Millennium Development Goals
MMR	Maternal Mortality Ratio
MSM	Men Having Sex with Men
NAC	National AIDS Council
NAP	National Accelerated Plan
NDHS	Nigeria Demographic Health Survey
NGOS	Non Governmental Organisations
NHA	National Health Accounts
NWDC	National Women's Development Centre
OVC	Orphans and Vulnerable Children
PARA	Paragraph
PEPFAR	Us President's Emergency Plan for AIDS Relief
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission
POA	Programme of Action
PPP INT $	Per Capita Expenditure (Expressed in International $ as Purchasing Power Parity or Ppp)
PRAYZ	Participatory Response to HIV and AIDS for Youth in Zanzibar
RH	Reproductive Health
RHS	Reproductive Health Services
RR	Reproductive Rights
SA	Sexually Active
SADC	Southern African Development Community
SDGEA	The Solemn Declaration of Gender Equality in Africa
SIGI	Sexual Orientation and Gender Identity
SLDHS	Sierra Leone Demographic Health Survey
SR	Sexual Reproduction
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
TB	Tuberculosis
TFR	Total Fertility Rate
TW	Transport Workers
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV and AIDS
UNGASS	United Nations General Assembly Special Session on AIDS
UNICEF	United Nations Children's Fund
USD	US Dollar
VAW	Violence Against Women
VCT	Voluntary Counselling and Testing
WDC	Women's Development Centre
WFR	Wanted Fertility Rate
WHO	World Health Organisation
WORLD YWCA	Young Women Christian Association
ZAPHA+	Zanzibar Association for People Living with HIV and AIDS
ZSBS	Zambia Sexual Behaviour Survey

PREFACE

The 20 year review of the International Conference on Population and Development Programme of Action provides a unique opportunity to bring critical attention to adolescent and young people's sexual and reproductive health and rights (SRHR) in Africa. In a region where harmful traditional practices such as female genital mutilation and early marriage continue to violate the rights of girls and young women and cause lasting health consequences, it is a timely reminder that we still have a long way to go to achieve lasting and widespread change.

Covering nine countries in Africa, this report serves to highlight government progress in implementing the ICPD PoA, as well as gaps in implementation. The report provides an independent account of progress, which is critical in ensuring accountability for implementation of global commitments. It draws on the first hand experiences of YWCAs working directly with women and girls in sub-Saharan Africa to provide comprehensive SRHR information and referrals. By providing safe spaces for young women to discuss SRHR, we have been able to document some of the barriers and challenges that continue to prevent the full realisation of SRHR. This has highlighted an urgent need for improved SRHR service delivery to young people and adolescents, which is confidential, nonjudgemental and evidence based. It has also affirmed the critical importance of keeping girls in school and facilitating transitions from education to employment as key factors in enabling young women and girls to access health services.

While the report highlights that a number of countries have introduced new laws and policies, a critical gap remains in implementation and awareness of these laws. Nowhere is this more profound than the statistics on abortion, where only 3% of abortions occur in safe conditions despite increasing legal grounds for abortion. Interestingly, the response to HIV on the continent has opened up new possibilities for sex education in schools, however this is far from comprehensive and fails to reach the significant numbers of young people out of school, who are among the most vulnerable.

The report highlights gaps in existing data and the need for more comprehensive data gathering by governments to obtain a more accurate picture of implementation. It also underscores the need for increased resource commitments in line with the Maputo Protocol on SRHR, whereby African governments have committed to direct at least 15% of national budgets to health care.

The overall aim of this report is to put critical information in the hands of civil society, and particularly young women who are among the most affected by the insufficient progress in implementing the ICPD PoA. It is designed to be a tool to mobilise evidence-based advocacy and call for greater accountability of governments to regional and international commitments on SRHR. Our hope is that young women throughout Africa will use this report to provide leadership in claiming their sexual and reproductive health and rights from governments and service providers.

The World YWCA thanks all of the young women and YWCAs who contributed to data gathering and analysis in support of this report. We acknowledge Hendrica Okondo and Nelly Lukale for their leadership in coordinating and writing the report. We also acknowledge the incredible leadership and support of the Asian-Pacific Resource and Research Centre for Women (ARROW) in facilitating the ICPD+20 Global South Monitoring Initiative. This has brought African YWCAs together with other partners in the Global South in a common quest to critique progress in the ICPD PoA implementation and use this evidence base to identify key areas for continued advocacy and action. Together, we are mobilizing to ensure international commitments turn into practical action and direct change in the lives of women and girls and their ability to claim their SRHR.

Nyaradzayi Gumbonzvanda
General Secretary, World YWCA

CHAPTER 1

Introduction

WORLD YWCA ICPD +20 MONITORING PROCESS AND OUTCOMES ACROSS NINE COUNTRIES IN SUB-SAHARAN AFRICA

The World YWCA has 31 member associations in Sub-Saharan Africa, who are part of women's health and rights networks in their countries.[1]

The Global South ICPD+20 monitoring study spearheaded by ARROW brings together Global South partners from Asia and the Pacific, Africa, Middle East and North Africa, Central and Eastern Europe, Latin America and the Caribbean. The Reclaiming and Redefining Rights report has been developed by the World YWCA.

The Global South International Conference on Population and Development (ICPD) monitoring initiative was conceptualised with an idea to bring together strong evidence base through the monitoring of key sexual and reproductive health and rights (SRHR) indicators. It has aimed to bring together perspectives of different SRHR stakeholders including Non-Governmental Organisations (NGOs) working with women at the grassroots in the Global South which was facilitated by means of a questionnaire survey in eight of the nine countries. Ultimately, it seeks to bring the voices of the women and how they experience SRHR in their personal lives.

This monitoring report focuses on nine countries in Sub- Saharan Africa namely, Angola, Benin, Ethiopia, Kenya, Nigeria, Rwanda, Sierra Leone, Tanzania and Zambia. For eight of the countries excluding Nigeria, the World YWCA is implementing a programme on the SRH needs of young women in the context of HIV. Nigeria was added to the list of countries taking into account several factors such as geographical size, diversity of cultures, poor indicators on sexual and reproductive health status of women and girls in Nigeria.

The questionnaire survey was administered to key SRHR representatives from various governments, Civil Society Organisations (CSOs), Faith Based Organisations (FBOs), young women living with HIV and health workers.

HOW WERE THE INDICATORS CHOSEN?

An initial project planning meeting of all Global South partners was held at ARROW in August 2011. ARROW is a regional women's organisation with a history of monitoring ICPD. ARROW concluded a monitoring project on ICPD+15 in 2009 and had developed a proven list of rights based SRHR indicators that would assess the progress or lack of progress towards the goals of ICPD.

These indicators and the monitoring methodology were introduced to the Global South partners at the planning meeting. World YWCA took into account these indicators to arrive at the final list of indicators for monitoring ICPD+20.

World YWCA with input from YWCA member associations, their partners and 6 young women based in some of the countries, collected and analysed the 69 cross country indicators for the ICPD+20 Africa regional project.

The indicators were divided into the following components:

- Fertility and Contraception
- Maternal Health and Abortion
- Reproductive Cancers
- STI, HIV and AIDS
- Sexual Rights
- Young People's Sexual Rights

The choice of indicators were presented and agreed upon at a workshop in Ethiopia in December 2011. This was followed by e-mail and online discussions, where young women discussed their experiences, vision, strategies for advocacy, and how a regional report could help in the process.

The World YWCA team consists of Hendrica Okondo, Global Programme Manager on SRHR & HIV; Nelly Lukale, Programme Associate; and Hannah Yurkovich, short term intern from the University of Kent. Research at the country level was done by the following young women representing eight of the nine countries who verified country data:Marta Guimares (YWCA of Angola), Huguette Yakpa (YWCA of Benin), Bethel Tesfaye (YWCA of Ethiopia), Marian Okondo and Edwina Makokha (YWCA of Kenya), Celine Uwera (YWCA of Rwanda), Letticia Morgan (YWCA of Sierra Leone), Jennifer Mbise and Neema Landay (YWCA of Tanzania), and Inunonse Ngwenya (YWCA of Zambia).

TIME LINE

The first planning meeting was held in August 2011, in Kuala Lumpur, Malaysia. This was followed by the Pre-workshop at the International Conference on AIDS and STI's in Africa (ICASA) meeting in December 2011 with young women from the eight countries, to introduce the SRHR indicators and the questions, which they reviewed, revised and provided inputs relevant to African context.

Research on the SRHR indicators was initiated in January 2012. In February 2012, consultations were held at the national level led by the young women in the eight countries. Young women presented their perspective on the indicators and completed the questionnaires.

The SRHR indicators, the data, and the national processes were reviewed with young women from the region at a meeting in Arusha, Tanzania in March 2012. Young women reviewed the data, verified the narrative, and included critical input on the key SRHR issues for their countries.

All this information and research was shared at the April 2012 Global South Regional Research Writing and Review meeting held in Kuala Lumpur, Malaysia. The findings were reviewed and inputs were provided by technical resource persons and Global South peer partners invited to the meeting.

An initial mapping and the questionnaire surveys in the nine countries pointed to critical SRHR issues in the respective countries.

Box 1:
Countries and country specific SRHR issues

Country	SRHR Issue
Angola	Maternal mortality
Benin	Reproductive health and violence against women
Ethiopia	Unsafe abortion and unmet family planning needs for young women
Kenya	Female genital mutilation, family planning for young people and HIV prevalence among young women
Nigeria	No questionnaire administered
Rwanda	Unsafe abortion and HIV prevalence among young women
Sierra Leone	Adolescent fertility and female genital mutilation
Tanzania	Adolescent fertility and unsafe abortion
Zambia	Unmet family planning needs and HIV among young women

Source: Distributed questionnaire surveys

Box 2:
Key Definitions [2]

Reproductive Health	Reproductive health implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the rights of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy child (World Health Organisation [WHO]).
Reproductive Rights	Reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents (International Conference on Population and Development [ICPD]).
Sexual Health	Sexual health implies a positive approach to human sexuality and the purpose of sexual health care should be the enhancement of life and personal relations as well as counselling and care related to reproduction and sexually transmitted diseases (adapted from the United Nations [UN]).
Sexual Rights	Sexual rights embrace human rights that are already recognised in national laws, international human rights documents and other consensus documents. These include the right of all persons, to be free of coercion, discrimination and violence, to live to the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive health care services; seek, receive and impart information in relation to sexuality; sexuality education; respect for bodily integrity; choice of partner; decide to be sexually active or not; consensual sexual relations; consensual marriage; decide whether or not, and when to have children; and pursue a satisfying, safe and pleasurable sexual life (WHO's working definition).

Source: ARROW ICPD+15 monitoring publication

METHOD AND FORMAT OF THE REPORT

The report is divided into three main sections. The first section sets the regional context and monitors the progress made on women's empowerment. It also reviews the status of the region's governments signing of international conventions, declarations and programmes of action. Women's empowerment is measured by comparing the female and male population with at least secondary education (an indicator included in calculating the gender inequality index, female and male labour force participation rate, and women's seats in parliament). It has been noted that women's empowerment and agency enable them to make informed decisions that lead to positive Sexual and Reproductive Health (SRH) outcomes. This chapter also reviews the health financing as a factor affecting women's access to quality SRH facilities and services. It analyses government expenditure on health as a percentage of total health expenditure from 2005 to 2010, and out-of-pocket expenditure as a percentage of private health expenditure.

The second section looks at reproductive health and reproductive rights and focuses on both the progress and the lack of progress in the nine countries examined.

The third section focuses on sexual health and sexual rights. Progress and challenges are reviewed based on HIV prevalence, legal age of marriage, sexual offences, sexual harassment acts, and legislation.

DATA SOURCES FOR THE INDICATORS

The sources for this report are the following: United Nations World Contraceptive Use for different years, United Nations World Abortion Policies, UN Secretary General's Database on Violence against Women, United Nations Development Programme's Human Development Reports, World Health Organisation National Health Accounts, Country Demographic and Health Surveys (DHS), United Nations General Assembly Special Session on AIDS (UNGASS) Progress Report, Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), Government reports of respective countries and NGO Shadow reports of the respective countries, and various scientific papers and journals.

CHAPTER 2

setting the context

THE AFRICAN REGIONAL CONTEXT WHICH AFFECTS THE IMPLEMENTATION OF THE ICPD PoA

"Africa rising: The hopeful continent", the cover headline run by The Economist in 2011, was about Africa in the current times showing the continent is on the pathway of progress as the region's economies are consistently growing with increased foreign direct investments and the falling number of people living in poverty, fewer children dying, and more children going to school.

African countries are topping the list of the fastest growing economies with a high annual average Gross Domestic Product (GDP) growth. HIV incidence rates have dropped more than 25% in 22 Sub-Saharan Africa countries between 2001-2009. Political participation of women is also improving. While there are setbacks, democracy is growing and governance standards are improving in the region.

The flipside of the coin, however, shows growing inequalities, higher unemployment rates, wealth disparities within countries, and unequal access to health, education, water, and sanitation. National averages conceal striking inequalities within countries with regards to education and health. Maternal Mortality continues to be unacceptably high. Corruption continues to hamper good governance, and there is a long way to go in achieving gender equality and realisation of SRHR.[3]

In terms of demography, on a positive note, the face of Africa is increasingly becoming youthful, with an increase in the number of young people living in the region. At the same time, due to growing poverty in rural areas, there is a trend of urbanisation with many young people moving to cities. Currently, at least one third of Africans live in urban areas and there are projections that this will increase. Countries in the region are alert to the fact that this will lead to an increasing food insecurity, lack of access to health and education, and limited availability of public goods such as water and energy.

Yet, at the same time, the growth and spread of information and communication technologies, especially mobile technologies, are shaping development outcomes for people by increasing access to cash, credit e-health, and e-governance.

While the above mixed state of affairs reflects Africa's position within the global context, we now look at specific development and health sector initiatives that are having an impact on the realisation of SRHR of people in the region. These include:

1. Health sector reforms: People in Sub-Saharan Africa face challenges arising from health sector reforms that were initiated in the 1980s and early 2000, when governments hastily implemented user fees in public institutions, leading to severe constraints and poor access to sexual and reproductive health services, especially for young women in marginalised communities. The governance and liberal democratisation process in previous one party States, led to election promises that included exemption from targeted user fee, especially for maternal health care services. However, developing partners support for vertical approaches that focus on health policy and biomedical technology has negative implications on realising the full expanded concept of sexual and reproductive health service delivery. At the same time, financing reforms brought about by health sector reforms have to be assessed as to whether they ensure the availability and accessibility of sexual and reproductive health services at the national level in the respective countries.[4]

2. Health system strengthening initiatives: The health system strengthening initiatives implemented as a result of the National HIV and AIDS response provided a window of opportunity for improving national health systems. The inclusion of CSOs and focus on vulnerable groups have led to programmes for addressing equitable access to health services, including community based solutions. However, many people have limited access to good quality health care, especially in rural and remote areas. Lack of health workers, management and organisational failures continue to stay as barriers to health system strengthening. With focus on certain conditions such as Malaria, TB and HIV, health care services as a whole is not addressed and the emphasis is also more towards a fragmented curative health care.[5]

3. Increasing political participation of women: The increasing political participation of women in Africa has also ensured that reproductive health agenda is regularly addressed both at the national and regional levels, leading to various progressive legal and policy frameworks in many African countries. Women's representation in parliament in Sub-Saharan Africa is higher than South Asia, the Arab States and Eastern Europe. The African Union (AU) also had adopted a 50% quota for women's representation, reflected in the composition of the AU commission. In 2008, Rwanda had 56% of female legislators elected to parliament.[6]

4. Programmes and Policy Reviews: Programme and policy reviews have been undertaken by many member states of the AU in fulfilment of their obligations to the AU Health Strategy, Maputo Plan of Action on SRHR, 2007-2010, and the Abuja Declaration 2001.

SRHR WITHIN THE CONTEXT OF WOMEN'S EMPOWERMENT, AND HEALTH FINANCING

The 1990s saw a series of United Nations inter-governmental conferences on development issues such as the environment, human rights, social development, and women. ICPD was another landmark meeting held in Cairo, Egypt, 5-13 September 1994, which shifted the thinking and discourse around issues of population and development. As a result of the ICPD conference in 1994, the outcome document (the ***ICPD Programme of Action*** (PoA)) was produced and subsequently adopted by 179 countries.

The PoA of the ICPD brings to the forefront the concepts of Sexual and Reproductive Health and Reproductive Rights, including universal access to related services and commodities. It also addresses issues of sustainable development, environment, climate change, migration, gender equality and empowerment of women, universal access to primary health care, and addressing infant, child and maternal morbidity and mortality, as well as increased life expectancy. The ICPD conference was a landmark turning point resulting in the paradigm shift from a population control development approach to a rights-based and people-centred approach. It is widely acknowledged that issues of the status of women in respective countries and the macro-economic framework have a bearing on the realisation of sexual and reproductive health and rights of individuals. In the sections below, we look at the progress or lack of progress in these areas within the Sub-Saharan region and specifically, in the nine countries under review.

The sections below will monitor:

A) National, sub-regional, regional, and international commitments to women's empowerment in the nine countries under review. It will also look at the indicators of violence against women.

B) The review will compare the Human Development Index (HDIs) to look at the nine countries in comparison with each other and in relation to other countries. A new measure, the Gender Inequality Index (GII), which includes the sexual and reproductive health indicators, is also measured in the review. The GII compares the participation of women in education, labour force, and political decision making structures.

C) The review will also analyse the government's responsibility and accountability using key indicators pertaining to health financing in the nine countries under review.

WOMEN'S EMPOWERMENT

SIGNATORIES TO INTERNATIONAL HUMAN RIGHTS INSTRUMENTS AND CONFERENCES

All 54 countries that are member states of the AU, including the nine countries monitored in this report, are also member states of the United Nations and have signed various declarations and treaties protecting the SRHR of women. At international and regional levels, African member states are signatories to a number of legal and policy documents that recognise the protection of women's SRHR. These human rights treaties are legally binding and when member states sign and ratify them, they have a legal obligation to report on their progress in implementation.

1. INTERNATIONAL CONVENTIONS AND COVENANTS RELEVANT TO SRHR

There are five major international human rights treaties relevant for protecting sexual rights and reproduction health rights (SRHR)

1. Convention on the Elimination of all forms of Discrimination Against Women (CEDAW)
2. International covenant on Economic, Social and Cultural Rights (ICESR)
3. Convention on the Rights of the Child (CRC)
4. International Covenant on Civil and Political rights (ICCPR)
5. Convention against Torture and other cruel inhuman or degrading treatment or punishment (CAT)

These instruments are monitored by the following treaty bodies or human rights committees, which consist of independent experts who review the periodic reports provided by the member states who are party to the treaties, and they also listen to complaints from individuals, as well as address issues highlighted in shadow reports from NGOs. They collate all this information and give recommendations and general comments called the concluding observations which member states are obliged to implement and report on their progress. A summary of all the countries' position on these instruments can be viewed in Table 31 (Annex).

Convention on the Elimination of All Forms of Discrimination against Women

All African Member states except Somalia and South Sudan are signatories to the CEDAW, adopted in 1979 by the UN General Assembly. CEDAW is an International Bill of Rights for women, a legal tool, which comes into force in the countries that have signed or ratified it and member states are required to report progress periodically. The CEDAW Committee is a powerful body for articulating, advocating, and monitoring women's human

rights. NGOs play a key role in monitoring their government's implementation of the treaty. The Convention's enforcement mechanism is based on the reporting system, where the member states are obliged to act upon the general recommendations or the concluding comments of the CEDAW Committee and report on its progress. CEDAW states that women's health is an issue that is recognised as a central concern in promoting the health and well-being of women. It requires State parties to eliminate discrimination against women particularly in accessing health care services, throughout their life cycle, especially in the areas of family planning, and pre-natal, delivery and post-natal periods (Articles 10 and 12).

Among the nine countries under review, only Ethiopia has reservation to CEDAW for paragraph 1 of Article 29 of the Convention.[7]

International Covenant on Economic, Social and Cultural Rights (ICESR): The ICESR Articles 10 and 12 recognise the right to health and require governments to ensure all people have access to facilities, services and conditions necessary for the realisation of the highest attainable standard of health and this includes reproductive health rights. All the nine countries under review are signatories to ICESR.

Convention on the Rights of the Child (CRC): The CRC was enforced in 1990 and applies to children and young people below the age of 18. Governments that have signed this instrument have a responsibility to implement a rights-based approach on the sexual reproductive health rights of adolescents and youth.

In Article 12, the convention recommends that adolescents and youth must have the opportunity to express their views freely on matters concerning their health and that an environment of trust must be established, where they can access accurate information, they can be heard and guidance is provided to parents to facilitate them in making informed decisions on their sexual and reproductive health rights.[8] All the nine countries under review are signatories to CRC.

Article 24 of CRC states that parties are encouraged to ensure adolescents and youth have the right to access sexual and reproductive health services regardless of their marital status and whether with or without the consent of their parents or guardian.

Article 28 states that parties must recognise the rights of a child to education and ensure that this right is achieved progressively on the basis of equal opportunities. The states are particularly encouraged to ensure access to secondary education and further education for both boy and girls. This is an important right as it contributes to the delay of marriage for women and girls, and if comprehensive sex education is included in the curriculum, this will also reduce the rate of unintended pregnancies and contribute to the reduction of HIV infection among young women.[10]

International Covenant on Civil and Political Rights (ICCPR): This covenant in Articles 3 and 23 as well as Article 26 require the states to protect equal rights for all, the rights to consent to marry and equality within marriage, and also to protect the rights of women and children from exploitation and discrimination. This can be used for legal protection against early and forced marriages, and sexual exploitation of women and girls. All the nine countries under review are signatories to ICCPR.

Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment: This convention holds that torture is any intentional act, inflicted based on discrimination, which causes severe physical or mental suffering, and is committed with the consent of a public official. It has been interpreted by the Committee to include denial of family planning services to women, which leads to illegal and unsafe abortions, coercive sterilisation or pregnancies.[11] All the nine countries under review are signatories to the convention.

2. REGIONAL INSTRUMENTS RELEVANT TO SRHR

There are three relevant regional instruments: the Solemn Declaration on Gender Equality in Africa (SDGEA), Maputo Protocol, and Abuja Declaration. The summary of the countries' position on the instruments is shown in Table 32 (Annex).

1) **The Solemn Declaration on Gender Equality in Africa (SDGEA):** SDGEA adopted at the AU Heads of State Summit in Addis Ababa, in July 2004, requires states to respect existing normative standards on women's human rights. Through the SDGEA, one of the standards that governments have agreed to is to "expand and promote the gender parity principle, ensure the active promotion and protection of all human rights for women and girls, actively promote the implementation of legislation to guarantee women's land, property and inheritance rights including their rights to housing." They undertook to sign and ratify the Protocol to the African Charter on Human and People's Rights, on the Rights of Women in Africa by the end of 2004. By June 2009, according to the AU, 45 nations had signed it and 28 had formally ratified it. It, therefore, reaffirms the commitment by Heads of States to a number of treaties such as CEDAW, the BPFA, and UN Security Council Resolution 1325 (2000).[12]

2) **The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol 2003)**: This protocol provides a continental legal framework for addressing the issues of gender inequality and the underlying aspects of society's arrangement that perpetuate women's subordination and disempowerment, and contribute to their marginalisation. Legal reforms have taken place in various countries in order to bring the national laws in line with the provisions

of the Protocol. The Continental Policy Framework on SRHR (2006) was developed in response to the call for reduction of maternal and infant morbidity and mortality in Africa. The framework calls for mainstreaming sexual and reproductive health care to accelerate the achievement of the MDGs.[13] **The Maputo Plan of Action (MPoA)** for the operationalisation of the Continental Policy Framework for Sexual and Reproductive Rights will be implemented by 2015 as it is linked to the achievements of the MDGs. Member states are committed to implementing this plan of action and reporting their progress, yearly, to the AU commission. The key strategies of the MPoA include the following:

- Integrating STI/HIV and AIDS with SRHR programmes and services, including reproductive cancers, to maximise the effectiveness of resource utilisation, and to attain a synergetic complementary of the two strategies.
- Repositioning family planning as an essential part of the attainment of health MDGs.
- Addressing the sexual and reproductive health needs of adolescents and youth as a key SRH component.
- Addressing unsafe abortion.
- Delivering quality and affordable services in order to promote safe motherhood, child survival, and maternal, newborns and child health.
- Fostering African and South-South cooperation for the attainment of ICPD and MDGs goals in Africa.
- The AU Gender Policy takes into account the diversity in society, culture and tradition and makes an effort to address cultures and practices that act as barriers to the enjoyment of freedom and rights of women and girls. The gender policy provides a mandate for the operationalisation of assembly commitments.

3) **The Abuja Declaration:** In April 2001, the Heads of State of The AU countries met and pledged to set a target of allocating at least 15% of their annual budget to improve the health sector. At the same time, they urged donor countries to "fulfil the yet to be met target of 0.7% of their GNP as Official Development Assistance (ODA) to developing countries." The AU member states in 2001 signed the Abuja declaration.[14]

3. SUB-REGIONAL INSTRUMENTS RELEVANT TO SRHR

They cover the Southern, East, Central and West African states.

The Southern African Development Community (SADC) Treaty in Article 6(2) prohibits discrimination based inter alia on sex or gender. Currently, SADC has 15 members. The SADC members through the SADC Declaration on Gender and Development call on member states to ensure the elimination of all gender inequalities in the region and aspire to the promotion of full and equal enjoyment of rights for all.
The SADC Protocol on Gender and Development aims to accelerate the achievement of gender equality and equity in all development processes at different levels through development and implementation of gender responsive legislation, policies, programmes and projects, and monitoring and evaluation mechanisms.[15]

Although the SADC protocol on Gender and Development of 2008 is broad based and addresses issues of gender based violence, it does not have a specific position on SRHR. SADC, however, has developed a regional SRH strategy for 2006-2015 which is aligned to the AU Maputo Plan of Action and deals with safe motherhood, making family planning services available, and prevention and treatment of STIs[16] a reality.

The Economic Community of West African States (ECOWAS):
The 15 member states of the ECOWAS adopted a Gender Policy in 2004. As a strategy for implementing the policy, a gender division was established at the secretariat, which later became the ECOWAS Gender Development Centre. Its mandate includes gender mainstreaming and coordinating programmes for reducing disparities between men and women, and promoting women's rights within the framework of objectives of the ECOWAS treaty. There is no specific ECOWAS policy on SRHR but it has acknowledged gender as a cross cutting issue in its health strategy.[17]

4. NATIONAL MACHINERY FACILITATING WOMEN'S EMPOWERMENT

In the nine countries under review, we examine the national machineries and constitutional provisions facilitating women's empowerment in these countries.

a) National machineries, laws and policies

The government of the Republic of Angola has ratified the Convention on the Elimination of all forms of Discrimination against Women without reservations. It has national machineries, which include the Ministry of Family and promotion of women's rights created in 1991 with a mandate to define and implement the national policy for the promotion of the rights of women in the public and private spheres. The policy also includes the establishment of gender focal points in all ministries and departments.

The government of the Republic of Benin has established the Ministry for Social Protection and Women Affairs, which is responsible for the advancement of women. The government has a national and a multi-sectoral policy for the advancement of women.

The Federal Democratic Republic of Ethiopia demonstrated its firm commitment to the equitable socio-economic development of women with the establishment of the National Policy on

Women in 1993 and the promulgation of the new Constitution in 1995. The National Policy on Women is intended to institutionalise the political and socio-economic rights of women by creating appropriate structures in government institutions. This policy enabled the government to develop a legal framework which addresses the previous discriminations and past gender based violation in the legal system, and to establish a structure for implementing gender mainstreaming policies from the federal to the grass root levels of local government and raising awareness of the policies at community level.

The Federal Republic of Nigeria signed CEDAW without reservations in 1985, but has not domesticated in the national law. The national machinery in Nigeria is the Department of Women Affairs of Federal Ministry of Women Affairs and Social Development (FMWA). All 36 states have regional ministries of women affairs. The National Women Development Centre (NWDC) was established to activate a Women Development Centre (WDC) in each state. There are gender focal points in all ministries and government offices mandated by a National Gender Policy which focuses on women empowerment through taking action on disparities in basic education and reducing the impact of harmful traditional practices on the well-being of women and girls. One of its key strategic objectives seeks to increase women's role in political leadership and to improve participation in both public and private sector, with the aim of having 30% of managerial positions occupied by women by 2015.[18]

The government of Rwanda has put in place the following policies for promoting gender equality and women's human rights. These policies include: The National Gender Policy, the Gender Cluster Strategic Plan, the National Action Plan (2009-2012) for the implementation of the United Nations Resolution 1325, the National Gender-based Violence Policy and its 5-year strategic plan, specific laws repressing GBV as well as gender economic empowerment strategies and policies, the National Accelerated Plan for Women, Girls, Gender equality and HIV (2010 – 2014) in response to HIV and AIDS and Gender issues, all of which are closely aligned to the country's National Gender Policy and the National Strategic Plan on HIV and AIDS 2009- 2012. The National Accelerated Plan (NAP) sets targets, including steps to improve Universal Access to HIV prevention, care and treatment, and to ensure national laws and policies aimed at protecting and promoting the rights of women and girls in the context of the HIV pandemic. The Ministry of Gender and Promotion of Women is mandated to monitor its implementation. Since its creation in 1999, this Ministry has achieved a lot on women's education and the promotion of their rights. It has organised training sessions, "solidarity camps", and awareness campaigns about women's rights targeted at a varied audience, including women themselves and the authorities. It has conducted or participated in surveys looking into potential obstacles to the advancement of women's rights and the current status of women vis-à-vis men in various fields, to provide data as input to the various policies promoting women human rights.[19]

Tanzania has operationalised its commitment to women's empowerment through the National Women and Gender Policy (2000) and the National Strategy for Gender and Development (NSGD, 2002) which identify the major constraints and interventions to achieving gender equity for sustainable human development in the country. There are three legal systems in the Tanzanian Mainland; the Constitution with the Bill of Rights, the Statutory Laws that come after the Constitution, and followed by customary laws (Islamic laws fall under customary laws). With regards to family matters, issues of inheritance, and family relationships, the customary laws are widely applied by communities and women rarely claim their rights or use the protection of the Constitution or the Bill of Rights. Review of other oppressive laws such as the Inheritance and Marriage Act has taken place and amendments have been proposed to offer more protection for women.

The government has also committed itself and followed through by implementing critical laws such as passing the Sexual Offences Act of 1998, which stipulates stiffer penalties for sexual offenders. Furthermore, reforms of the Land Act 1999 and the Village Land Act 1999, which empower women through ownership of assets, have translated into improved productivity and increased incomes. The implementation of all gender polices are monitored by the Ministry of Community, Development, Gender and Children. The objective of putting these three departments together was that they are interlinked in terms of providing the appropriate vision for a balanced and effective social and human development. The Policy and Planning Department is in charge of coordinating, policy formulation, and planning for the three departments. The Ministry has the following mandates: to design interventions aimed at improving the status of women in terms of social, political and economic development; to enhance the coordination mechanisms for the implementation of the Post-Beijing Action Plan; and providing psycho-social rehabilitation, and education/professional training to street children and orphans. All sectoral ministries have gender focal points.[20]

The Government of the Republic of Zambia (GRZ) has signed and ratified CEDAW and the SADC declaration on 30% representation of women in decision making positions. The GRZ has also recorded some progress in terms of female representation in the civil service through the implementation of the Public Service Training Policy, affirmative action, capacity building for female candidates in top decision making positions, and overall, gender sensitisation of policy makers.

Zambia still fell short of attaining the 30% target of female representation in politics and decision-making positions, as per commitment to the SADC Declaration on Gender and Development of 1997, due to various factors. The GRZ plans to continue to implement programmes to enhance women's

participation in decision making. Some of these measures include the review of the electoral process to provide affirmative action for women, implementation of affirmative action for women in the appointments, promotion and training in the Public Service, and awareness creation on the importance of women's participation in decision-making.

In 2003, the government of the Republic of Kenya established the Ministry of Gender, Sports, Culture and Social Services, and passed the Sessional Paper No. 2 in 2006, which defines the government's policy on gender equality and development. Recognising that gender inequalities and socio-cultural factors contribute to the unequal status of men and women, this sets out the government's commitment to advance the status of women as stated in CEDAW and other international instruments. The overall objective of the Policy is to ensure women's empowerment and mainstreaming of their needs and concerns take place in all sectors of development in the country so that they can participate and benefit equally from development programmes.[21]

b) Constitutional provisions in the nine countries on women's equality and empowerment

Angola has shown some political will by ensuring that the national constitution has provisions for ***defacto*** equality for women and men and for implementing the articles of CEDAW. Angola has also enacted laws and adopted strategic plans in support of the goal of gender equality and the implementation of the provisions of the Convention, including the Family Code. In 2005 Angola developed the strategy and strategic framework for the promotion of gender. However, it has been noted that while Article 18 of the Angolan Constitution guarantees equality between women and men, and prohibits discrimination on the basis of sex, it does not contain a definition in line with Article 1 of the Convention. It has also been stated in the 4th and 5th CEDAW report that the state has not fully domesticated the convention in the law, and many judges, lawyers, prosecutors and public are not aware of CEDAW provisions, and that there is a general lack of understanding of and respect for women's human rights.

The Republic of Benin has incorporated in its Constitution (Article 7), the rights and duties to human rights as set forth in the Charter of the United Nations (1945), the Universal Declaration of Human Rights (1948), and the African Charter of Human and Peoples' Rights adopted and ratified by Benin on 30 January, 1986.[22] The Constitution reaffirms Benin's attachment to all international instruments that take precedence over internal law. The Benin Constitution protects the rights of women and prohibits all discrimination against them.

Article 26 provides that "men and women are equal before the law. The State protects the family, and in particular the mother and child...." The Constitution, thus, enshrines the principle of equality of everyone before the law. A law was brought to parliament which led to the legislative framework - "The 2004 Code of Persons and the Family Code" which abolished the country's customary laws. Under the new Family Code, the marriage age has been set at 18 years for both men and women; marriage is monogamous; distribution of duties within the household is to be shared; and inheritance rights are equal for both sexes.

The Rwandan Constitution of 2003 has amended to date, the law on decentralisation in Rwanda, organic law on land use and ownership, family law and succession law, promulgation of the law against gender based violence, on the one hand, as well as the ratification of international conventions such as CEDAW, the Protocol to the African Charter on the Rights of Women in Africa, and the Pact on Security, Stability and Development in the Great Lakes Region, on the other.

The Ministry for Women, Youth and Children Affairs has worked with the support of women's organisations in Ethiopia to ensure the principles of women's equality and non-discrimination, which had been incorporated into Ethiopia's Federal Constitution and resonated across its federal and regional laws, including the revised Federal Family Code and the new Criminal Code, which contained "strong and comprehensive" measures to support women's rights. Among them were new provisions penalising trafficking in women and children, and establishing units to investigate and prosecute criminal acts against women. The Government of Ethiopia in its CEDAW report notes that it has criminalised early marriage, one of the most endemic traditional practices harmful to women in Ethiopia, by providing a range of awareness-raising, sensitisation, advocacy and rehabilitation programmes in collaboration with national and international partners. Regions in which early marriage was practised had adopted systems to ensure that girls attain the legal minimum age of 18 years before marriage as per the revised Federal Family Code.

However, as in all other countries in Sub-Saharan Africa, implementation of the law is a challenge as the patriarchal cultural norms are deep rooted, especially in rural areas, where the government CEDAW report notes that marriage by abduction is still practised and women suffer severe cases of violence but are afraid to report as law enforcing agents are part of the community and rarely arrest the perpetrators. It does also state that gender sensitisation programmes have been initiated to ensure these agents are aware of their duties as law enforcers.[23]

The Constitution of the United Republic of Tanzania proclaims equality between men and women, and prohibits discrimination based on sex. The Government has signed several international and regional agreements on protection of women, and in

coordination with civil society, the government is taking steps towards the revision of national legislation that discriminates women, promotes informative campaigns on women's rights, and condemns violence against women.

The process of reviewing the Zambian Constitution has provided an opportunity for various gender issues and concerns to be taken on board in a more systematic and comprehensive manner. The GRZ has also recently embarked on an effort to review all overtly gender discriminatory laws. Yet, there are still cases where some discriminatory laws, though repealed, are still applied. In Zambia, the customary law, which is unwritten, tends to take precedence over statutory law, especially in the areas of marriage and personal law. Customary laws also differ according to matrilineal and patrilineal societies. In matrilineal societies, descent or succession is done through the mother's line, that is, children would inherit from their mothers rather than their own father. A number of ethnic groups in Zambia practise the matrilineal pattern of descent and notably among these are the Tonga, Chewa and Bemba. Other groups practise the patrilineal pattern of descent, meaning succession takes place through the father's line and notable among ethnic groups practising this are the Ngoni, Namwanga and Mambwe. The Lozi appears to be the only bilateral group where succession could pass either through the father or the mother. Under statutory laws, the Law Development Commission has recommended substantial changes in laws with a view to protecting women's rights and these are notably in improving women's access to employment with reference to mining and working night-shifts, equality in the age of retirement for both men and women in the civil service, clear entitlement rights and share in the marital property for widows, and eliminating discrimination on the basis of sex, specifically in personal law and the marriage act. Moreover, more recent reforms prohibit discrimination against women under customary practices, and clearly stipulate that women should have equal rights with men regarding the use, transfer, administration and control of land, and enjoy the same rights with men with respect to inheritance.[24]

Given these positive actions, however, there is a long way to go to actually implement the laws, policies and frameworks pertaining to women's empowerment in the nine countries.

Table 1:
Anti-domestic violence laws in nine African countries

Country	Anti -Domestic Violence laws
Angola	Law on Domestic Violence (July, 2011).
Benin	No law documented.
Ethiopia	Proclamation no.414/2004 - Criminal Code of Ethiopia addresses Violence against women in general, however, there is no explicit Domestic Violence Act mentioned.
Kenya	Draft Family Protection Bill 2007 and Witness Protection Act No. 16 (2006) deals with Violence Against Women, in general.
Nigeria	Law to prohibit Domestic Violence Against Women and Maltreatment no. 10 of 2004 (Cross River State). This legislation exists in provincial and state level. Domestic Violence Prevention Bill (2005) draft legislation. Elimination of Violence Against Women in the Society Bill (2006) addresses Violence Against Women, in general.
Rwanda	Law No. 59/2008 on Prevention and Punishment of Gender Based Violence (2008).
Sierra Leone	Domestic Violence Act (2007). Child Rights Act 2007.
Tanzania	Sexual Offences (Special Provisions) Act of 1998 addresses Violence Against Women, in general.
Zambia	Draft Bill on Gender-Based Violence (2009).

Source: The Secretary General's database on Violence against Women.

Barriers include the strong persistence of patriarchal attitudes and deep-rooted stereotypes regarding the role and responsibilities of women and men in society, which are discriminatory to women, inadequate human and financial resources, which prevent the implementation of programmes promoting the advancement of women and gender equality.[25]

5. NATIONAL LEGISLATION ELIMINATING VIOLENCE AGAINST WOMEN

In Table 1 we see that except for Benin, all the other eight countries have legislations to address domestic violence, in particular violence against women. Angola, Nigeria, and Sierra Leone have specific legislations addressing domestic violence. The other countries have laws addressing violence against women but with no explicit mention of domestic violence.

In Angola, the law intends to ensure women are not discriminated within their families and prevents women from being agents of violence.[26] This law signed into the Statue books on 8 July supports and guarantees victims through safe houses, medical treatment, and financial and legal help. The law designates violence as a "public crime," and this means that anyone can report the violence to the police, not just the victim.[27]
In Ethiopia, Proclamation no.414/2004 - Criminal Code of Ethiopia addresses Violence against Women, in general, in addition to early marriage, female genital mutilation, forced marriage, harmful traditional practices, sexual harassment, and trafficking. This legislation, however, does not mention domestic violence explicitly.

In Kenya, the Draft Family Protection Bill 2007 takes domestic violence into account. In addition, the Witness Protection Act No. 16 (2006) deals with Violence against Women, in general.
In Nigeria, the Domestic Violence Prevention Bill (2005) draft legislation which seeks to prevent domestic violence and empower courts to grant protection orders to victims of such violence. The Law to prohibit Domestic Violence Against Women and Maltreatment no. 10 of 2004 (Cross River State) exists at the provincial and state level.

In Sierra Leone, according to a report by the International Rescue Committee (IRC), husbands, not strangers or men with guns, are now the biggest threat to women in post-conflict West Africa. Sierra Leone passed a domestic violence act in 2007, establishing basic rights for women in the home and entitlements for survivors such as free medical care. Domestic violence is now punishable by a fine of up to 5m leones (£720) and up to two years in prison. However, the report notes that by the end of 2010, only one person was prosecuted and the lack of access to police, exorbitant fees charged by medical officers, and pressure to make out-of-court settlements, all contribute to impunity and state action.[28]

MEASURES OF HUMAN DEVELOPMENT AND GENDER INEQUALITY

This section examines the status of key human development indicators and gender inequality indicators in the nine countries to arrive at where the countries rank in relation to each other and in relation to the all the countries across the globe.

1. HUMAN DEVELOPMENT INDEX (HDI)

The HDI is a summary measure of human development. It measures the average achievements in a country in three basic dimensions of human development of long and healthy life, access to knowledge, and a decent standard of living.[29] In 2013, HDI data was collated for 186 countries. The regional average for Sub-Saharan Africa is 0.475 in 2013.

From Table 2, Sierra Leone, Ethiopia, Benin, Rwanda, Zambia, and Nigeria all fall below the regional average of 0.475 in 2013. Tanzania, Angola, and Kenya fall above the regional average.

2. INEQUALITY ADJUSTED HUMAN DEVELOPMENT INDEX

While the HDI represents a national average of human development achievements in the three basic dimensions of health, education and income, it does not take into account disparities in human development across the population within the same country. To account for inequalities, the Inequality adjusted Human Development Index (IHDI), which takes into account not only the average achievements of a country on health, education, and income, but also how those achievements are distributed among its citizens by discounting each dimension's average value according to its level of inequality, has been developed.[30]

Further to this, while analysing the data, the HDI is seen as the benchmark of "potential human" development if all achievements were distributed equally, in contrast, the IHDI reflects the level of human development that the average person experiences, given the inequality in the distribution of achievements across people. The IHDI will be equal to the HDI when there is no inequality in the distribution of achievement across people in society, and will fall below the HDI as inequality rises.

The 2013 Human Development reports that data on IHDI shows an overall loss in potential human development due to inequality

Table 2:
Human Development Index, Inequality adjusted Human Development Index and Gender Inequality Index

Name of the Country	Human Development Index Rank (Value)	Inequality adjusted Human Development Index (Value)	Gender Inequality Index Rank (Value)
Angola	148 (0.508)	0.285	-
Benin	166(0.436)	0.280	135 (0.618)
Ethiopia	173(0.396)	0.269	-
Kenya	145 (0.519)	0.344	130 (0.608)
Nigeria	153 (0.471)	0.276	-
Rwanda	167(0.434)	0.287	76 (0.414)
Sierra Leone	177(0.359)	0.210	139 (0.643)
Tanzania	152(0.476)	0.346	119 (0.556)
Zambia	163(0.448)	0.283	136 (0.623)

Source: Human Development Report 2013.

by 23.3% at the global level. According to the report, people in Sub-Saharan Africa suffer the largest losses due to inequality at 35% in all three dimensions, followed by South Asia, the Arab States, Latin America, and the Caribbean.[31]

The IHDI value in all the countries rank below the respective HDI. The overall loss in human potential due to inequality is highest in Angola, Sierra Leone, Nigeria, Zambia, Benin, Rwanda, Ethiopia, and Kenya, respectively. Comparatively, a lower loss in human potential due to inequality is seen in Tanzania and Zambia.[32-33]

3. GENDER INEQUALITY INDEX (GII)

"The Gender Inequality Index is a composite measure reflecting inequality in achievements between women and men in three dimensions: reproductive health, empowerment and the labour market. It varies between zero (when women and men fare equally) and one (when men or women fare poorly compared to the other in all dimensions). The health dimension is measured by two indicators: maternal mortality ratio and the adolescent fertility rate. The empowerment dimension is also measured by two indicators: the share of parliamentary seats held by each sex and by secondary and higher education attainment levels. The labour dimension is measured by women's participation in the work force. The Gender Inequality Index is designed to reveal the extent to which national achievements in these aspects of human development are eroded by gender inequality, and to provide empirical foundations for policy analysis and advocacy efforts."[34]

Based on the 2013 Gender Inequality Index data, it is observed that none of the countries have an ideal gender equality measure. It needs to be noted here that higher GII values indicate lower achievement in terms of gender equality. A 49.2% loss in achievements across three dimensions of reproductive health, empowerment, and labour market has been observed at the global level due to gender inequality. Sub-Saharan Africa faces the largest percentage of losses at 61% in comparison to other regions of the world. Reproductive health dimension is the largest contributor to gender inequality in Sub-Saharan Africa.[35]

The GII rank for Rwanda is comparatively higher in comparison to the other nine countries. The gender inequality dimensions analysed for the countries is observed in the table below and data on GII is shown for 6 countries but is not available for Angola, Ethiopia, and Nigeria.

The number of seats in national parliament, occupied by women, is less than half in majority of the nine countries with the exception of Rwanda that has 51.9% of the seats held by women.

Across the other six countries where data is available for female population with at least a secondary education, female secondary education levels are lower than the male population. Zambia has a higher percentage of population with at least a secondary education (25.7% for females and 44.2% for males).

An examination of the critical GII dimensions in Sierra Leone (with the lowest GII rank of 139 among the nine countries) and Rwanda (a higher GII rank of 72) shows the following results:
It is observed that Sierra Leone has a high maternal mortality

Table 3:
Gender inequality dimensions in the nine countries

Country	Maternal Mortality Ratio	Adolescent Fertility Rate	Seats in national parliament (% female)	Population with At least secondary education (%)		Labour Force participation rate (%)	
				Female	Male	Female	Male
Angola	450	148.1	38.2			62.9	77.1
Benin	350	97.0	8.4	11.2	25.6	67.4	78.2
Ethiopia	350	48.3	25.5	-	-	78.4	89.8
Kenya	360	98.1	9.8	25.3	52.3	61.5	71.8
Nigeria	630	111.3	6.7	-	-	47.9	63.3
Rwanda	340	35.5	51.9	7.4	8.0	86.4	85.4
Sierra Leone	890	104.2	12.9	9.5	20.4	66.3	69.1
Tanzania	460		36.0	5.6	9.2	88.2	90.3
Zambia	440	138.5	11.5	25.7	44.2	73.2	85.6

Source: Human Development Report 2013

of 890, in comparison to a relatively lower MMR of 340 in Rwanda; a high adolescent fertility rate of 104.2 in Sierra Leone, in comparison to an adolescent fertility rate of 35.5 in Rwanda. In addition, Rwanda has 51.9% of seats in national parliament, in comparison to 12.9% in Sierra Leone. The population with at least a secondary education is very low both in Rwanda and Sierra Leone. With regards to labour force participation, there is not much difference between female and male labour force participation in both countries. Dimensions of reproductive health are seen as a marker in defining gender inequality between the highest and lowest GII ranking in the nine countries.

Taking the two measures of HDI and IHDI, it is observed that Sierra Leone has the lowest HDI and IHDI. This means Sierra Leone not only ranks lowest among the nine countries under review in terms of human development dimensions, but Sierra Leone is also a country with significantly high levels of inequality among population groups within the country. Rwanda ranks 82 among the 146 countries with respect to GII with a relatively lower maternal mortality, adolescent fertility, and high number of seats in national parliament occupied by women, in comparison to the other eight countries under review. Sierra Leone ranks lowest among the nine countries in terms of GII as well.

HEALTH FINANCING BACKDROP AND REFORMS

WHO's Member States have set themselves the target of developing their health financing systems to ensure that all people can use health services, while being protected against financial hardship associated with paying for them.[36] The promotion and protection of health of individuals is a right in itself and was recognised more than 30 years ago by the Alma-Ata Declaration signatories, who noted that "Health for All" would contribute both to a better quality of life and also, to global peace and security.

It is important to look at issues of health financing in Africa as most of the countries in the region lack adequate financial resources to meet the health needs of the population. In addition to this, the persistent situation of the HIV and AIDS epidemic and the impact of the structural adjustment programmes introduced by the IMF in Africa in the 1980s and the 1990s make it a necessity to look at the region's health financing situation.[37]

Recent developments in Africa in the area of health financing include advocacy and action around the removal of user fees in some of the countries, including Kenya; the emphasis on health insurance mechanisms with an aim to increase insurance

coverage in light of the 2005 World Health Assembly encouraging even greater pursuit of insurance strategies in respective countries and the move by donors to provide general budget support (channelling the donor funds via the Ministry of Finance) rather than direct funding to the health sector; and the increasing shift towards privatisation in the health sector - all provide both opportunities and risks, and these need to be assessed in light of the fulfilment of "health for all" target.[38]

The World Health Report 2010 says that all countries could take actions in at least one of the following areas to move closer towards universal coverage - raise additional funds for health; reduce financial barriers and increase financial risk protection through prepayment and pooling; and use the available funds more equitably and efficiently.[39] The 2010 World Health Report estimates that globally, 20-40% of all health spending is wasted due to inefficiency.[40] In Africa, more than half of the total health spending is paid out-of-pocket by African households and plunges the poorest into further poverty. The reduction of development aid to Africa additionally calls for increased domestic spending and greater domestic accountability.
This section presents data on certain critical health financing indicators such as:

- The Total Health expenditure as a percentage of the GDP;
- General government expenditure on health as percentage of total health expenditure;
- Private expenditure on health as percentage of total health expenditure;
- Per capita total expenditure on health; and
- Out-of-pocket expenditure as a percentage of the private expenditure on health

Data on the indicators are generated from the National Health Accounts (NHAs) that collect expenditure information within an internationally recognised framework. These indicators aim to look at health financing situation in the nine countries identified for the Africa regional report.[41]

1. TOTAL HEALTH EXPENDITURE

The total expenditure on health as percentage of GDP in the nine countries under review shows most of the countries spend 5% or less of the GDP on health. Only in Sierra Leone (13.1%) and Rwanda (10.5%) are the total expenditure on health as percentage of GDP above 10%. It should be noted that in Rwanda there is a very high external contribution to total health expenditure, exceeding 45% (47% in 2010).[42] These expenditures would also not mean that the level of expenditure would be adequate to meet the health need of the citizens in respective countries. The per capita health expenditure is more of a determining indicator to achieve health goals of the population which is also looked at in this review.

2. GOVERNMENT EXPENDITURE ON HEALTH AS PERCENTAGE OF TOTAL GOVERNMENT EXPENDITURE

The indicator government expenditure on health as percentage of total government expenditure, points to the extent to which respective governments prioritise and allocate financial resources to the health sector in comparison to the other sectors. An overall assessment of the government priorities in the African countries shows that defence receives more financial resources in comparison to the health sector. In Africa, the other factor that constrains the government's ability to allocate resources to the health sector includes the total government spending on debt servicing and repayment.[43]

In April 2001, heads of state of AU countries met and pledged to set a target of allocating at least 15% of their annual budget to improve the health sector. The general government expenditure on health as percentage of total government expenditure in the nine selected countries is shown in the Table 34. [44]

Achieving the 15% target of the Abuja Declaration by the African countries would be a positive reflection on the respective government's commitment on health.[45] Rwanda and Zambia have met the 15% target of Abuja. Nigeria and Sierra Leone spend the least as general government expenditure on health as percentage of total government expenditure.

3. GOVERNMENT EXPENDITURE ON HEATH AS A PERCENTAGE OF TOTAL EXPENDITURE ON HEALTH

Total expenditure on health includes both government expenditure on health and private expenditure on health. As noted earlier a substantial government expenditure on health as percentage of total expenditure on health would mean a greater commitment of the government to the health of its citizens.

Government health expenditure has increased considerably from 2005 to 2010 in Tanzania, Nigeria, Angola, and Zambia. At the same time, the government health expenditure has decreased in Ethiopia, Rwanda, Sierra Leone, and Benin.[46] A decrease in the government expenditure on health would mean an increase in the private health expenditure which is a negative trend.[47] At this point, it is also important to look at the external resources for health as percentage of total expenditure on health since Africa receives external resources for health.[48]

The highest external resources are seen in Tanzania, Rwanda, Ethiopia, and Zambia which correlate with higher government expenditure on health in these countries. These trends need to be addressed if the focus is on sustainable government expenditure on health. From the above data, it can be noted that there is

a high level of reliance on donor funding in African countries. Donor funding accounts for over a quarter of total health care funding in about 35% of countries, with 5% of countries having more than half of all health care funding coming from external sources.[49]

4. PER CAPITA TOTAL EXPENDITURE ON HEALTH (PPP INT$) AND PER CAPITA GOVERNMENT EXPENDITURE ON HEALTH (PPP INT $)

Per capita expenditure shows resource availability for health in a country, including public and private spending. The Per Capita Expenditure (PPP int $) on health shows the following trends in 2010: Angola spent the most ($168) and Ethiopia ($51), the least. An examination of government contribution to the per capita expenditure shows that the government of Angola contributed 82.7% to the total per capita expenditure on health. The least contribution to the total per capita expenditure is by the government of Sierra Leone at a meagre 11.2%. (Table 4)

5. OUT-OF-POCKET EXPENDITURE AS PERCENTAGE OF PRIVATE HEALTH EXPENDITURE

Private expenditure on health takes into account pre-payment schemes, private insurance schemes, and out-of-pocket payments.[50]

Out-of-pocket payments take two major forms, in the African context, namely user fees for public sector health services, and direct payments to private sector providers. Out-of-pocket payments impact the poorest households. (Table 34 annex)

Insurance coverage in African countries is limited, especially in relation to mandatory health insurance. Only Kenya has a mandatory requirement for health insurance for all employees and is also available on a voluntary basis for other subscribers. However, community pre-payment schemes have been on the increase.[51]

In conclusion, government spending on health care includes that of tax revenues, and funds from donor sources in most African countries. Donor funds account for more than a quarter of health care expenditure in 31% of countries, and account for as much as 66% of expenditure in some countries (Benin) in 2005.[52] External funds in the African context not only flow via the government but may also go directly to the private sector (e.g. to mission hospitals).[53] Heavy reliance on donor funding has been observed, and this has to be looked at from a sustainable angle. Health insurance is limited.

Table 4:
Per capita total expenditure on health (PPP int $ (2010) and Per capita government expenditure on health (PPP int $) (2010)

Name of the country	PPP int $ on health (2010)	Per capita government expenditure on health (PPP int $) (2010)	Percentage contribution of government to the per capita total expenditure on health
Angola	168	139	82.7%
Benin	65	32	49.2%
Ethiopia	51	27	52.9%
Kenya	78	34	43.5%
Nigeria	121	46	38%
Rwanda	121	61	50.4%
Sierra Leone	107	12	11.2%
Tanzania	83	56	67.4%
Zambia	90	54	60.0%

Source: World Health Organization. (n.d.). Global Health Observatory Data Repository.

CHAPTER 3

reproductive health and rights

INTRODUCTION

This chapter assesses progress in the nine countries: Angola, Benin, Ethiopia, Kenya, Nigeria, Rwanda, Sierra Leone, Tanzania, and Zambia with respect to key Reproductive Health (RH) and Reproductive Rights (RR) indicators. The RH and RR indicators include key aspects of:

1. Contraception
2. Pregnancy and childbirth related mortality and morbidity including adolescent pregnancies
3. Abortion
4. Reproductive cancers.

The ICPD PoA defines RH as a complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. This implies people have a satisfying and safe sex life, and they have the capability to reproduce and the freedom to decide if, when and how often to do so. This points to the right of men and women to be informed, and have access to safe, effective affordable, and acceptable, methods of family planning of their choice, and the right of access to appropriate health-care services to enable women to have a safe pregnancy and childbirth.[54]

Furthermore, the ICPD PoA defines Reproductive Rights (RR) as rights that embrace certain human rights already recognised in national laws, international human rights documents, and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, and have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free from discrimination, coercion and violence, as expressed in human rights documents.[55]

In addition, paragraph 7.6 of the ICPD PoA calls for all countries to strive to make accessible through the primary health-care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015. RH care, in the context of primary health care, should inter alia, include: family-planning, counselling, information, education, communication, and services for prenatal care, safe delivery and post-natal care, especially breast-feeding and infant and women's health care; prevention and appropriate treatment of infertility; abortion as specified in paragraph 8.25, including prevention of abortion and management of the consequences of abortion; treatment of reproductive tract infections; sexually transmitted diseases and other reproductive health conditions, and information, education and counselling, as appropriate in human sexuality, reproductive health and responsible parenthood.

Referral for family planning services, and further diagnosis and treatment for complications of pregnancy, delivery and abortion, infertility, reproductive tract infections, breast cancer and cancer of the reproductive systems, sexually transmitted diseases including HIV and AIDS should always be available, as required. Active discouragement of harmful practices, such as female genital mutilation, should be an integral component of primary health care, including reproductive health care programmes.[56]

We aim to monitor the progress in the nine Sub-Saharan countries in accordance with the ICPD PoA reproductive health, reproductive rights and reproductive health services benchmarks using sensitive gender and rights-based indicators.

We first look at the respective government views and policies concerning population in the nine countries. In all the nine countries under review, governments view fertility levels as too high, and government policies focus on reducing the fertility levels.[57] In all the nine countries, direct support in terms of provision of family planning services through government-run facilities is provided for access to contraceptive methods.[58]

1. CONTRACEPTION

In this section, we look at the following key reproductive health and rights indicators pertaining to contraception:

a) Total Fertility Rates;
b) Wanted Fertility Rates compared to Total Fertility Rates;
c) Contraceptive Prevalence Rates among married and sexually active unmarried women;
d) Male contraception as % of total contraception;
e) Contraceptive use: Informed choice;
f) Unmet need for contraception;
g) Reasons for not intending to use contraception.

The ICPD PoA has been an important consensus document that notes access to contraception as a human right. The PoA states that women are entitled "to safe, effective, affordable and acceptable methods of family planning of their choice."[59] Women's right to contraceptive information and services is an important aspect of basic human rights of the right to life, the right to attain the highest standard of health, and the right to decide the number, spacing and timing of one's children. Access to contraceptive information and services enables couples and individuals to decide freely and responsibly the number and spacing of children; to have information and means to do so; and to ensure they make informed choice and make available a full range of safe and effective methods.

A. Total Fertility Rates

The total fertility rates (TFR) trends from 1995-2011 of the countries are looked at and discussed below.

The TFR refers to the number of live births that a woman would have if she were subject to current age-specific fertility rates (ASFRs) throughout her reproductive years (age 15-49).[62] It is generally expressed as the average number of births per woman.[63] The TFR across nine countries has not changed significantly since 1995 and they show a decreasing trend with the exception of Nigeria that has increasing TFRs.[64] Zambia has the highest TFR at 6.2 [65] and the lowest TFR of 4.6 is seen in Kenya.[66]

Interestingly, in Nigeria, the TFR increased over the years and now remains stagnant at 5.7. While the Government of Nigeria recognises the importance of access to contraception, high unmet need for contraception still exists. The Demographic and Health Survey 2008 shows widespread knowledge levels of any contraceptive method, however, the actual use of contraceptive is still quite low. Some of the possible reasons cited by researchers for this trend include the high value placed on childbirth and fertility in African societies. The culture of polygyny also has the tendency to promote competition among co-wives, contributing to high fertility. A special communication on "Family planning in Nigeria and prospects for the future," published in the International Journal of Gynaecology and Obstetrics, notes that, to improve contraceptive uptake in Nigeria, joint as well as individual efforts are needed. Health care

Table 5:
Total fertility rate trends from 1995-2011

Country	Total Fertility Rate		
	1995	2003	2008-2011
Angola	7.2	6.2	5.8
Benin	6	5.6	5.7
Ethiopia	5.5	5.4	4.
Kenya	4.7	4.9	4.6
Nigeria	4.7	5.7	5.7
Rwanda	5.8	6.1	5.5
Sierra Leone	-	-	5.1
Tanzania	5.6	5.7	5.4
Zambia	6.1	5.9	6.2

Source: Angola MIS, 2006-07;[60] Benin DHS, 1996, 2001, & 2006; Ethiopia DHS 2000 & 2005; Kenya DHS, 1998, 2003, & 2008-09; Nigeria DHS 1999, 2003, & 2008; Rwanda Interim DHS, 2011, DHS 2005 & 2000; Sierra Leone DHS, 2008; Tanzania DHS, 1999, 2004-05, & 2010; Zambia DHS 1996, 2001-02, & 2007 [61]

VOICES FROM THE GROUND

Box 3: **Case study- access to contraceptives**

When I innocently went to the health clinic near my home to seek advice on which contraceptive I could use because I had just fallen in love with this young man but I was not ready for unintended pregnancy as I was still in school. I desperately needed some form of family planning contraceptives. When I explained to this Nurse what I wanted, she looked at me from top to bottom and asked me if I was married. I told her that I was not married but had a boyfriend but was not ready for any pregnancy. The next question was which family I was willing to plan if I am not married. I did not know what to say or do.

Little did I know that more lectures were on the way? She told me that she was not going to give me any kind of contraceptives as that was just encouraging me to sleep around with men, and that if I wanted that then I had to come with my mum or dad to sign some paper. I was over 18 and did not understand this at all. But because she was so nasty and did not want to get into bad books with the nurses I decided to leave but wondering what would happen if I got pregnant - Lillian 26. Kenya

providers need to provide user friendly services. Social change and access to education for girls until at least secondary level are equally important. [67] A closer examination of the TFRs based on background characteristics in respective countries shows that the TFR has declined for women with most education, women living in urban residence and women from the richest wealth quintile over the last decade.[68]

In terms of residence characteristics, a trend seen across the nine countries is that, the women in the rural areas have a higher TFR than women in urban areas. This observation again stresses the lack of knowledge of their reproductive rights, and limited access to reproductive health services (Reproductive Health Services) for women in rural areas. They are at higher risk for early marriages and sexual assault, and are unable to control their fertility. They lack access to knowledge of their SR and RR, and access to family planning methods, and this may be the reasons why they have higher fertility rates.

The levels of education show a strong inverse relationship with fertility levels. Women, who have secondary to higher education, have lower TFRs than those without. This trend is seen in all the nine countries. Women with higher levels of education gain more knowledge and also control over their fertility. They have easier access to family planning methods and also the resources to choose what type of methods to use.

In terms of the background characteristic of wealth, there is also a significant difference between women from wealthy households who have lower TFRs than women from poorer household. This is most likely attributed to the resources available to women to access Reproductive Health Services. Women from wealthier households have better access to sexual and reproductive health services where they have the option to choose the type of family planning methods that would be most effective in their lives. From the above data, marked variations can be seen in terms of background characteristics of residence, education, and wealth. Angola and Ethiopia continued to show most marked difference among the countries examined across all three characteristics of residence, education and wealth.

Seven of the nine countries under review have a total fertility rate above 5.0 (Table 5). These trends of comparatively higher fertility in the countries are characteristic of comparatively higher fertility rates seen across Sub-Saharan African countries. A study by Caldwell et al. on the cultural context of high fertility in Sub-Saharan Africa has looked at the possible reasons for higher fertility levels in the African context. These include the countries being primarily rural and have highly gender-stratified cultures which are very supportive of high fertility. Pronationalist institutions with notably patrilineal descent, patriarchal residence, inheritance and succession practices, perpetuate the lower status of women. Women generally have less control and decision making with regards to their lives. At marriage, a woman assumes a low status relative to all members of her husband's extended family, which is elevated usually by the attainment of high fertility.[69] Other reasons include a high unmet need for contraception.

B. Wanted Fertility Rate compared to TFR

The Wanted Fertility Rate (WFR) is an estimate of what TFR would be if all unwanted births were avoided. A birth is considered wanted if the number of living children at the time of conception of the birth is less than the ideal number of children as reported by the respondent according to the demographic heath survey.[70]

WFR is a rights indicator as it denotes women's control over her fertility and her ability to exercise this control. The table below compares TFR with wanted fertility rates across nine countries in Africa. TFRs have not shown any steep declines in the last decade. Similarly, among the nine countries monitored, the WFRs are not substantially lower than the TFRs except for Ethiopia, Rwanda, and Kenya.

The difference between WFR and TFR is highest in Ethiopia[73] where women are having 60% more children than they wanted to have (approximately two children or more); in Rwanda[74] and Kenya,[75] women are having 48% and 35% more children than they actually wanted to have, respectively. This shows that women in these countries are not able to plan their pregnancies and are having more children than they actually want to have.

Table 6:
Wanted fertility rates and total fertility rates in 2011

Country	Total Fertility Rate	Wanted Fertility Rate	Percentage difference
Angola	5.8	-	
Benin	5.7	4.8	19%
Ethiopia	4.8	3.0	60%
Kenya	4.6	3.4	35%
Nigeria	5.7	5.3	8%
Rwanda	5.5	3.7	48%
Sierra leone	5.1	4.5	13%
Tanzania	5.4	4.7	15%
Zambia	6.2	5.2	19%

Source: Angola MIS, 2006-07;[71] Benin DHS, 2006; Ethiopia DHS, 2011; Kenya DHS, 2008-09; Nigeria DHS, 2008; Rwanda Interim DHS, 2011; Sierra Leone DHS, 2008; Tanzania DHS, 2010; Zambia DHS, 2007 [72]

Nigeria[76] and Sierra Leone[77] show the least difference between the TFR and WFRs of 8% and 13%, respectively. Tanzania follows close behind at a 15% difference.

The Nigeria DHS 2008 notes the difference between the two measures (both total and wanted fertility rates) decreases with increasing level of education and wealth quintile, indicating that educated and wealthier women are better able to control their fertility.[78] While the Sierra Leone DHS 2008 does not show any significant difference between the total and wanted fertility rates, the gap between wanted and observed fertility is greatest among women living in rural areas, those in the northern region, women with no education, and those in the middle quintile.[79] In Tanzania, urban women are closer to achieving their wanted fertility than rural women.

C. Contraceptive Prevalence Rates among married and sexually active unmarried women

Access to safe, effective, affordable, and acceptable methods of family planning of their choice is a key determining factor to enable women to control their fertility. An examination of contraceptive prevalence in the nine countries under review sheds light on women's access to contraception.

The Contraceptive Prevalence Rates (CPR) is defined as the percentage of currently married women who currently use any method of contraception.[80]

Acceptance for contraception has been traditionally low in the region and cultural resistance to contraception has been high.[81]

The CPR for any method is much higher among sexually active unmarried women in comparison to currently married women, except for Rwanda. This indicates a higher use of contraception among sexually active unmarried women in comparison to currently married women. Among the methods, injectable pills, traditional methods, and implants rank as the most frequent contraceptive methods among currently married women. It has been noted that in Sub-Saharan Africa, the use of contraception is higher among sexually active unmarried women and this trend points to the desire of sexually active unmarried women to avoid pregnancy before marriage and avoid HIV and STI infection as the condom is the most predominant method of contraception among this group.[82]

In comparison to the other countries under review, Benin, Nigeria and Sierra Leone,have a higher percentage of sexually active unmarried women who are currently not using any method of contraception. Again, this may be attributed to the lack of knowledge of RR, RH and Reproductive Health Services, and socio-cultural barriers that have taboos about contraceptive use. There is also a huge gap between the knowledge and usage of contraceptives in this group.[83]

D. Male contraception as Proportion of Total Contraception Users

A review of modern methods of male contraception method use as proportion of all contraceptive methods among currently married women from research shows that only 0.1% of couples in Sub-Saharan Africa consider male sterilisation, a contraceptive

Table 7:
Male condom users as proportion of all contraceptive users (percentage)

Country	Male condom users as proportion of all contraceptive users(%)
BENIN	
Currently married women	6.47
Sexually active unmarried women	41.3
ETHIOPIA	
Currently married women	0.6
Sexually active unmarried women	19.0
KENYA	
Currently married women	3.9
Sexually active unmarried women	35.7
NIGERIA	
Currently married women	16.4
Sexually active unmarried women	57.5
RWANDA	
Currently married women	5.6
Sexually active unmarried women	28.3
SIERRA LEONE	
Currently married women	7.3
Sexually active unmarried women	15.7
TANZANIA	
Currently married women	6.6
Sexually active unmarried women	31.2
ZAMBIA	
Currently married women	11.5
Sexually active unmarried women	55.0

*No data available for Angola. No data available on Male sterilization users as proportion of all contraceptive users.
Source: Benin DHS, 2006; Ethiopia DHS, 2011; Kenya DHS, 2008-09; Nigeria DHS, 2008; Rwanda Interim DHS, 2011; Sierra Leone DHS, 2008; Tanzania DHS, 2010; Zambia DHS,2007 [84]

method despite it being a safer, less invasive, and cheaper option to female sterilisation. Among the nine countries, only Kenya, Rwanda, Tanzania, and Ethiopia provide the service.[85] This may be due to lack of knowledge of the method.

In Nigeria, low use of vasectomies is credited to misconceptions and limited information about the procedure and because of this, they view it as an unacceptable method of contraception.[86] The use of male condoms as proportion of all contraceptive methods among currently married women is highest in Nigeria (16.4%) and Zambia (11.5%). The use of male condoms as proportion of all contraceptive methods is lowest in Ethiopia (0.6%). The low condom use may be attributed to the taboos that go along with condom use. One of the taboos is that condom use is only for promiscuous people and commercial sex workers.

The use of male condoms among sexually active unmarried women is higher than married women (Table 7). The fear of unwanted pregnancies, health concerns about the use of modern contraceptives, anxieties that future childbearing will be jeopardised, and the dual protection against HIV transmission and pregnancy offered by condoms are seen as factors contributing to higher use of condoms among sexually active unmarried women.[87]

E. Contraceptive Use: An Informed Choice

Informed choice is an essential Reproductive Rights indicator and takes into account the percentage of current users of selected contraceptive methods who were informed about side effects or problems of the method used; who were informed of what to do if they experienced side effects or problems with the methods used; who were informed of other methods of contraception that could be used; and the percentage of women who have had contraceptive sterilisation and were told that they would not be able to have any more children. The ICPD PoA paragraph 7.17 calls for government action to secure conformity to human rights and to ethical and professional standards in the delivery of family planning and related reproductive health services aimed at ensuring responsible, voluntary, and informed consent. Information on these indicators can be found in respective demographic and health surveys.

In Ethiopia, around 28% of current users of the pill, IUD, injectable, or implants were informed about potential side effects of their method, 24% were told what to do if they experienced side effects, and 37% were given information about other methods.[88]

In Kenya, the DHS 2008-09 notes that almost all women (92%), who were sterilised during the five-year period preceding the survey, were informed that they would not be able to have any more children. 61% of users of modern contraceptive methods were informed of other methods available that could be used, while 57% were informed of the side effects or health problems of the method they were provided, and 52% were informed of what to do if they experienced side effects.[89]

In Nigeria, 59% of contraceptive users were informed of the side effects of the method they use, 54% were informed about what to do if they experienced side effects, and 65% were informed of other available methods of contraception.[90]

In Rwanda, a majority of users were given information about each of the three issues considered to be essential parts of informed choice: 64% were informed about potential side effects of their method, 68% were told what to do if they experienced side effects, and 78% were given information about other contraception methods and options.

In Sierra Leone, over half (55%) of modern contraceptive methods users were informed of the side effects or health problems that can be associated with the method they were provided and what to do if they experienced side effects. About six in ten (58%) users of modern methods were told of other methods that were available.

In Tanzania, a majority of users were given information about each of the three issues considered to be essential parts of informed choice; 57% were informed about potential side effects of their method, 57% of women were told what to do if they experienced side effects, and 77% of the users were given information about other contraception methods and options.

In Zambia, 74% of contraceptive users were informed of the side effects of the method they used, 73% were informed about what to do if they experienced side effects, and 63% were informed of other available methods of contraception.

From the above data, it is noticed that informed consent is widespread, and more than half and up to three fourths of

Table 8:

Respective countries' unmet need for contraception trends in percentage

Country	2003	2008-2011
Angola	-	-
Benin	27.9 (2001)	27.3 (DHS 2006)
Ethiopia	36.6 (2000)	26.3 (latest data: EDHS 2011)
Kenya	28.0 (1998)	25.6 (DHS 2008-09)
Nigeria	17.5 (2003)	20.2 (2008) 18.9 (2011MICS)
Rwanda	36.4 (2000)	20.8 (latest data: DHS2010/11)
Sierra Leone	-	28.4 (2008)
Tanzania	22.3 (1999)	25.3 (2009-10)
Zambia	27.5 (2001-02)	26.6 (2007)

Source: Benin DHS, 2006; Ethiopia DHS, 2011; Kenya DHS, 2008-09; Nigeria DHS,2008; Rwanda Interim DHS, 2011; Sierra Leone DHS, 2008; Tanzania DHS, 2010; Zambia DHS, 2007 [91]

current users of contraception in the above countries have been informed of side effects, what to do when a situation arises, and a range of other methods. Except for Kenya, there is little or no information on contraceptive sterilisation users knowing that the method is irreversible.

F. Unmet need for Contraception

Women who say they are not using contraception and who say either that they do not want any more children or that they want to wait two or more years before having another child are considered to have an unmet need for contraception.[92] Women who want to avoid pregnancy but are not using an effective contraceptive method add to a large majority of unintended pregnancies in developing countries.[93] According to Guttmacher estimates in 2009, if all women who wanted to avoid pregnancy used modern contraceptives, the number of unintended pregnancies in developing countries would fall from 75 million to 22 million annually, and this would translate to 22 million fewer unplanned births, 15 million fewer unsafe abortions and 90,000 fewer maternal deaths.[94]

In Sub-Saharan Africa, it is estimated that pregnancy related deaths would drop by 48,000. The measure of unmet need is an important RR indicator which measures a woman's control over her fertility matters and her ability to decide whether to have children, when, and how many.[95]

In Sub-Saharan Africa, the number of women with unmet needs for modern contraception shows an increase from 31 million in 2008 to 36 million in 2012, according to a recent Guttmacher-UNFPA report. The report also notes that in 2012 modern methods were used by 57% of married women in the developing world. In Sub-Saharan Africa, however, the figure is a low 17% and the same as recorded in 2008.[96] There is no significant change in unmet need statistics between 2003 and 2012.[97] However, the unmet need for contraception has, in fact, increased in Nigeria and Tanzania, and it also shows a higher unmet need among rural and less educated women.

In Kenya, a high one quarter of currently married women have an unmet need for contraception, and this figure almost remained unchanged in three consecutive DHS. The unmet need was, in fact, only slightly higher in 2003 in comparison to the 2010 survey.[98] (Table 8)

In Nigeria, 20% of currently married women had an unmet need for contraception in 2008.[99] The use of modern methods is very low and the unmet need remains unchanged and this trend needs to be examined.[100] This trend may be a contributing factor to the high TFRs in Nigeria seen earlier.

In Zambia, an overall 26.5% of currently married women have an unmet need for contraception with the highest unmet need in spacing births. The unmet need remains unchanged since 1996. Overall trends in Kenya, Nigeria and Zambia show a higher unmet need among rural and less educated women. In Tanzania, 25% of currently married women have an unmet need for contraception. The unmet need for contraception in Tanzania remained unchanged from 2004. The range of unmet need for contraception among married women in 2011 is between 19.8% (Rwanda) - 29.9% (Benin).

In Rwanda and Kenya, the unmet need for spacing and limiting births is almost equally distributed. The data on unmet need in the DHS shows a higher unmet need among rural women in Ethiopia, Kenya, Nigeria, Rwanda, and Zambia. The unmet need is much higher among women with no education in Ethiopia, Kenya, Nigeria, Rwanda, and Zambia. Women in the lowest wealth quintile in Ethiopia, Kenya, Rwanda, and Zambia show a higher unmet need for contraception. Unmet need is also highest among women in the age group of 15-19 in Ethiopia, Kenya, and Rwanda. Sierra Leone did not show major differences in unmet need by background characteristics.[101] It needs to be noted here that Benin DHS was not examined to look at the background differentials.

G. Reasons for not intending to use contraception

The reasons why women are not using contraception are important indicators to assess the extent to which women's non-use of contraception is involuntary and can be addressed. Data on this indicator was found in four most recent DHS in Kenya (2008), Nigeria (2008), Sierra Leone (2008), and Zambia (2007). The main reasons for not intending to use contraception among currently married women who are not using a method and who do not intend to use a contraceptive method in the future points to following reasons:

In the four countries where the data on the indicator is available, the data shows that opposition to use by respondent and partner were the most commonly cited reasons for not intending to use contraception in future in Nigeria (39.4) and Sierra Leone (37.4). Fertility related reasons, most importantly, infecundity and menopause were cited as the most common reason for not intending to use contraception in Zambia (54.7%). Method related reasons recorded a 38.4%, in particular, the fear of side effects and health concerns, were cited as the most common reason for not using contraception in Kenya. Fertility related reasons ranked the second most common reason for not intending to use contraception in Kenya (29.9), Nigeria (28.6), and Sierra Leone (27.4). (Table 9)

It is interesting to note that "opposition to use by partner/ husband and respondent" and "wants as many children as possible" constitute major reasons for higher percent distribution of currently married women who are not using contraception and who do not intend to use contraception in the future.

Table 9:
Reasons for not intending to use contraception in the future

Reason	Kenya DHS 2008-09	Nigeria DHS 2008	Sierra Leone DHS-2008-09	Zambia 2007
Fertility-related reasons	29.9(2)	28.6(2)	27.4(2)	54.7(1)
Infrequent sex/ no sex	6.7	2.7	1.4	7.9
Menopausal/had hysterectomy	8.5	4.0	6.0	13.4
Sub fecund/in fecund	6.9	5.4	9.5	22.5
Wants as many children as possible	7.8	16.5	10.5	10.9
Opposition to use	23.0(3)	39.4(1)	37.4(1)	10.5(3)
Respondent opposed	7.9	20.8	13.5	4.9
Husband/ partner opposed	6.0	9.8	14.4	4.1
Others opposed	0.1	0.9	0.2	0.1
Religious prohibition	9.0	7.9	9.3	1.4
Lack of knowledge	4.2(4)	9.1(4)	12.0(4)	2.1(4)
Knows no method	2.3	8.1	11.3	1.7
Knows no source	1.9	1.0	0.7	0.4
Method-related reasons	38.4 (1)	15.5(3))	17.6(3)	26.2(2)
Health concerns	14.9	2.7	3.4	4.3
Fear of side effects	15.8	8.1	10.8	17.6
Lack of access/too far	0.8	0.2	0.3	0.4
Costs too much	0.4	0.2	1.3	0.1
Inconvenient to use	0.5	0.6	0.5	0.7
Interfere with body normal process	5.9	3.7	1.3	3.1
Other	3.6	4.7	3.1	4.7

Source: DHS data of respective countries [102]

SUMMARY

In the nine countries under review, seven of the nine countries have a total fertility rate above 5.0. These trends of comparatively higher fertility rates are characteristic of trends of higher fertility seen across Sub-Saharan African countries. The TFR is higher primarily among women in rural areas, with lower education and in poorer households. Overall literature on the reasons for high fertility in the region points to highly gender-stratified cultures which are very supportive of high fertility. Pronationalist institutions notably patrilineal descent, patriarchal residence, inheritance and succession practices, show that hierarchical relations actually perpetuate the lower status of women.

Women in these households have less control and decision making with regards to their lives. At marriage, woman assumes a low status relative to all members of her husband's extended family, which is elevated usually by attaining high fertility.

Early marriages, economic status, and religious affiliation also contribute to high fertility rates.[103] Significant differences between TFR and WFR were not observed, except for Ethiopia, Rwanda and Kenya. The difference is highest in Ethiopia[104] where women are having 60% more children than wanted; in Rwanda[105] and Kenya,[106] women are having 48% and 35% more children than wanted, respectively. There was no significant difference in Nigeria, although the country has a high TFR, indicating that women were actually having as many children as they wanted.

However, all the countries had an unmet need for contraception, a major contributing factor to the high TFRs. Opposition from their partners for contraceptive use, fear of infertility, and wanting to have as many children as possible, are among the reasons for not using contraceptives and contribute to the high rates.

The CPR for any method points to the higher use of contraception among sexually active (SA) unmarried women, in comparison to married women who want to avoid pregnancy before marriage and also avoid HIV and STI infection as using a condom is the most predominant method of contraception among SA unmarried women. Although there is a high use of contraceptives among SA unmarried women compared to married women, we also observe the high percentage of SA unmarried women not using contraceptives, suggesting there is a huge gap between knowledge and usage. The use of contraception is also highly influenced by the background characteristics of the woman.

A review of male condoms usage as proportion of all contraceptive methods among currently married women and SA unmarried women indicates a relatively much higher use of male condoms among SA unmarried women, which as mentioned earlier, may be because it is difficult for married women to negotiate condom use with their partners. We do not see any significant changes in unmet need statistics between 2003 and 2011, although the unmet need for contraception has, in fact, increased in Benin, Kenya, Nigeria and Zambia. Opposition to use by partner/husband and respondent, low chances of pregnancy, and wanting as many children as possible, constitute as some of the major reasons for a higher distribution percentage of currently married women who are not using contraception and who do not intend to use contraception in the future.

2.
PREGNANCY AND CHILDBIRTH-RELATED MORTALITY AND MORBIDITY

Pregnancy related mortality and morbidity are among the leading causes of death and disability among women. Globally, an estimated 287,000 maternal deaths occurred in 2010, a decline of 47% from recorded levels in 1990. Sub-Saharan Africa accounts for 56% of the global burden in 2010.[107] Nigeria accounts for a high 14% (40000) of the global maternal deaths. Sub-Saharan Africa had the highest maternal mortality ratio (MMR) at 500 maternal deaths per 100 000 live births. In the nine countries under review, Sierra Leone, and Nigeria fall in the category of the eight highest MMR countries.[108]

In this review, we deal with key RH and RR indicators relating to pregnancy and childbirth related mortality and morbidity:

A. Maternal Mortality Ratio (MMR)
B. Lifetime risk of maternal death
C. Interventions to prevent maternal deaths
    i. Emergency Obstetric Care (EmOC)
    ii. Skilled Attendants
    iii. Postpartum care
D. Interventions towards the promotion of maternal health
    i. Antenatal care
E. Maternal Morbidity status on Sub-Saharan Africa: Fistula
F. Adolescent pregnancy

PREVENTION OF MATERNAL DEATHS

In this section, we will focus on the prevention of maternal deaths and examine indicators of MMR, lifetime risk of maternal death and interventions to prevent maternal deaths such as - EmOC, skilled attendants at birth, and post-partum care.
The ICPD PoA urges that all countries should also aim to reduce maternal morbidity and mortality to levels where they no longer constitute a public health problem, keeping in mind that disparities in maternal mortality within countries and between geographical regions, socio-economic and ethnic groups should be narrowed. "***Countries with the highest levels of mortality should aim to achieve by 2005 a maternal mortality rate below 125 per 100,000 live births and by 2015 a maternal mortality rate below 75 per 100,000live births. However, all countries should reduce maternal morbidity and mortality to levels where they no longer constitute a public health problem" (ICPD, Para. 8.21).***

A. Maternal Mortality Ratio

A maternal death is "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration or site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes."[109] The direct causes of maternal deaths worldwide are haemorrhage, sepsis, obstructed labour, pre-eclampsia and eclampsia or the hypertensive disorders of pregnancy, and complications of unsafe abortion. The most important fact about maternal deaths is that these complications cannot be predicted or prevented, except those resulting from unsafe induced abortion.

None of the countries are likely to achieve the ICPD target of maternal mortality level of 75/100,000 live births by 2015. In 2010, Sierra Leone and Nigeria have the highest MMR at 890 and 630, respectively. An examination of trends in MMR in Sierra Leone, Nigeria, and Rwanda shows some improvements in MMR reduction. The region also has 10% of maternal deaths attributed to HIV.[110]

Rwanda, among the nine countries under review, has shown progress in reducing the MMR from 1400 in 1995 to 540 in 2008. The primary factors for progress include a holistic approach with the focus on universal coverage, increase in the health workforce and their skills, performance-based financing, community-based health insurance, and better leadership and governance.

Table 10:
MMR, and lifetime risk of maternal death

	Maternal Mortality Ratio: Maternal Deaths per 100,000 live births						
Country	1990	1995	2000	2005	2010	Lifetime risk of maternal death: 1 in ... 2010	ICPD Target for 2015 met
Angola	1200	1200	890	650	450 (210-1000)	39	No
Benin	770	660	530	430	350 (220-600)	53	No
Ethiopia	950	880	700	510	350 (210-630)	67	No
Kenya	400	460	490	450	360 (230-590)	55	No
Nigeria	1100	1000	970	820	630 (370-1200)	29	No
Rwanda	910	1000	840	550	340 (200-590)	54	No
Sierra Leone	1300	1300	1300	1000	890 (510-1700)	23	No
Tanzania	870	840	730	610	460 (190-740)	38	No
Zambia	470	530	540	500	440 (220-790)	37	No

Source: WHO; UNICEF; UNFPA; The World Bank. (2012). Trends in Maternal Mortality: 1990 to 2010. Estimates developed by WHO, UNICEF, UNFPA and the World Bank. Geneva, Switzerland: WHO. *ICPD targets for 2015 met? Countries with intermediate levels of mortality should aim to achieve a maternal mortality rate below 60 per 100,000 live births by the year 2015, and countries with highest levels of mortality should aim to achieve by 2015, a maternal mortality rate below 75 per 100,000 live births.

Despite some improvements, Sierra Leone still records a very high maternal mortality. Poor utilisation of labour and delivery services, poor utilisation of EmOC services, lack of skilled birth attendants, user fees, and distance from the health facility, all these act as barriers to improving maternal health services. In the post-conflict recovery period, it is important to invest significant additional resources to improve the infrastructure and equipment, as well as recruit a health workforce, including midwives, to further reduce maternal mortality.

In Nigeria, a report by the Centre for Reproductive Rights, "Broken Promises: Human Rights, Accountability and Maternal Death in Nigeria in 2008" highlights a number of factors that inhibit the provision and availability of maternal health care in the country. These include: the inadequacy or lack of implementation of laws and policies, the prevalence of systemic corruption, weak infrastructure, ineffective health services and the lack of access to skilled health-care providers. Financial, infrastructural, and institutional barriers to maternal health care also fuel the high rate of maternal death in the country. Each obstacle reflects the gross inadequacy of essential building blocks of a health system. Formal and informal user fees in both public and private facilities constitute serious barriers to obtaining quality maternal health care, resulting in women either not seeking care or being denied essential services when they are unable to pay the accompanying fees.

Another unfortunate outgrowth of user fees is the detention of women who cannot pay for the maternal health care services they have received until they find the necessary funds. The fear of being detained could discourage pregnant women from seeking skilled maternal care. Even those who do have the courage to seek professional treatment during delivery may risk foregoing postnatal care in order to escape detention. Overall, most of the issues raised in Nigeria are also present in the other Sub-Saharan countries, so a concerted effort by the respective governments to address these barriers will go a long way in reducing the current high MMR.

Table 11:
Emergency Obstetric Care Indicators

Indicator	Acceptable level
1. Availability of emergency obstetric care: basic and comprehensive care facilities	There are at least five emergency obstetric care facilities (including at least one comprehensive facility for every 500,000 population)
2. Geographic distribution of emergency obstetric care facilities	All subnational areas have at least five emergency obstetric care facilities (including at least one comprehensive facility) for every 500 000 population.
3. Proportion of all births in emergency obstetric facilities	(Minimum acceptable level to be set locally)
4. Met need for emergency obstetric care: proportion of women with major direct obstetric complications who are treated in such facilities	100% of women estimated to have major direct obstetric complications are treated in emergency obstetric care facilities
5. Caesarean sections as proportion of all births	The estimated proportion of births by caesarean section in the population is not less than 5% or more than 15%
6. Direct obstetric case fatality rate	The care fatality rate among women with direct obstetric complications in emergency obstetric care facilities is less than 1%
New indicators for emergency obstetric care	
7. Intrapartum and very early neonatal death rate	Standards to be determined
8. Proportion of maternal deaths due to indirect causes in emergency obstetric care facilities	No standard can be set

B. Adult Lifetime Risk of Maternal death

The Adult Lifetime Risk of Maternal Death is the probability that a 15-year-old woman will die eventually from a maternal cause.[111] The Adult Life Time Risk of Maternal Death is the function of both the likelihood of surviving a single pregnancy and the number of pregnancies an average woman has.

The Adult Lifetime Risk of Maternal Mortality in women from Sub-Saharan Africa was the highest at 1 in 39, in contrast to 1 in 130 in Oceania, 1 in 160 in Southern Asia, 1 in 290 in South-eastern Asia, and 1 in 3800 among women in developed countries.[112] The highest adult lifetime risk of maternal death was recorded in Sierra Leone at 1 in 23 and Nigeria at 1 in 29. This is no surprise, as countries that have a high MMR, high TFR and also cases of low contraceptive use would have a high lifetime risk.

C. Interventions to prevent maternal deaths

i. Emergency Obstetric Care

The provision of EmOC is the core component of any programme to reduce maternal deaths. Based on the updated emergency obstetric care guidelines in 2009, the current recommendation is to have "at least five EmOC facilities including at least one comprehensive facility per 500,000 population."[113]

WHO, UNICEF, and UNFPA, issued the guidelines for the monitoring and availability of EmOC in 1997. A new edition was published in 2009 entitled, "Monitoring emergency obstetric care: a handbook," which updated the previous set of indicators to monitor emergency obstetric care. The updated indicators are presented in the Table 11 These guidelines introduced a set of six process indicators and two new indicators to monitor obstetric services. The UN process indicators, as they are widely known, are based on the understanding that in order to prevent maternal deaths, basic and comprehensive EmOC must be available to women who need them.[114]

Given the high level of MMR in Africa, many countries have invested heavily in EmOC facilities in an attempt to achieve the MDG target of reducing the MMR by 75% between 1990 and 2015.

The updated guidelines define specific process indicators to measure the "minimum acceptable" level of access to EmOC in any given region. The UN Guidelines divide health facilities into two groups, basic EmOC facilities and comprehensive EmOC facilities, based on their ability to perform defined signal functions. Basic EmOC facilities can:

1. Administer parenteral antibiotics
2. Administer uterotonic drugs (i.e. parenteral oxytocin)
3. Administer parenteral anticonvulsants for pre-eclampsia and eclampsia
4. Perform manual removal of placenta
5. Perform removal of retained products
6. Perform assisted vaginal delivery
7. Perform basic neonatal resuscitation.

Comprehensive EmOC facilities can perform all seven basic functions, plus Caesarean section and blood transfusion.[115] Women with obstetric complications will seek EmoC services if these services are made available. This was the conclusion arrived at during a facility review and focus group discussions based study in a Government hospital located in the town of Makeni - one of the district hospitals in Sierra Leone. Following improvements such as posting a physician with obstetric skills, a trained second physician, courses in life saving obstetric skills for nurses and midwives, and operating theatre being made functional with simple modifications, the following results were observed - the number of women seeking treatment for major obstetric complications at the district hospital increased from 31 in 1990 to 98 in 1995, 444 abortion related procedures were performed compared with only 22 in 1990. Caesarean sections increased from 2 in 1990 to 38 in 1995.[116]

Thousands of women and girls die every year in Sierra Leone as a result of treatable complications of pregnancy and childbirth as mentioned earlier.[117] There is a need to expand the referral and emergency obstetric care capacities in the health systems in the above countries. There is a need for trained staff, community workers, midwives, nurses and doctors, to provide quality emergency obstetric services to deal with obstetric complications such as haemorrhage, hypertensive disorders of pregnancy, sepsis infections, and obstructed labour, which cause more than 60% of maternal deaths.

The AMDD works with national governments, UN agencies, and local NGOs to implement innovative strategies that address the massive shortage of health workers able to deliver EmOC. These strategies include, utilising non-clinician physicians to treat women facing life-threatening obstetric complications. For many years, in countries such as Malawi, Mozambique, and Tanzania, non-physician clinicians have successfully delivered EmOC in communities unable to attract and retain doctors.[118]

In Tanzania, the Tanzanian Maternal, Newborn and Child Health partnership was launched in 2007 with the goal of reducing mortality through One Plan. One of the targets of One Plan is to have 100% of hospitals and 50% of health centres provide comprehensive EmOC, and 70% of health centres and dispensaries provide basic EmOC by 2015. Despite this goal, there has been, however, little clarity about who is expected to provide EmOC and this may be one of the factors contributing to the low performance of EmOC.

ii. Skilled Attendants at Birth

A skilled attendant, according to WHO, refers to an accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns. Traditional birth attendants, trained or not, are excluded from the category of skilled attendant at delivery.[119] It was agreed at the ICPD in 1994, that all births should be assisted by trained persons, preferably nurses and midwives, but at least by trained birth attendants. The key actions for further implementation of the PoA of the ICPD noted that countries have to achieve 85% skilled attendance by 2010.

None of the nine countries have achieved the ICPD target of skilled attendance at birth of 85% attendance.[120] Rwanda recorded the highest skilled birth attendance at 69%, whereas Ethiopia was the lowest at 10%. For all the countries, the likelihood of deliveries with skilled health care workers is also dependent on background characteristics, where women in urban areas, women with secondary or higher education, and women in the rich and wealthy quintile are much more likely to be assisted by skilled birth attendants. Younger mothers and first births are also more likely to be assisted by skilled birth attendants compared to older women and second or more births.

In Ethiopia, 61% of women do not consider it necessary to be assisted by a skilled attendant.[121] The Sierra Leone DHS states that only 42% of births in Sierra Leone are delivered with the assistance of a skilled birth attendant. Almost all births that occur in health facilities are assisted by trained providers. The Zambia DHS notes that in 2007, 47% of the births were assisted by a skilled birth attendant. Benin has the highest skilled birth attendance at 74%, which explains why they have been able to lower their MMR in the last decade to 410 and have reduced lifetime risk to 1 in 53.[122]

The Tanzania DHS notes that 50.6% of births are assisted by skilled attendants and this is still below the ICPD target. This explains the limited change in MMR over the decade and high number of maternal deaths. Although the Averting Maternal Death and Disability (AMMD) programme was established in Tanzania, the lack of clarity, as mentioned earlier, of who is to provide the care may be a major factor for the high rates.

According to the Kenya DHS, 43.8% of births are assisted by skilled birth attendants. Maternal age and the child's birth order are associated with the type of assistance at delivery. Older women, who have had earlier births, are not likely to seek assistance by skilled birth attendants compared with births to younger women and those of first of order births. Regional differentials in regards to the type of assistance at delivery are also pronounced in Kenya.

According to the Nigeria DHS 2008, 38.9% of births were assisted by a skilled health worker. Young women below 20 years of age and older women (35-49 years) are most likely to deliver without any assistance. Women in urban areas are most likely to be assisted by a nurse or midwife (40%), while women in rural areas are most likely to be assisted by a traditional birth attendant (25%).

The Rwanda DHS 2010 states that 69% of births were assisted by a skilled provider; this is a significant increase over a five year period. Deliveries assisted by skilled birth attendants were more frequent among the youngest mothers (83%), those in the first birth order category (88%), and those who delivered in health facilities (100%). In the research undertaken by Sonya Crowe et al in their paper titled, "How Many Births in Sub-Saharan Africa and South East Asia Will Not Be Attended By A Skilled Birth Attendant Between 2011 and 2015", she notes that in many cases the skilled birth attendant may not be a qualified health professional, that the disparity between access in the urban rural divide is likely to increase. The study projects that many women in rural areas will not have access to qualified health professionals and in most cases, they will go to facilities where the skilled birth attendance is not part of a system which holds them accountable. The paper also noted that in the next five years, Nigeria and Ethiopia will contribute to the 342,900 global maternal deaths due to the lack of access to skilled birth attendants.[123]

Another study by Nancy Gerien et al, on "The implications of Shortages of Health Professionals For Maternal Health in Sub-Saharan Africa", highlights that the work force in Africa is in crisis and is depleting due to HIV and emigration to international organisations, particularly in Nigeria and Zambia, noting that staff migration accelerates staff attrition. A needs assessment for five countries in Africa, including Tanzania, notes that availability of quality staff is an important determinant of utilisation of emergency obstetric care, together with the availability of drugs, equipment and management capacity.

A nurse working in an urban hospital in Kenya shares her frustration of working in a very busy hospital with staff shortages - "We have 80 deliveries in 24 hours, so you can imagine with my skeleton staff. It has not been easy, you get frustrated as the queue is too long, you don't satisfy the clients, you are upset the employer is upset and women don't get adequate care." This has implications for young women who will normally avoid going to such facilities.

Skilled attendance at birth is highly associated with the background characteristics of women as mentioned earlier. At the same time, lack of skilled birth attendants who are also trained in the use of EmOC services, staff shortages, and drugs and equipment shortages impact the availability of skilled attendance for pregnant women in the above countries under review.

Table 12:
Women not receiving post natal care

Country	No Postnatal Care
Ethiopia	92(2011)
Kenya	53(2008-09)
Nigeria	56(2008)
Rwanda	82(2010)
Sierra Leone	33(2008)
Tanzania	65(2010)
Zambia	51(2008)

* No data available for Angola and Benin
Source: DHS data

iii. Postpartum care

A large proportion of maternal and neonatal deaths occur during the 48 hours after delivery, and the first two days following delivery are critical for monitoring complications arising from the delivery. It is recommended that all women receive a health check-up within two days of delivery.[124] According to a study, haemorrhage is one of the main causes of maternal deaths in Africa. Skilled attendance at delivery and postpartum care are critical to preventing and managing this condition. About one half of all births in Sub-Saharan African countries occur outside health facilities and three quarters of these births do not receive postpartum care. The timing of first care is also critical as delay in providing postpartum care can result in maternal deaths.[125]

The 2011 Ethiopia DHS records a low postnatal care coverage. A disturbingly high 92% of women with a live birth in the preceding five years did not receive postnatal care. Among the women who received postnatal check-ups, only 7% of women received it within the recommended two days.[126]

In most countries, the small proportion that received postpartum care did not get it within the crucial 48 hours after delivery. At the same time, there is no data available on the quality of postpartum interventions including early detection and management of obstetric complications immediately after delivery, education and provision of contraception for birth spacing or limiting, counselling and support for breastfeeding, voluntary counselling and testing for HIV in the African context, advice and recommendation regarding postnatal nutrition, social and psychological support to women.[127] (Table 12)

D. Interventions towards the promotion of maternal health: Antenatal care

Antenatal care coverage is an indicator of access and utilisation of care during pregnancy. It is defined as the percentage of women who utilised antenatal care provided by skilled birth attendants for reasons related to pregnancy at least once during pregnancy among all women who gave birth to a live child in a given time period.[128] Antenatal care for one visit has increased for all countries under review since 2001, except for Nigeria.[129] With respect to four antenatal visits, only Rwanda showed some significant improvements. In all the other countries under review, the proportion covered appears to have declined over time, however, by very little. One antenatal visit is much higher in all the countries under review, but when it comes to four antenatal visits, there is a comparatively lower percentage of women who are able to benefit from four antenatal visits. A study on risk factors for maternal mortality in Northern Tanzania noted that the high MMR is due to traditional beliefs, age of the women, and low education of male spouses, who are the de-facto decision makers. Frequency of antenatal clinic visits was also defined as a key factor increasing risk and the paper proposes an increase in antenatal clinic visits as a key strategy for reducing the risk of maternal mortality. Looking at who provides antenatal care and what components of care were provided is also important. Antenatal Care (ANC) is mostly provided by skilled health care workers. In countries, where skilled health care worker attendance is low and ANC is low, such as Ethiopia, their health system lacks the resources to provide maternal health care.

ANC is an important indicator in the promotion of maternal health. Antenatal care detects and manages conditions during pregnancy that have the potential to lead to complications and adverse maternal outcomes. The detection of hypertension, proteinuria, STIs/HIV, anaemia, and foetal mal-presentation can be detected if women have quality antenatal care.

Table 13:
Components of antenatal care provided to women, based on birth in three years preceding the survey.

Country	Informed of signs of pregnancy complications	Blood Pressure measured	Urine Sample taken	Blood Sample Taken
Benin (2006)	39.0	98.6	91.4	39.3
Ethiopia (2011)	20.3	70.9	40.6	55.6
Kenya (2008-09)	42.4	84.2	66.6	82.7
Nigeria (2008)	60.7	84.4	73.6	72.9
Rwanda (2010)	72.0	85.7	33.6	93.7
Sierra Leone (2008)	59.6	86.8	40.0	46.4
Tanzania (2010)	52.0	66.2	49.8	76.3
Zambia (2007)	73.3	79.0	20.8	57.6

Source: DHS data[130]

E. Maternal Morbidity: Fistula

While the recent estimates show some 287,000 women died of maternal causes in 2010, between 10 and 15 million more suffer debilitating complications annually, severely affecting their well-being. Only the DHS in Nigeria and Tanzania captured situations of morbidity in the nine countries under review.

Obstetric fistula refers to a complication arising from obstructed or prolonged labour resulting in a hole or opening in the birth canal. Fistula-vesico vaginal fistula resulting in uncontrollable leakage of urine from the bladder through the vagina and recto vaginal fistula, the leakage of stool from the vagina, are debilitating complications resulting not only in poor quality of life but also social problems of rejection shame and stigma. These conditions affect most disadvantaged women. Obstetric fistula is preventable with timely and effective medical intervention. An estimated 2 million women in Sub-Saharan Africa, South Asia and Arab region are living with this condition, and some 50,000-100,000 new cases occur every year.

The findings from the Nigeria DHS 2008 pointed to a very small proportion of women (1%), who experienced symptom consistent with fistula. Of the very small proportion of women, 46% reported they experienced the symptoms following the delivery of their first child, 30% reported the symptoms following the delivery of their second, third or fourth child. The proportion of women reporting fistula symptoms decreased to 21% for women delivering five or more children. Three quarters of women reported the symptoms began after a difficult labour.[131]

Similarly, in Tanzania (DHS 2010), less than 1% of women reported experiencing symptoms of fistula, while majority (67%) of women heard of the problem. Based on the DHS data, fistula is a condition affecting about 1% of women. More studies need to be done on this issue to accurately measure its magnitude.

F. Adolescent Pregnancies

The ICPD (1994) calls for a substantial reduction of adolescent pregnancies (ICPD PoA para 7.44). It also endorses the right of adolescents to the highest level of sexual and reproductive health care.

According to WHO, ***the term "adolescent pregnancy" means pregnancy in a woman aged 10-19 years. In most statistics, the age of the woman is defined as her age at the time the baby is born. Because a considerable difference exists between a 12 or 13-year-old girl, and a young woman of say 19, authors sometimes distinguish between adolescents aged 15-19 years, and younger adolescents aged 10-14 years. Birth rates and pregnancy rates are counted per 1000 of a specific population. Statistics comparing the incidence between countries often give rates per 1000 adolescents aged 15-19 years. Sometimes statistical data on pregnancies and births among younger adolescents are also available. The pregnancy rate includes pregnancies ending in births and also pregnancies ending in abortion.***[132]

About 16 million adolescent girls aged 15-19 years, gave birth in 2008, representing 11% of all births worldwide. Half of all adolescent births occur in just seven countries: Bangladesh, Brazil, the Democratic Republic of Congo, Ethiopia, Nigeria, India, and the United States (Population Division 2008). About 95% of these births occurred in low and middle income countries.

Table 14:
Adolescent birth rate per 1,000 women

Country	1995	2003	2008
Angola	145.6 (1996)	122.4 (2001)	165.0 (2005)
Benin	123.0 (1994)	114.0 (2004)	-
Ethiopia	98.9 (1994)	109.1 (2003)	79 (2011)
Kenya	111.0 (1996)	116.0 (2001)	106.3 (2007)
Nigeria	111.0 (1997)	126.0 (2002)	123.0 (2006)
Rwanda	45.0 (1996)	44.2 (2003)	43.0 (2006)
Sierra Leone	177.5 (1992)	113.3(2003)	143.0 (2006)
Tanzania	130.0 (1994)	139.0 (2003)	116.0 (2009)
Zambia	156.0 (1994)	161.0 (2000)	151.1 (2005)

Source: Millennium Development Goal official database

Although there is a decline in the adolescent birth rate in most of the African countries, the pace of decline is painfully low. Another factor contributing to this decline is the increasing number of adolescent population, rather than absolute number of adolescent's births. It is observed that pregnancies and births to adolescents aged 10 to 14 years are relatively rare events in most countries; nevertheless, in some Sub-Saharan African countries, the proportion of women who give birth before the age of 15 years has ranged from 0.3% to 12% since 2000, according to various sources.[133]

Sexual activity is initiated between 15 and 19 years of age, and this is earlier in boys than girls, generally. In low income countries, sexual activity for girls is often initiated within the context of marriage, as a result of coercion, frequently with older men. Sexual activity is more frequent and higher among adolescents in stable relationships, such as marriage or union, and in such relationships, there is a greater possibility of pregnancy. The rates of having a child outside marriage vary across Sub-Saharan Africa.[134]

Adolescent girls also face many other barriers, though the ICPD and other SRHR documents emphasize the right of adolescents to sexual and reproductive health information and services. At the implementation level, adolescents face unique barriers to health services. Many countries have laws that prohibit people less than 18 years of age from accessing sexual and reproductive health services without parental or spousal consent, effectively denying many sexually-active adolescents access to those services.

Evidence points to the fact that adolescent mothers are more likely to suffer from pregnancy and delivery complications than older mothers, resulting in higher morbidity and mortality for both themselves and their children. In addition, early childbearing reduces other opportunities such as education and employment, thus, blocking adolescent girls' right to full development.

In the nine countries of this study, the adolescent birth rate ranges between 165 per 1000 women in Angola to 106.3 per 1000 women in Kenya. One exception of a lower birth rate is Rwanda with a birth rate of 43.0 in comparison with the other eight countries.[135] High adolescent birth rates are observed in all the nine countries. Across all the nine countries, the adolescent birth rate has a negative association with:

1. residence - adolescent fertility rate is higher in rural areas,
2. education - adolescent girls with lesser education have a higher adolescent fertility rate, and
3. wealth - adolescent girls in poorer households tend to have a higher adolescent fertility rate.

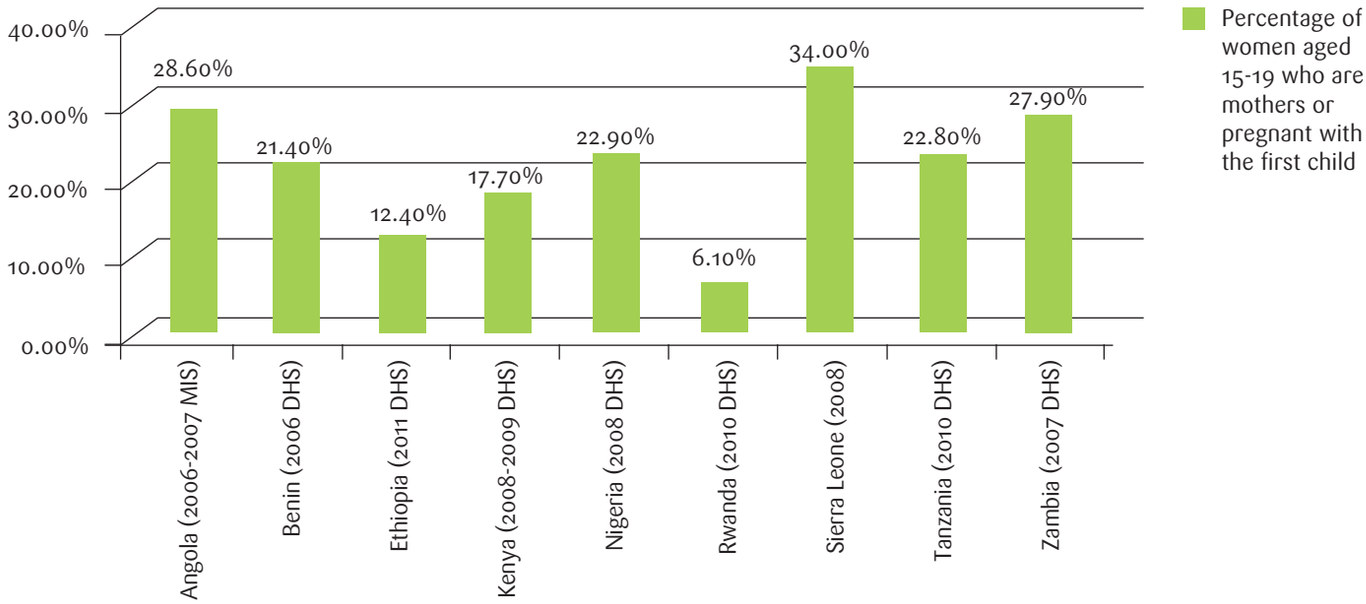
In Angola, childbearing is universal and starts very early. Three out of ten adolescents aged 15-19 have a live birth. There is a negative relationship between adolescent birth rate and the background characteristics of residence, education, and wealth. Adolescent birth rate among uneducated adolescents is 57%, and 47% among the poorest wealth quintile groups. Rural adolescents are more than twice as likely to have given birth to a child as urban teenagers (47% compared with 18%).[136]

In Ethiopia, 12% of adolescent girls aged 15-19 have begun childbearing or are pregnant with their first child.[137]

In Kenya, the proportion of teenage mothers declined from 19% in 2003 to 15% in 2008-09.[138] However, the adolescent birth rate is still a high 106.3 per 1000 women.[139]

Diagram 1:

Percentage of women aged 15-19 who are mothers or pregnant with the first child



Source: DHS data

In Nigeria, high adolescent pregnancy is prevalent with 23% of young women age 15-19 who have begun childbearing, that is, they have given birth or are currently pregnant with their first child.[140] 29% of adolescents in rural areas have begun childbearing compared with 12% adolescents in urban areas.[141]

The Nigeria DHS 2008 further notes that the percentage of teenagers who have started childbearing decreases with increasing level of education and increasing wealth quintiles. Teenagers with no education are more than twice as likely to start childbearing early (55%), as those with primary education (27%). Only 3% of teenagers with more than secondary education have begun childbearing. Teenagers in the lowest wealth quintile (46%) are more than twice as likely to have started childbearing as those in the middle wealth quintile (21%) and almost 10 times as likely as those in the highest wealth quintile.[142] The adolescent birth rate in Nigeria is a high 123.0 per 1000 women.[143]

In Sierra Leone, 34% of all adolescent women age 15-19 have already had a birth or were pregnant with their first child at the time of the DHS survey in 2008. Adolescent childbearing in rural areas is 44% compared to 23% in urban areas. Education is negatively associated with adolescent fertility, with uneducated adolescents being more than three times as likely to have begun childbearing as those with secondary or higher education. Adolescents in the poorest households are most likely to have begun childbearing in comparison to the middle and high wealth quintile.

In Tanzania, 23% of women age 15-19 have started childbearing. Adolescents in rural areas (26%) are more likely to start childbearing than their urban counterparts (15%). There is a strong inverse relationship between early childbearing and education in Tanzania, as well. Adolescents with less education are much more likely to start childbearing than better-educated women. 52% of teenagers who had no education had begun childbearing compared with only 6% of adolescents who attended secondary education. Teenagers in the lowest wealth quintile are more than twice (28%) likely to start childbearing early compared with women in the highest wealth quintile (13%).

In Zambia, adolescent pregnancy is high with about three in ten young women age 15-19 have begun childbearing. A larger proportion of teenagers in rural areas (35%) have begun childbearing compared with teenagers in urban areas (20%). The percentage of teenagers who have started childbearing decreases with increasing level of education, with adolescents having no education more than twice (54%), and to start childbearing early as those with secondary education (21%). Teenagers in the lowest wealth quintile (37%) are more than twice as likely to have started childbearing as those in the highest wealth quintile (14%).[144]

While Rwanda has a lower adolescent birth rate compared to the nine countries under study, about 6% of young women between the ages of 15 and 19 have already begun childbearing. While adolescents aged 15 did not begin childbearing at age 15, the percentage increased steadily and rapidly with age: 3% with at least one child at age 17; 20% at age 19 - 16% of whom have already had at least one child. Adolescents in rural areas (6%) begin childbearing slightly earlier than their urban counterparts (5%).

Early childbearing also has been observed among adolescents with no education (25%) than among those who are educated with primary education (6%); and 4% with secondary education and higher. Differentials by wealth quintile are also observed with adolescents who have begun childbearing in the lowest wealth quintile (9%) compared to 4% in the highest quintile.

SUMMARY

In the nine countries under review, none of the countries are likely to achieve the ICPD target of maternal mortality level of 75/100,000 live births by 2015 (Table 10). In 2010, among the countries under review, Rwanda (340), Benin (350), and Ethiopia (350) record the lowest MMR in comparison to the other countries under review in the region. Sierra Leone and Nigeria have the highest maternal mortality ratio at 890 and 630, respectively, in 2010. Rwanda, among the nine countries under review, has shown significant progress in reducing the MMR from 910 in 1990 to 340 in 2008. The highest adult lifetime risk of maternal death was recorded in Sierra Leone at 1 in 23; 1 in 29 in Nigeria and Tanzania; 1 in 39 in Angola; and 1 in 37 in Zambia.

An examination of all the maternal health services in Rwanda shows consistent improvements. The skilled birth attendance was recorded at 69% which is comparatively much higher than the other eight countries under review. Antenatal care for at least one visit is as high as 98% in 2010. The rate for antenatal care visit for at least four visits is 35%.

Rwanda also has comparatively lower adolescent birth rates. Other factors such as a holistic approach with the focus on universal coverage, increase in the health workforce and their skills, performance-based financing, community-based health insurance, and better leadership and governance have also added to the improvements in the reduction of maternal mortality in Rwanda. The unmet need for contraception, in Rwanda, has also declined in comparison to the other eight countries under review.

This pattern shows consistent investments and resources towards maternal health services. An examination of the health financing indicators for Rwanda also points to a higher expenditure on health as percentage of GDP, higher government expenditure on health; a high per capita expenditure on health and a comparatively lower out-of-pocket expenditure.

The expansion of referral and emergency obstetric care capacities in the health systems in the nine countries is critical to reduce maternal mortality in the countries. Trained staff, community workers, midwives, nurses and doctors provide quality emergency obstetric services to deal with obstetric complications such as haemorrhage, hypertensive disorders of pregnancy, sepsis infections, and obstructed labour, which cause more than 60% of maternal deaths are also important. None of the nine countries have achieved the ICPD target of skilled attendance at birth of 80% attendance. The highest skilled birth attendance was recorded for Rwanda at 69% and the lowest was recorded in Ethiopia at 10%.

Although maternal mortality has reduced to a greater extent over time in Sierra Leone, with relatively better antenatal and postnatal care, the maternal deaths in Sierra Leone are still quite high and this needs to be further examined.

Based on the DHS data, fistula is a condition affecting about 1% of women. More studies need to be done on this issue to accurately measure its magnitude.

3. ABORTION

The annual number of induced abortions in Africa rose between 2003 and 2008, from 5.6 million to 6.4 million. In 2008, most abortions occurred in Eastern Africa (2.5 million), followed by Western Africa (1.8 million), Northern and Middle Africa (0.9 million), and Southern Africa (0.2 million). According to Guttmacher 2012 brief, the increase in the number of abortions is largely due to the increase in the number of women of reproductive age.[145]

In this section, we assess the progress in the nine countries taking the following indicators into consideration:

A. Grounds on which abortion is permitted;
B. Legal status of abortion in the region;
C. Changes in abortion law/policy since ICPD;
D. Unsafe abortion and percentage of maternal deaths attributed to unsafe abortion;
E. Extent to which abortion law is known and acted upon by health professionals and the public.

A. Grounds on Which Abortion Is Permitted

At the ICPD in 1994, the issue of abortion was framed as a major public health concern. Paragraph 8.25 of the ICPD PoA notes that "***all Governments and relevant intergovernmental and non-governmental organisations are urged to strengthen the commitment to women's health, to deal with the impact of unsafe abortion as a major public health concern and reduce the recourse to abortion... In all cases, women should have access to quality services for the management of complications arising from abortion. Post-abortion counselling, education and family planning services should be offered promptly, which will also help to avoid repeat abortions***."

Paragraph 7.6 of the PoA states that "***[r]eproductive health care in the context of primary health care should, inter alia, include abortion as specified in paragraph 8.25, including prevention of abortion and the management of the consequences of abortion; referral for family-planning services and further diagnosis and treatment for complications of pregnancy, delivery and abortion."***

It was at the Fourth World Conference on Women, held in China in September 1995, in which Paragraph 106 was called for recognition and to deal with the health impact of unsafe abortion as a public health concern, as agreed in Paragraph 8.25; Section (k) notes that in the light of Paragraph 8.25 of the ICPD PoA, reviewing laws containing punitive measures against women who have undergone illegal abortions was considered. This was a major step towards looking at abortion from both a public health and human rights perspective.

Further to this, the CEDAW Committee General Recommendation 24, Paragraph 31(c), 1999 notes, when possible, legislation criminalising abortion should be amended, in order to withdraw punitive measures imposed on women who undergo abortion.[146] At the regional level in Africa, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, also known as the Maputo Protocol, entered into force in 2005 and became the first human rights treaty to explicitly address women's right to safe abortion. Article 14 of the regional human rights treaty notes that ***"[p]arties shall take all appropriate measures to: ... c) protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus."***

With the above context at the international and regional levels, we now examine the legal status of abortion in the countries under review.

B. Legal status of abortion in the region

The conditions under which abortion is legally permitted vary in different countries. Every country in Africa has at least one ground on which abortion is permitted. Most of the restrictive abortion laws that prevail in Africa have been inherited from pre-independence colonial laws, either from the laws of France, England, Belgium, Portugal and Dutch-Roman. While the former colonial countries (except for Portugal) have made attempts to amend their own national laws in recognition of the public health problem of unsafe abortion and women's reproductive rights, African countries still continue to practise the colonial legacy of restrictive abortion laws.[147]

In many countries, additional procedural requirements are required to be met before an abortion can be legally performed. This includes gestational limits, mandatory waiting period, parental and spousal consent, third party authorisation, the categories of health providers permitted to perform abortions, the types of medical facilities where abortions may be performed and mandatory counselling.[148]

An examination of abortion laws and policies in the countries above shows different levels of legality governing access to abortion. In the nine countries studied, abortion is restrictive and permitted only to save the life of a woman in Angola. The law in Angola does not make an explicit exception to save a woman's life; the law is interpreted to permit lifesaving abortion on the grounds of general criminal law defence of "necessity."[149]

Table 15:
Grounds on which abortion is permitted

COUNTRY	Grounds on which abortion is permitted						
	To save the woman's life	To preserve physical health	To preserve mental health	Rape or incest	Fetal impairment	Economic or social reasons	On request
Angola	X						
Benin	X	X	X	X	X		
Ethiopia	X	X	X	X	X		
Kenya	X	X	X				
Nigeria	X	X	X				
Rwanda	X	X	X				
Sierra Leone	X	X	X				
Tanzania	X	X	X				
Zambia	X	X	X		X	X	

Source: World Abortion Policies 2011 (UN)

In five countries, Kenya, Nigeria, Rwanda, Sierra Leone and Tanzania, abortion is permitted to save the woman's life, to preserve physical health and to preserve mental health. Nigeria has two laws on abortion: one for the northern states and one for the southern states. Both laws specifically allow abortion to be performed to save the life of a woman. In addition, in the southern states, abortion is allowed to be performed on grounds of preserving physical and mental health.[150]

In Benin and Ethiopia, abortion is permitted on more liberal grounds such as to save the woman's life, to preserve physical health and preserve mental health; in cases of rape or incest and foetal impairment. Zambia permits abortion on more liberal grounds including socio-economic reasons.[151] However, abortion is not permitted on grounds of rape or incest and on grounds of request in Zambia.

There may be discrepancies between the laws (***de jure***) and its application (***de facto***) implementation of the law, even where the law is liberal, safe abortion may be accessible; there may be additional requirements regarding consent; the limit on the period during which abortion can be permitted, and attitudes of the medical professionals. Women lack awareness on the availability of services or their right to access abortion within the legal framework.[152]

In Zambia, while the country has the most liberal law on abortion, these have not been translated into access to safe abortion services for Zambian women. Deaths from unsafe abortion are still high with serious barriers to accessing services, including the endorsement of several doctors; lack of service delivery guidelines and lack of trained providers. Many Zambians, including doctors are still unaware of the law and think abortion is illegal in Zambia.[153]

C. Changes in abortion law/policy since ICPD

The legal approach to abortion is evolving from criminal prohibition to accommodation of abortion as a life preserving and health preserving option, especially since ICPD and the adoption of other human rights instruments mentioned earlier.[154] Since the International Conference on Population and Development in 1994, abortion law has been reformed in some of the countries in the region under this study. In 2004, the Ethiopian Parliament passed an progressive abortion law. A year later, the Ethiopian Ministry of Health (MOH) released guidelines for safe abortion services, making major progress towards implementing revisions of the country's abortion law.[155]

Ethiopia has made revisions to its abortion law where abortion is permitted before the foetus is viable (conventionally interpreted as 28 weeks after the last menstrual period); if the pregnancy resulted from rape or incest; the health or life of the woman or baby is in danger; the foetus has an incurable and serious deformity; the woman has physical or mental disabilities or the woman is a minor and is unprepared to raise a child.
In Benin, the abortion law was amended in 2003, and the law covers grounds such as rape or incest, or where the pregnant woman's life is in danger.[156]

Kenya adopted a new constitution in 2010. The constitution provides stronger protection for the lives and health of women. The previous law only allowed abortion to protect the pregnant woman's life, the new constitution explicitly permits abortion when "in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the [pregnant woman] is in danger, or if permitted by any other written law." The constitution also states that "a person shall not be denied emergency treatment."

D. Unsafe abortion and percentage of maternal deaths attributed to unsafe abortion

Yemmi had no idea that Saron, her 14-year-old daughter, was pregnant until she found the girl — unconscious and bleeding profusely — on the dirt floor of their ramshackle house. She begged a neighbour to load Saron onto a donkey cart and take her to the nearest clinic, 12 miles away. Their efforts were too late, however, and on the way to the clinic, Saron died from blood loss and infection — the result of an unsafe abortion (Ipas, 2013).

The WHO defines unsafe abortion as a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both.[157]

It is estimated that approximately 210 million pregnancies occurred in 2008. Worldwide unsafe abortions are estimated to be between 21-22 million in 2008,[158] which means one in 10 pregnancies ended in unsafe abortion. The global abortion rate remained unchanged since 2003 at 14 per 1000 women aged 15-44 years. Nevertheless, the increase in numbers of unsafe abortion is mainly an effect of the increasing numbers of women of reproductive age in the world.[159]

In 2008, 13% of all pregnancies in Africa ended in abortion.[160] According to WHO, Africa accounted for 14% of maternal deaths (29,000) due to unsafe abortion in 2008.[161] Of the total 6.4 million abortions carried out in 2008, only 3% were performed under safe conditions.

In Table 16, we note that regional unsafe abortion rates in Africa vary from a high 36 per 1000 women aged 15-44 in Eastern and Middle Africa, to a low 9 per 1000 women aged 15-44 in Southern Africa. Although the total number of unsafe abortions has risen to 6.2 million since the 2003 WHO report, the unsafe abortion rate for the Africa Region has decreased due to the improvements in CPR and the partial availability of safe abortion services in the Northern and Southern Africa Sub-regions which have contributed to countering the high numbers of the other African Sub-regions to an average 28 per 1000 women aged 15-44 for the Africa Region.[162]

About 1.7 million women in the Africa region are hospitalised annually for complications of unsafe abortion. The most common complications from unsafe abortion are incomplete abortion, excessive blood loss, and infection. Less common but very serious complications include septic shock, perforation of internal organs, and inflammation of the peritoneum.[163]
Wealth plays an important role in access to safe abortion. In Nigeria, for example, a 2002 national household-based survey found that almost six in ten non poor women who had an abortion had a surgical procedure, compared with just three in ten women.[164]

Poor and rural women tend to depend on the least safe methods and on untrained providers; these women are especially likely to experience severe health consequences. In Nigeria, women who obtain abortions from traditional healers or induce abortion themselves are the group with the highest incidence of complications.[165]

There is no national data on the contribution of unsafe abortion to maternal mortality in Kenya. A study of hospital records in the

Table 16:
The regional estimates of unsafe abortion

Region	Grounds on which abortion is permitted		
	Number (rounded)	Unsafe abortion rate (per 1000 women aged 15-44 years)	Unsafe abortion ratio (per 100 live births
Africa	6 190 000	28	18
Eastern Africa	2 430 000	36	20
Middle Africa	930 000	36	18
Northern Africa	900 000	18	19
Southern Africa	120 000	9	10
Western Africa	1 810 000	28	16

Source: Global and regional estimates of the incidence of unsafe abortion

slum areas of Nairobi, Kenya found complications from unsafe abortion to be the fourth largest cause of maternal mortality in those areas, accounting for 7% of maternal deaths.[166] At the same time, in a pilot study conducted in Nakuru Provincial General Hospital, complications from unsafe abortion accounted for 25% of all maternal deaths recorded there in 2002.[167]

Many women who have unsafe abortions are likely to experience negative health consequences. One hundred women die in Ethiopian health facilities each year from abortion-related complications, but many more suffer from injuries or illness related to unsafe procedures. Four out of ten women seeking post-abortion care show signs of infection or invasive injuries when they arrive at a health facility.[168]

Ethiopian health professionals estimate that 58% of all women, who have an abortion, experience serious complications and that only about a quarter of these women (or about 14% of all women who have an abortion) receive treatment for these complications. The remaining 42% do not have complications that require medical care.[169]

Unsafe abortion is one of the most significant and preventable causes of maternal death and injury in Nigeria. Abortion procedures are not accessible even for women who meet the legal requirements, forcing women to seek out unsafe procedures.

E. Extent to which abortion law is known and acted upon by health professionals and the public.

The 2010 Kenyan constitution provides stronger protection for the lives and health of women, however, it is unclear how widely the new abortion law is understood or practised within the medical community. Furthermore, sections of the Kenyan penal code have not been revised to reflect the language of the new law, and medical providers may be reluctant to perform abortion for any reason for fear of legal consequences, even though these penalties do not apply to the provision of legal abortions. The Kenyan penal code currently lists self-inducing abortion, or providing any other type of "unlawful" abortion, as felonies punishable by a 7 to 14-year prison sentence.

Thirty-six of the forty-nine policymakers knew that abortion is illegal in Nigeria, except to save the life of a woman. However, none of them could report the specific provisions of the law (e.g. the circumstances under which abortion can be legally performed). One respondent reported that abortion is illegal except on "medical grounds," while twelve said they were not conversant with the abortion law. Thus, poor knowledge of the law was widespread, which some policymakers attributed to the fact that the law is rarely enforced, and very few women or health professionals have ever been prosecuted.

SUMMARY

Every country in Africa has at least one ground on which abortion is permitted. Most of the restrictive abortion laws that prevail in Africa have been inherited from pre-independence colonial laws, either from the laws of France, England, Belgium, Portugal and Dutch-Roman. In many countries, additional procedural requirements are required to be met before an abortion can be legally performed. This includes gestational limits, mandatory waiting period, parental and spousal consent, third party authorisation, the categories of health providers permitted to perform abortions, the types of medical facilities where abortions may be performed and mandatory counselling.

Abortion law have been reformed in Ethiopia, Benin and Kenya since ICPD. In 2008, according to WHO, Africa accounted for 14% of maternal deaths (29,000) due to unsafe abortion. An examination of abortion laws and policies in the countries above shows different levels of legality governing access to abortion. In the nine countries studied, abortion is restrictive and permitted only to save the life of a woman in Angola. In five countries, Kenya, Nigeria, Rwanda, Sierra Leone and Tanzania, abortion is permitted to save the woman's life, to preserve physical and mental health. In Benin and Ethiopia, abortion is permitted on more liberal grounds such as to save the woman's life, to preserve physical and mental health; in cases of rape or incest and foetal impairment. Zambia permits abortion on more liberal grounds including socio-economic reasons but abortion is not permitted on ground of rape or incest and on request in Zambia.

4. REPRODUCTIVE CANCERS

The 58th World Health Assembly resolution on cancer prevention and control (WHA58.22) was adopted in May 2005.[170] This resolution calls for Member States to intensify action against cancer by developing and reinforcing cancer control programmes. Prevention, early detection, diagnosis and treatment, and palliative care are important components of cancer control programmes.

In 2010, the General Assembly adopted a resolution 64/265, which called for convening a high-level meeting of the Assembly in September 2011, with the participation of Heads of State and Government, on the prevention and control of non-communicable diseases. At the high-level meeting of the UN General Assembly, the resolution titled "Political declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases" was adopted in September 2011.

All the above resolutions take into account cancers and apply to the context of reproductive cancers among women.

According to IARC, about 715,000 new cancer cases and 542,000 cancer deaths occurred in 2008 in Africa. These numbers are projected to nearly double (1.28 million new cancer cases and 970,000 cancer deaths) by 2030. Cancer continues to be on the low priority list in Africa mostly because of limited resources and other pressing public health problems, including communicable diseases such as AIDS/ HIV infection, malaria, and tuberculosis.[171]

Cancers of the reproductive system, such as cervical cancer and breast cancer, continue to impact the quality of life and survival of women. In 2008, cervical cancer accounted for 21% of the total newly diagnosed cancers in females in Africa.[172] Some systematic attempts to assess the incidence and mortality for cancers have been undertaken by IARC. In the section below, some data and analysis is presented on cervical cancer and breast cancer incidence, mortality and prevalence in the selected countries.

Data on incidence and mortality in the nine countries shows the following patterns with respect to cancers among women. Cancer of the cervix and breast cancer have the highest incidence and mortality compared to other cancers among women in the countries studies.

In Angola, Benin, Rwanda, Sierra Leone, and Zambia, cervical cancer has the highest incidence and mortality followed by breast cancer. In Ethiopia, Kenya and Nigeria, the incidence and mortality of breast cancer ranks highest followed by cervical cancer.

A. Cervical cancer screening, diagnosis and treatment

In Sub-Saharan Africa, cervical cancers accounts for 22% of all cancers in women and it is also the most common cause of cancer death among woman. Programmes for screening and treatment are barely present in the area. Weak health systems and lack of trained providers, lack of awareness of people about cervical cancer, absence of policy framework, inadequate infrastructures, and insufficient of data and evidence serve as barriers to universal access to cancer prevention and control services difficult.

According to the IARC, cervical cancer is the third most common cancer in women, and the seventh overall, with an estimated 530,000 new cases in 2008. More than 85% of the global burden occurs in developing countries, where it accounts for 13% of all female cancers. In Africa, high risk regions include Eastern and Western Africa (ASR greater than 30 per 100,000), and Southern Africa (26.8 per 100,000).[173]

Cervical cancer is responsible for 275,000 deaths in 2008, with 53,000 deaths in Africa.[174] Cervical cancer was the most frequently diagnosed cancer (31,500) and the leading cause of cancer death (21,600) in women in Eastern Africa in 2008, accounting for about 25% of the total new cancer cases and deaths. Countries like Tanzania show the highest cervical cancer rates worldwide. This is due to a high prevalence of human papillomavirus (HPV) infection, which causes cervical cancer, coupled with a lack of screening services (Pap test) for prevention and early detection of the disease.[175] While cervical cancer in East Africa and breast cancer in Southern and Northern Africa were the most commonly diagnosed cancer among women in 2008, these two cancers occurred with similar frequency in Middle and Western Africa.

Tanzania and Sierra Leone show both high incidence and mortality in terms of cervical cancer. Primary prevention of cervical cancer is essentially healthy lifestyles and vaccinations against HPV. The secondary prevention of cervical cancer is by screening for pre-cancerous lesions and early diagnosis followed by treatment. The main techniques used here include cytological screening of cervical cells and visual inspection of the cervix. Some pilot projects have been initiated in six African countries, and these studies have shown efficacy, safety and effectiveness of visual inspection as a screen method. Tertiary prevention of cervical cancer involves diagnosis and treatment of confirmed cases of cancer through surgery, radiotherapy and sometimes, chemotherapy. In incurable stages, palliative care needs to be provided.[176]

Africa faces several issues and challenges related to cervical cancer include lack of cervical cancer control policy, strategies

Table 17:
Cervical Cancer incidence, mortality and prevalence rates

Country	Cervical Cancer				
	Incidence /100,000		Mortality/100,000		5 year Prevalence (prop.)
	Number	%	Number	%	
Angola	1504	28.9	1008	27.2	75.5
Benin	925	28.0	616	26.8	95.3
Ethiopia	4648	17.2	3235	16.3	49.5
Kenya	2454	16.1	1676	14.8	56.5
Nigeria	14550	23.6	9659	22.9	84.4
Rwanda	986	25.3	678	22.6	86.2
Sierra Leone	670	37.2	466	35.8	105.1
Tanzania	6241	52.9	4355	51.2	132.8
Zambia	1839	33.4	1276	31.9	136.1

Source Globocan 2008

and programmes; lack of recent and comprehensive data on cervical cancer in respective countries; insufficient or lack of information and skills among women on available services and population as well as health professionals, high cost of immunisation against HPV; and lack of secondary prevention and the cost of cervical cancer prevention can be reduced by using simple technologies in the screening of precancerous states. To overcome the difficulty of providing quality cytology services in low-income countries, screening by means of visual inspection of the cervix should receive greater emphasis. However, this service is under developed in Sub-Saharan African countries; lack of affordability of therapeutic resources and neglect of palliative care.

The limited resources available for treatment are not enough to provide effective surgical, radiotherapy and chemotherapeutic services. Not much of the palliative care needed at this stage of the disease is available; geographical inaccessibility of tertiary prevention. Treatment used in tertiary prevention is generally not available in countries of the African Region; and even when it is available, the infrastructure, equipment and specialists are poorly distributed and hard to reach.[177]

B. Breast cancer

Breast cancer is by far the most frequent cancer among women with an estimated 1.38 million new cancer cases diagnosed in 2008 (23% of all cancers), and ranks second overall (10.9% of all cancers). It is now the most common cancer both in developed and developing regions with around 690,000 new cases estimated in each region. Incidence rates vary from 19.3 per 100,000 women in Eastern Africa to 89.7 per 100,000 women in Western Europe.[178]

In Africa, breast cancer was the most commonly diagnosed cancer and the leading cause of cancer death among women in Southern Africa (9,000 cases, 4,500 deaths) and Northern Africa (28,000 cases, 14,600 deaths) in 2008.

Among the countries studied, breast cancer incidence is highest in Nigeria (30.7%); followed by Benin (24.6), Angola (19.3%), and Ethiopia (18.2%). Lower incidence of cancer is reported in Rwanda (9.6%), followed by Tanzania (11.1%). Mortality from breast cancer is highest in Nigeria (24.9%), Benin (19.55), and Angola (15.1%). Lower mortality rates have been observed in Rwanda (7.0%) and Tanzania (8.7%). Breast cancer screening data is very limited in the nine countries. (Table 18)

SUMMARY

There is a clear need to expand the number of high quality population-based cancer registration systems, as these registries provide reliable, evidence-based and population-based information on cancer incidence, prevalence and mortality. They also have a role in implementing and monitoring initiatives which aim to improve the quality of care and survival for cancer patients. However, only 11% of the African population is covered by population-based cancer registries. Cancer registries are present in Ethiopia, Nigeria, Kenya, Rwanda, Sierra Leone, and Tanzania.[179]

Table 18:
Breast Cancer incidence, mortality and prevalence rates

Country	Breast Cancer				
	Incidence /100,000		Mortality/100,000		5 year Prevalence (prop.)
	Number	%	Number	%	
Angola	1004	19.3	558	15.1	62.7
Benin	813	24.6	449	19.5	105.3
Ethiopia	4935	18.2	2790	14.1	65.2
Kenya	2660	17.5	1491	13.2	75.1
Nigeria	18935	30.7	10469	24.9	139.2
Rwanda	376	9.6	211	7.0	39.2
Sierra Leone	325	18.1	184	14.2	63.8
Tanzania	1307	11.1	739	8.7	34.5
Zambia	709	12.9	401	10.0	65.6

Source: Globocan 2008

Furthermore, many cancer registries in Africa do not meet IARC's criteria for high-quality incidence data (completeness, validity, timeliness), only five cancer registries (covering 1% of Africa's population) met the criteria for inclusion in Cancer Incidence in Five Continents Volume IX.8. Therefore, there is a greater need for establishing or strengthening population-based cancer registration systems in Africa in order to implement effective and evidence-based cancer control programmes.[180] The advances in verbal autopsy methods have created another opportunity for enhanced monitoring of breast and cervical cancer. The lack of early detection programmes for cancers at the primary health care level is resulting in late diagnosis, catastrophic complications, disabilities and premature death. Low public sector availability of technologies and medicines leads people with non-communicable diseases to the private sector, where services are frequently unaffordable. Up to 80% of cancer patients have no access to radiotherapy and over 27 countries have no operating radiotherapy services in Africa.

Most countries in Africa have established a programme on non-communicable diseases within the ministry of health or other comparable government health authority, but these programmes are generally inadequately staffed and funded. By December 2009, only 9 countries in Africa had operational policies and plans in place, while 10 countries were in the process of developing national multisectoral frameworks for the prevention and control of non-communicable diseases.[181]

Effective interventions exist for the two leading causes of cancer deaths in women: 70% of cervical cancer is now vaccine preventable and breast cancer is largely treatable through early detection and screening. However, affordable access to these interventions is not possible for a large proportion of people in low- and middle-income countries.[182]

The comprehensive approach to cancer control encompasses all the steps from primary prevention with vaccines and secondary prevention, i.e. screening for and management of precancerous lesions, to treatment and palliative care, within the context of continuum of care. HPV vaccines provide a great opportunity to decrease the incidence of cervical cancer within 20 years, but even with successful vaccination, the need for screening will continue for women who have not yet been vaccinated as well as for those who have been vaccinated, as the vaccines cover only 80% of cancers.

The WHO has developed guidelines for regional and national cancer control programmes according to national economic development. In its 58th World Health Assembly in 2005, the WHO urged member states to develop and reinforce comprehensive and evidence-based cancer control programmes in order to curb the growing global burden of cancer. African countries need to take the initiative and make the political commitment to invest in the programmes with a dedicated budget and required staff.

CHAPTER 4

sexual health and sexual rights

INTRODUCTION

This chapter asseses the progress in the nine countries: Angola, Benin, Ethiopia, Kenya, Nigeria, Rwanda, Sierra Leone, Tanzania, and Zambia with respect to key sexual health and sexual rights indicators. These include:

1. Sexually Transmitted Infections
- A. An overview of sexually transmitted infections (STIs)
- B. Syphilis sero-positivity data among women attending antenatal care, sex workers, and men having sex with men

2. HIV and AIDS
- A. HIV and AIDS estimated number and prevalence percentage
- B. Vulnerable groups and most at risk populations
- C. National Response- Laws, strategies and frameworks; addressing stigma and discrimination
- D. Access to antiretroviral therapy treatment

3. Adolescent Sexual Rights
- A. Comprehensive sexuality education

4. Sexual Rights
- A. Early and forced marriages
- B. Harmful practices
- C. Sexual violence against women
- D. Trafficking
- E. Status of sex work
- F. Status of diverse sexual and gender identities

1. SEXUALLY TRANSMITTED INFECTIONS (STIs)

The WHO 2005 estimates a record of about 448 million new infections of curable STIs, including syphilis, gonorrhoea, chlamydia, and trichomoniasis occurring annually throughout the world among population aged 15-49 years. This does not include HIV and other STIs. In developing countries, STIs and their compilations rank among the top five disease categories. In pregnant women with untreated early syphilis, at least 25% of pregnancies result in stillbirth and 14% in neonatal deaths. Sexually transmitted infections are a preventable cause of infertility, particularly among women.[183] There are more than 30 different sexually transmissible bacteria, viruses and parasites. HIV and Syphilis, in particular, can also be transmitted from mother to child during pregnancy and childbirth, through breastfeeding, blood products and tissue transfer.

The ICPD PoA calls upon the governments "to prevent reduce the incidence of and provide treatment for sexually transmitted diseases, including HIV and AIDS, and the complications of sexually transmitted diseases such as infertility, with special attention to girls and women." At ICPD+15, governments were called to ensure that prevention of and services for sexually transmitted diseases and HIV and AIDS are an integral component of reproductive and sexual health programmes at the primary health care level.

Table 19:
Reported proportion of women attending antenatal care seropositive for syphilis, sex workers seropositive for syphilis and men having sex with men seropositive for Syphilis

Country	Women attending antenatal are seropositive for Syphilis	Sex workers sero positive for syphilis	Men having sex with men sero positive for syphilis
Angola	Not available	Not Available	Not Available
Benin	Not Available	Not Available	Not Available
Ethiopia	2.2% (2007)	Not Available	Not Available
Kenya	1.8% (2010)	0.8% (2010)	0.9% (2010)
Nigeria	1.5% (2005)	Not available	Not Available
Rwanda	1.5% (2010)	Not available	Not Available
Sierra Leone	1.4 % (date not reported)	Not available	Not Available
Tanzania	2.8% (2007-08)	2.5% (2010)	Not available
Zambia	5.3% (2010)	Not available	Not available

Source: WHO/UNAIDS Towards Universal Access 2011 data

The interactions between sexual and reproductive health and STI and HIV and AIDS are now widely recognised. In addition, sexual and reproductive ill-health and HIV and AIDS share root causes, including poverty, gender inequality and social marginalisation of the most vulnerable populations.

Nearly a million people acquire STIs, including HIV, every day. The results of infection include acute symptoms, chronic infection, and serious delayed consequences such as infertility, ectopic pregnancy, cervical cancer, and the untimely deaths of infants and adults. The presence of other STIs in a person, such as syphilis, chancroid ulcers or genital herpes simplex virus infection, greatly increases the risk of acquiring or transmitting HIV. New research suggests an especially potent interaction between very early HIV infection and other STIs. This interaction could account for 40% or more of HIV transmissions. Despite this evidence, efforts to control the spread of STIs have lost momentum as the focus has shifted to HIV.

Table 19 presents data in the nine countries on the sero-positivity of syphilis among antenatal women, sex workers and men having sex with men. For the countries with available data, the percentages are low but still significant. Antenatal infections do impact pregnancy outcomes.

Most of the STI interventions have been integrated through the HIV and AIDS programmes in the nine countries.

VOICES FROM THE GROUND

Box 4: **Young women living with HIV**

I have lived with HIV for ten years, I tested positive for HIV at the age of twenty, when I went for ante-natal care. Once my parents found out, I was pregnant and HIV positive, they disowned me and with no income I found myself on the street with my daughter. With the help of my brother and the YWCA Kisii members, I was able to acquire some start up capital to start my business. Now that I have an income I can take my daughter to school and I am very active in educating other young women and girls on SRHR and HIV and for those who are pregnant , I also mentor them to go for PMTCT and accompany them through their journey so they don't suffer the isolation and stigma that I went through.

Lucy, 27 years Kenya

2.
HIV AND AIDS

A. HIV and AIDS estimated number and prevalence percentage

An estimated 23.5 million (22.1 - 24.8 million) people were living with HIV in Sub-Saharan Africa at the end of 2011,[184] representing almost 69% of the global HIV burden.[185] In addition, in 2011, 92% of pregnant women living with HIV lived in Sub-Saharan Africa. In this region, where most of the people newly infected with HIV live, an estimated 1.8 million (1.6-2 million) people became infected in 2011. This number is 25% fewer than the estimated 2.4 million people newly infected with HIV in 2001[186] and 27% fewer than the annual number of people newly infected between 1996 and 1998, when the incidence of HIV in Sub-Saharan Africa peaked overall.

At the same time, the number of people dying from AIDS-related causes began to decline by 32% between 2005-2011 in Sub-Saharan Africa.[187] In nearly all countries in Sub-Saharan Africa, the majority of people living with HIV are women, especially girls and women aged 15-24 years. In 2011, data shows that women constituted 58% of all people living with HIV in the region.[188] The vulnerability of women and girls to HIV remains particularly high in Sub-Saharan Africa.

Angola has one of the lowest HIV prevalence rates in Sub-Saharan Africa, partly because during the 1975–2002 Angolan civil wars, cross-country travel was nearly impossible, impeding the spread of HIV and AIDS. Since the war ended, movement has become less restricted, and the likelihood of HIV reaching once isolated communities has increased.[189]

Ethiopia has a population of 73.9 million, and has an adult prevalence rate of HIV of 1.4%, which, though low in percentage, has an impact due to a large population of people living with HIV in Ethiopia. Its HIV and AIDS epidemic is classified as "generalised" among the adult population with significant heterogeneity regions and population groups.

Zambia has a predominately young population where over 60% are below the age of 21 years. It, therefore, has a mature and stable epidemic with an adult prevalence rate of 12.5% in 2011.

Paragraph 8.29 of the ICPD PoA objective on HIV and AIDS calls upon governments to prevent, reduce the spread of, and minimise the impact of HIV infection; to increase awareness of the disastrous consequences of HIV infection and AIDS, and associated fatal diseases at the individual, community and national levels, and of the ways of preventing it to address

VOICES FROM THE GROUND

Box 5: **The story of Mukatmui**

When Mukatmui joined a local YWCA in Zambia, she didn't realize that decision would save her life.

She grew up in Kaoma District, a rural area about an 8 hour bus ride from Lusaka, the capital. Like many young girls in her community, Mukatmui didn't learn much about her reproductive health. Like the nearly six of every 10 young girls who are not in school, she didn't grow up with the very basic health information she needed in order to be healthy.

She also thought she had little say in her future. "Traditionally I was taught that whatever a man tells you to do, you have to do it because he is the head of the house," she says. This included "sex every day when I am not having my monthly period, having a child when a man needs to have one, [and] doing all the domestic work and growing food crops to feed the family."

Like Mukatmui, women in Zambia typically marry early and begin having children right away. Rates of maternal death in the country are high. So are HIV infections. And, with little education about how HIV is transmitted or treated, many living with HIV and AIDS face stigma and discrimination.

Fortunately for Mukatmui, her local YWCA had joined in a project with the World YWCA designed to empower and mobilize young women as sexual and reproductive health advocates. The initiative, supported by the Packard Foundation, includes programs in eight African countries. To date, they have trained more than 500 women to strengthen their leadership skills and build their confidence to speak out about the reproductive health issues that affect their daily lives. Mukatmui says that the training by the Kaoma YWCA helped educate her about sexual and reproductive health and gave her greater confidence about her rights.

"The YWCA has really changed my life," Mukatmui says. "I never knew anything about sexual and reproductive health and rights and HIV, but now I have learned that as a woman I have a right to say no to things I do not want to do."

She also learned how HIV is transmitted and realized that she might be at risk. She had been forced into marriage at an early age. Knowing that her husband had paid a dowry for her, she felt obligated to have unprotected sex without asking any questions. After the YWCA training, she got tested for HIV and found out she was positive.
Despite this new challenge, she remains hopeful about her future—and the future of others living with HIV.

Mukatmui admits that like many people in her community, she felt stigma against those living with HIV. "At first I used to discriminate against people who are living with HIV by not listening to them, not caring for them or interacting with them," she said. But her new knowledge and her own journey living as someone with HIV "made me love and start caring for the sick," she says.

By giving young women like Mukatmui the voice to tell their stories, the World YWCA is empowering them to improve their own lives and serve as leaders to others. Together, these women are breaking the silence on important issues and rallying community support to advance reproductive health for many more African women.

ACCESSED FROM http://www.packard.org/what-we-fund/population-reproductive-health/grantee-stories/zambian-women-as-reproductive-health-champions/

the social economic gender and racial inequities that increase vulnerability to the disease.

B. Vulnerable groups and most at risk populations

The vulnerable groups and most at risk population in the nine countries are discussed and we review the prevalence rates among the various groups to see who is most affected in each country.

Young women

Young women are particularly at risk to HIV infection in the region. In Angola, young women aged 15–39 years old have a high prevalence compared to women 40–59 years old. This disparity may be attributed to early onset of sexual activity, changing social norms, gender unequal relationships and increasing poverty.[191]

In Rwanda, young women are particularly at risk for HIV infection, especially in the context of relationships with older men. HIV prevalence rate in Sierra Leone is higher in young women ages 15-24 than in young men of similar ages. In Kenya, young women 15 to 19 years old are 3 times more likely to be infected than their male counterparts, and women 20 to 24 years old are 5.5 times more likely to be infected.[192]

Women

The high proportion of displaced and mobile populations, limited access to health care, lack of perception about risk and inadequate knowledge about HIV and AIDS and its prevention are contributing factors to the high magnitude of HIV infection among women. The Kenya DHS (2008) notes women have a higher prevalence of 8% compared to men at 4.3%. Sex differential is more pronounced among young women 15-24 age group who tend to have HIV prevalence four times higher than young men at 4.5% and 1.1%, respectively. Similarly, Nigeria has more women living with HIV in comparison to men. The primary mode of transmission is heterosexual sex, and this accounts for 80-95% of HIV infections in Nigeria. In Benin, women (1.5% prevalence) are twice as likely to be infected as men (0.8%).[193]

Data from the 2011 EDHS indicates HIV and AIDS prevalence is higher among women (1.9%) than men (1.0%). In urban areas, women are more likely to be infected than men (5.2% and 2.9%, respectively). In addition, gender based violence, substance abuse and spread of HIV among certain groups. Between 40% and 60% of women experience sexual and/or physical abuse from their partners, increasing their vulnerability to HIV.[194]

Pregnant women

Data on the women attending antenatal clinics suggests the intensity of the HIV epidemic varies among Angola's different provinces, the provinces with the highest rates are Cunene and Benguela, with a prevalence of 4.4%. Based on data in 2006, 60% of all reported HIV and AIDS cases occurred among people aged 20 to 39.[195] In Nigeria, education had a slight impact on HIV prevalence. Women in the ANC survey report showed women with primary, secondary and tertiary education had HIV prevalence of 5.1%, 5.8%, and 4%, respectively. In Rwanda, the percentage of young pregnant women who are HIV positive remains very high, particularly for the 15-19 age group, in Kigali, where the 2007 ANC survey finds overall HIV prevalence for young pregnant women between ages 15-19 is 5.1% while young women aged 20-24 years old is 3.5%.

Association with Marital Status

A UNAIDS survey noted HIV risk is significantly higher for women who are widowed and divorced than for women who are married or single. The Demographic and Health Survey data from different Sub-Saharan African countries also shows a similar pattern with individuals who are divorced, separated or widowed showing a higher HIV prevalence than single, married or cohabiting persons. However, the relationship of marriage and HIV is quite complex and needs further examination.

The Kenya AIDS Indicator Survey (KAIS), a naturally based representative population based survey undertaken in 2007 and that informed the 2008-2009 DHS notes, showed that sexually active, never married women in Kenya had higher HIV prevalence, indicating that being single is not universally protective against HIV infection, especially among women. Among women who are married, risk of HIV infection depends on the type of marriage. The risk of infection tends to be higher among polygamous unions. Concurrent partnerships dramatically increase the spread of the epidemic. This also accelerates transmission of sexually transmitted infections as it co-relates with low rates of condom

use, poor communication among partners, age, and power imbalances.[196]

One of the key characteristics of the HIV epidemic in Kenya is the risk of infections among people in unions. It notes that there is a significant variation of HIV prevalence by marital status, the highest being among widowed respondents (44.4%) and the lowest among those who had never been married (2.4%). About 14.3% of respondents who are married or cohabitating are HIV positive. HIV prevalence is twice as high among respondents in polygamous unions (12.9%) compared to respondents in non-polygamous union (6.1%).[197] The Kigali Province in Rwanda, estimated a much lower HIV prevalence for married women (2.5%) than for separated (14.6%), widowed (9.7%), single (6.8%), divorced (6.4%), and cohabiting (5.9%) women (ANC Data 2007).

Most at Risk Groups

In Ethiopia, the 2007 "epidemiological synthesis" exercise that reviewed and analysed available data over a period of 15 years classified uniformed service personnel, truckers, refugees and displaced people, children on the street, causal labourers, students and other mobile populations as groups at risk of HIV infections. A study in 2009 further identified students (from high school through university), migrant labourers, out-of-school youth, and indigenous populations in remote foreign tourist destinations that are involved in high risk commercial sex transactions as populations potentially at greater risk of HIV infection. Mobile populations including cross-border populations may also be considered among the most at risk groups in the country. The most at risk peoples (MARPs) in Kenya include female sex workers (FSWs), and their clients, men having sex with men (MSMs) and injecting drug users (IDUs). Surveillance for MARPs is weak; there is no adequate prevalence data for these groups. The Mode of Transmission study noted that FSW and their clients contribute about 14% of new infections, while MSM and prison populations contribute 15% of new infections. Finally, injecting drug users and HIV transmission in health facilities settings contributed 6.3% of new cases.

In Nigeria, single women had higher HIV prevalence than married women (5.9% versus 4.7%). The HIV and AIDS IBBSS conducted in 2007 among sub-populations whose behaviours or occupations expose them to higher risk of acquiring or contracting STIs. These sub-groups include MSM, FSW, IDU, Transport workers (TW) and uniformed service personnel. The survey was conducted in five states namely: Anambra, Cross River, Edo, Kano, Lagos and the Federal Capital Territory (FCT). HIV prevalence was highest among female brothel-based sex workers (37.4%) followed by non-brothel-based sex workers (30.2%), MSM (13.5%), IDU (5.6%), TW (3.7%), police (3.5%), and armed forces (3.1%).

In Sierra Leone, most at risk groups include gold and diamond miners (1.13%), uniformed personnel military (3.29%), police (5.8%), mobile and cross border populations (2.2%), and female sex workers (8.5%). The HIV prevalence rate among discordant couples is also very high with women having a higher rate than men (1.2 % and 0.7%), respectively.

In Benin, most at risk population include mobile populations and FSWs. Among FSWs, 25.5% were found to be HIV positive in 2006. According to a 2008 survey data reported in the 2010 UNGASS report, substantial differences in sero-prevalence exist among sex workers by region, although there is little difference between urban and rural populations. The survey also provided estimates for clients of sex workers (3.9% prevalence) as well as for truck drivers (1.5%), with drivers over the age of 30 most likely to be infected (2.6%). [198]

In Ethiopia, besides those who purchase and/or sell sex, other populations most vulnerable to HIV include members of the military, police officers, displaced people and refugees, truck drivers, migrant workers and day labourers, street children, high school and university students, and out-of-school youth. Cross-border and other mobile populations are also at high risk for HIV infection.[199]

In Rwanda, the most at risk of HIV infection include female sex workers, men who have sex with men, truck drivers, and prison inmates.[200]

In Tanzania, few data exist on the most at risk populations in Tanzania. Several small studies suggest the importance of the epidemic among these populations. A study found a HIV prevalence rate of 30.2% in 2011 among female sex workers from Dar es Salaam. On the island of Zanzibar, HIV prevalence was estimated at 16.3% in 2007 among injecting drug users in Unguja. Injecting drug use in Tanzania, however, remains a relatively small, localised problem.

The HIV prevalence rate was estimated at 12.3% in 2011 among men who have sex with men in Unguja, Zanzibar. As expected, high-risk behaviours overlap: 13.9% of men who have sex with men reported injecting drugs in the previous 3 months, and 77.5% reported being paid for sex in the last year. Other groups affected by HIV in Tanzania include youth, people living in poverty (68% of households live on less than $1.25 a day), and mobile populations who are prone to risky sexual behaviours, including commercial sex workers, petty traders, migrant workers, military personnel, and long-distance truck drivers.[201]

In Zambia, available data confirms that FSWs, sexually transmitted infection and tuberculosis (TB) patients, MSM, and prisoners are disproportionately infected. In 2004, a study of FSWs found a prevalence of 65.4%.[202]

Table 20:
Vulnerable and Most at risk populations in the nine countries

Country	Vulnerable groups and most at risk populations
Angola	Young women, sex workers, truck drivers, miners, military personnel, youth, pregnant women, internally displaced people, prisoners, injecting drug users, blood transfusion recipients, traditional healers, birth attendants, and health workers
Benin	Sex workers, Widowed and Divorced women, Young Women
Ethiopia	Uniformed Service Personnel, Truckers, Refugees, Displaced People, Children on the Street, Casual Labourers, Students, Out of school youth and Sex workers- young women[190]
Kenya	Most at risk: Female Sex workers (FSW) and clients, MSM, IDUs. Vulnerable: Young women, Widowed and Divorced women Married couples People in Polygamous unions- higher in men than women
Nigeria	Most at risk: Young Women, MSM, FSW, IDU, Transport worker(TW)
Rwanda	Young Women
Sierra- Leone	Most at risk: gold and diamond miners, uniformed personnel military, police, mobile and cross border populations (2.2%), and FSW
Tanzania	Most at Risk: FSW, MSM and IDUs Vulnerable: Young women, Widowed, divorced and separated women
Zambia	Women

Source Country information

Sex Workers

The extent and magnitude of the commercial sex industry remains difficult to characterise in Rwanda. In 2009 Behavioural Surveillance Surveys (BSS) covered HIV prevalence among this population for the first time and carried out a female sex workers mapping that identified a minimum of 5,000 commercial sex workers in the country. Unfortunately, due to a high public morality perception driven by policy initiatives promoting alternative occupations for female sex workers, there is scant data on sex workers.

In Ethiopia, the HIV and AIDS prevalence rate among sex workers was 25.3% in 2009. This estimate is based on data from a study of mobile clinics in 40 towns located along transportation corridors linking Addis Ababa to Ethiopia's borders.[203]

In Benin, a concentrated HIV epidemic exists among most at risk populations, particularly sex workers which is a high of 25% according to 2008 survey data reported in the 2010 UNGASS report.[204] Substantial differences in sero-prevalence exist among sex workers by region, although there is little difference between urban and rural populations.

In Angola, a 2009 study by UNAIDS estimated that the infection rate among sex workers is 23%.

C. National response: strategies, policies, framework and resources

The nine countries have set their own strategies, policies and framework on handling the HIV and AIDS epidemic and how to implement them and also how they allocate their resources to the different programmes. We will discuss the strategies, policies, frameworks and resources so as to get a better view of the current situation.

The government of Angola financed 82% of total expenditures for HIV, including 50% of expenditures on targeted prevention programmes, according to the U.S. Government's (USG's) 2009 Partnership Framework. The National Commission to Fight HIV and AIDS and Large Endemics, led by Angola's President and comprising of ministers from all government sectors, was established in 2002 to coordinate the national, multi-sectoral response to HIV and AIDS; civil society, however, is not represented in the Commission.[205]

Since 1987, the Government of Angola (GRA) has released several plans to combat HIV and AIDS, the most recent is the 2011-2014 National Strategic Plan on HIV and AIDS. The Plan's objectives include providing HIV and AIDS education and teaching safe sex practices. It targets vulnerable populations, particularly sex workers, truck drivers, miners, military personnel, youth, pregnant women, internally displaced people, prisoners, injecting drug users, blood transfusion recipients, traditional healers, birth attendants, and health workers.[206]

In 2004, the Angolan National Assembly passed a comprehensive HIV and AIDS law to protect the rights of PLWHA, which includes the right to employment, free public health care, and confidentiality in the health care system. Angola still faces challenges in implementing and enforcing the law through the judicial system, but it has national guidelines for providing PLWHA with integrated care. For example, centres in Angola's 18 provincial capitals provide ART for infection management and PMTCT.[207]

In Benin, an institutional and regulatory framework relating to interventions for the PMTCT was set up by ministerial order in June 2003. PMTCT Training and quality improvement initiatives were launched expanded and included in the integrated HIV/RH/ family planning services.

Mass media campaigns and community education outreach activities promoted protective commodities and services through radio, television, and a youth magazine. For example, a programme focusing on sex workers encouraging them to ensure consistent condom use with their regular non paying partners was accompanied by a blitz campaign which increased the availability of condoms was increased in night clubs, bars, and guesthouses. This was in response to the findings in a 2009 study which reported that despite increases in HIV and AIDS knowledge, risk behaviours appear to have worsened, as the percentage of truckers with occasional partners increased from 37% to 63%, while condom use with occasional partners declined from 65% to 57% from 2008 to 2009. Social marketing of a new brand of condoms that includes a variety of colours and flavours targeting youth was developed in February 2010.[208]

Kenya has adopted a multi-pronged approach to provision of HIV testing and counselling (HTC) services. HTC is provided through voluntary counselling and testing provided in 960 sites countrywide; while Provider initiated testing and counselling (PITC) is provided in 73% (4,939) of health facilities and through Outreach/Mobile Counselling and Testing which target MARPS and Vulnerable Populations in community settings.[209]

For instance, in Mlolongo and Nairobi, over 6,000 female sex workers and their clients were tested for HIV during a 5-day "moonlight" testing campaign. The moonlight testing for MARPs, which includes involvement of their peers (commercial sex workers, barmaids), is an innovative method moving the testing services to the site of the targeted group. As a result of the multiple approaches to HTC, there has been a significant increase in the number of people tested for HIV between 2003 and 2009. In 2009, 3,471,567 individuals above 15 years of age took a HIV test, raising the percentage of the total tested from 14.3% in 2003 to over 56.5% in 2008.[210]

Total expenditure on HIV and AIDS in Rwanda increased from USD 74.6 million in 2007 to USD 110.8 million in 2008 (an increase of about 33%). The government of Rwanda ranks as the third largest single contributor in terms of financing HIV and AIDS interventions (after the group of bilaterals). The share of the total expenditure 24% contributed by the Rwandan government was 8% in 2007 and 6% in 2008, but the amount spent in absolute terms was approximately the same in both years. Public funds are spent in two main areas: first, to support OVC education and basic health care; and second, support of public institutions mandated to plan and coordinate the epidemic.

In Sierra Leone, the National HIV response is highly dependent on international funding (98%), the central government provides the balance, the resources are spent mainly on prevention activities (61%), and only 11% is for treatment and care of which only 2% is targeted to PMTCT.

In Tanzania, the budget for HIV and AIDS prevention treatment and care is heavily donor dependent. 93% of all foreign funding comes from two donors: GFATM (20%) and PEPFAR (73%). The remaining 7% from 13 other multi and bilateral politically significant groups as almost all are part of the GBS dialogue. Of the total foreign funded, 12% is on-budget, 88% is off-budget.

Care and treatment takes the largest proportion of foreign spending. Zanzibar has received Global Fund support in Rounds 2 and 6 to address the HIV and AIDS pandemic. Round 2 focuses

on the Participatory Response to HIV and AIDS for Youth in Zanzibar (PRAYZ) while Round 6 focuses on Joint Accelerated Access to HIV and AIDS Initiatives (Prevention, Treatment, Care and Support) in Zanzibar (JAHAZI). The UN is a significant donor for HIV and AIDS activities in Zanzibar.

The government of Zambia has had notable success in scaling up Anti-retroviral (ARV) treatment. They have involved faith-based organisations, civil society and NGOs, and have also entered into a partnership with the private sector to administer some of the treatment. The decline in HIV prevalence among some young women suggests that some prevention campaigns may be working. However, it is clear that stigma, gender inequality and opposition to condoms remain deeply entrenched. Most of the funding for HIV and AIDS in Zambia is externally funded with a high level of funds from PEPFAR (50%), followed by the Global Fund and the World Bank. Concern about this reliance on donor funding has been voiced by the Southern African AIDS Trust which has urged the Zambian government to scale up its funding for HIV and AIDS programmes.[211]

In Zambia, noting that only 15% of sexually active adults know their HIV status, multiple approaches have been implemented to improve access, for instance, home-based and mobile testing, fixed sites where clients can seek services, testing and counselling in health facilities for pregnant women, testing of TB patients, and testing of in-patients and out-patients in health care facilities. Regular testing and early identification of infected adults is a critical path to access of care and treatment, while testing and counselling of couples aids prevention. 11% of married couples are discordant for HIV. Lack of knowledge of partner status and low levels of condom use contribute to high transmission of HIV even within stable relationships. Integrated reproductive health services at antenatal clinics enable 80% of pregnant women to be tested for HIV and yet, only 10% of partners are tested and this is a missed opportunity which must be addressed.[212-213]

D. Addressing stigma and discrimination in national strategies and laws

According to the 2010 UNAIDS Global Report on HIV, 91% of governments globally reported that they address stigma and discrimination as cross cutting issues in their national strategies. The international HIV and AIDS Alliance study which assesses 56 countries on addressing stigma and discrimination at the national level, showed 90% of country activity plans included stigma and discrimination reduction programmes, fewer than 50% budgeted for such programmes. The review also indicated that countries rarely included a comprehensive package of programmes to reduce stigma and discrimination in national strategies.[214] Based on the People Living with HIV (PLHIV) Stigma Index, Rwanda has more than half of PLHIV verbally insulted, some physically harassed, physically assaulted, and a large number losing their jobs or income and denied access to family planning services due to their HIV status.[215]

Some measures of law reform processes are underway in Benin, Rwanda, and Sierra Leone.[216] Ethiopia has laws and regulations that protect PLHIV against discrimination. These include both general non-discrimination provisions and articles that specifically mention HIV, with a focus on schooling, housing, employment, health care etc. Mandatory HIV testing for employment is strictly prohibited in the country's labour law (Labour Proclamation No. 262/2001 and 377/2003 Article 14.1 d). Additionally, the Civil Service Workplace HIV and AIDS Guideline of the country also protects PLHIV from discrimination by employers.[217]

Table 21:
Status of countries laws to protect PLHIV from discrimination

Country	Have Laws that Protect PLHIV from Discrimination
Angola	Yes
Benin	Under reform
Ethiopia	Yes
Kenya	Yes
Nigeria	Yes
Rwanda	Under reform
Sierra Leone	Under reform
Tanzania	Yes
Zambia	Yes

Source: 2010 Global Report

Table 22:
People of all ages receiving and needing antiretroviral therapy and coverage percentages, 2011

Country	Estimated number of people needing antiretroviral therapy based on 2010 WHO guidelines	Estimated antiretroviral therapy coverage based on 2010 WHO guidelines
Angola	93,000 (69,000-139,000)	36%(26%-49%)
Benin	33 000 (29 000 – 37 000)	61%(54%-68%)
Ethiopia	470000 (430,000-510,000)	56%(52%-62%)
Kenya	750 000 (700 000 – 790 000)	72%(68%-76%)
Nigeria	1 400 000 (1300 000- 1 600 000)	30% (28%-34%
Rwanda	120 000 (110 000 – 130 000)	82% (75-90%)
Sierra Leone	20000 (17000-23000)	41% (35%-49%)
Tanzania	700000 (650 000 – 760 000)	40% (37%-43%)
Zambia	510 000 (480 000-540 000)	82% (76%-87%)

Source: World Health Organization (WHO), Joint United Nations Programme on HIV and AIDS (UNAIDS), & United Nations Children's Fund (UNICEF). (2011). ***Progress Report 2011: Global HIV and AIDS Response - Epidemic Update and Health Sector Progress Towards Universal Access.***

Zambia has laws that have a bearing on the protection of PLHIV against discrimination. While most of these laws and regulations do not specifically protect people living with HIV against discrimination, there are general non-discrimination provisions that can be applied to the protection of people living with HIV. Apart from the Citizens Economic Empowerment Act (2006) which is HIV and AIDS specific, others including the Employment Act and the Constitution of Zambia are not HIV and AIDS specific. The specific laws are:

4. The Citizens Economic Empowerment Act (2006) which prohibits HIV based discrimination at workplaces;
5. The Employment Act which stipulates that people cannot be discriminated against based on social status;
6. The Disability Act which prohibits discrimination against people with disabilities; and
7. The Constitution of Zambia which has a clause protecting citizens against discrimination.[218]

E. Access to antiretroviral therapy treatment and PMTCT

Sub-Saharan Africa has recorded the greatest increase in the absolute number of people receiving treatment in 2010 from 3,911,000 in December 2009 to about 5,064,000 in 2010.[219] In 2011, from the estimated 56% of people eligible for HIV treatment based on data of the nine countries under review (Table 22), it is observed that the estimated antiretroviral therapy coverage based on 2011 WHO guidelines ranges between a low 30% in Nigeria to 82% in Rwanda and Zambia. At the end of 2011, only Rwanda and Zambia, among the nine countries, with a generalised epidemic has achieved universal access to ART, with universal access defined as at least 80% of the people who need ART are receiving it.

In Benin, the percentage of pregnant women receiving ART has more than doubled since 2005. Benin officially opted for an ART access strategy that included young children, and triple combination ART became a reality beginning in February 2002.[220] Since December 2004, the Government of Benin has provided ART free of charge and by the end of 2007; almost half of HIV-infected people were receiving ART. In 2009, >40,000 pregnant women received counselling and >29,900 were tested for HIV. A total of 1,023 health facilities were providing PMTCT services at the end of 2009.

More than 616,763 pregnant women made at least one antenatal clinic visit during the last fiscal year, and 417,841 underwent HIV testing, of which 10,267 (2.4%) tested positive. Of the total pregnant women diagnosed with HIV, only 6,466 (63%) received anti-retroviral prophylaxis (ARV/NVP) and only 5,025 infants received prevention of mother to child transmission (PMTCT) prophylaxis in the same year. The proportion of diagnosed HIV positive pregnant mothers receiving antiretroviral prophylaxis was significantly greater than the 52% in 2007/08. From July to December 2009 alone, 343,476 pregnant women visited antenatal clinic of which 253,459 (73.7%) underwent HIV testing with the same (2.4%) positivity rate as the previous year. Unfortunately, out of those who tested positive, only 57.7% received ARV/NVP. The progress for implementing PMTCT has been slow, STIs are not systematically monitored. [221]

The PMTCT services in Kenya are free and integrated into Maternal and Child Health (MCH) services. They includes various interventions, such as HIV testing and counselling, preventive treatment with antiretroviral (maternal and infant), counselling and support for appropriate infant feeding, access to safe obstetric care, and family planning services. The health facilities offering PMTCT services have been increased from about 2000 in the year 2007 to 3,397 in 2009. Thus, about 50% of the health facilities in the country are offering PMTCT services. KDHS 2008-09 showed that more than half of HIV positive pregnant women were tested and received their results during ANC. About 39,482 children are getting ARV to prevent HIV infection out of the 81,000 estimated number of children born of HIV positive mothers.[222]

In Nigeria, there is an ongoing scale up of anti-retroviral therapy (ART), PMTCT, and HIV care and treatment (HCT) services across public, private and faith-based institutions across the country. As at March 2009, there has been scale-up of ART, PMTCT and HCT to 393,670 and 1050 sites respectively across the country, from an initial 20 sites in 2002. Free ARV provision policy in 2006 has led to increased access and uptake. Annual number of clients on ART has increased from 50,581 at inception of 80 ARV provision in Nigeria in 2005 to 30,297 in 2009. The contributions of the US President's Emergency Plan for AIDS Relief (PEPFAR) programme within the country and the Global Fund Round 5 support have also played a significant role in the scale up of ART services in Nigeria. The main donors are the PEPFAR, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the World Bank. In 2002, the World Bank loaned US$90.3 million to Nigeria to support the five-year HIV and AIDS Programme Development Project.

In Rwanda, during 2008, 6,387 HIV-positive pregnant women received ARVs to reduce the risk of PMTCT, and this number increased 7,030 in 2009. The government is aiming to reach the target of 90% coverage for 2012 (NSP 2009-12). Most importantly, in 2008, two-thirds of pregnant women who were eligible for HAART for treatment received it during pregnancy. However, one-third of PMTCT sites are not yet equipped to initiate HAART. The number of health facilities offering PMTCT increased from 11 in 2001 to 372 in 2009. Given that the current total number of health facilities in Rwanda is 517, this number corresponds to 72% coverage across all districts in the country.[223]

Although less than 25% of pregnant women had the four WHO recommended ANC visits, nearly all women come at least for one antenatal care visit, which has been used as an excellent opportunity to provide PMTCT services. In order to increase the uptake of HIV testing among pregnant women, provider-initiated testing and counselling with informed consent was initiated in 2008 and is currently included in national PMTCT guidelines. Rapid HIV testing with same-day return of results is also currently provided. The number of pregnant women tested for HIV reached 294,704 and 294,457 in 2008 and 2009, respectively. Nearly all women tested received their results in 2009. 235,113 of these women were also tested for syphilis (2% prevalence found). In Rwanda, great efforts are made to encourage the partners of pregnant women to be tested for HIV and to offer couple counselling and testing. Among pregnant women who tested for HIV, an average of 78% in 2008 and 84% in 2009 of their partners agreed to have a test, while the number of partners who tested was only 33% in 2005. Expanding this approach is very important given the high number of discordant couples. About 3.7% of heterosexual couples are HIV sero-discordant as per national VCT data. In Kigali, 7.1% of cohabiting couples seeking voluntary counselling and testing services are HIV discordant. The proportion of discordant couples with a HIV positive man is almost the same as that of discordant couples with a HIV positive woman. Knowing the HIV status of the partner is the first step to avoid HIV infection during pregnancy, where the risk of HIV transmission to the child is higher.[224]

In Sierra Leone , a total of 145,405 people were counselled, tested and received their results, this number consists of only 9% of women and 7% men who have ever been tested out of whom only 4% women and 3% men know their results in 2008. According to SLDHS 2008, the mean age for marriage for women is 17 years for women and 25 years for men, yet over 25% of women and 11% of men have had sex before the age of 15 years, this means that young women are vulnerable due to the likelihood of exposure to early sexual activity which increases their risk to HIV and STI. In conformity with the national guidelines on STI treatment over 19,461 and 27,310 were treated for STIs in 2008 and 2009, respectively.

Between 2008 and 2009, uptake of ART services and subsequent scale up of ART services and sites the number receiving treatment increased from 1950 to 3660 clients. The number of pregnant women receiving treatment increased from 579 to 637, from 2008 to 2009, which represents 18% of the total number of pregnant women requiring ART.[225]

Tanzania mainland began care and treatment services late 2004 where there were 96 CTC targeted to enrol 44,000 patients. By December 2006, CTC sites increased to 200 with total enrolment of 125,139 of whom 12,563 were children under 15 years, and 73,087 were women. Recent data (March 2009) shows that the cumulative number of clients enrolled in HIV CTCs totalled 454,681 representing 21.5% of the 2,113, 158 estimated PLHIV. While there has been a positive trend among women accessing services at CTC, the number of children accessing these services represented only 9% of the total CTC clients by December 2008, way below the 20% target set by the Ministry of Health and Social Welfare (MOHSW).

Overall, about 78% (3,626) of 4,647 health facilities providing RCH services are currently providing PMTCT services (December 2009). However, there are still regional variations that could

be attributable to constraints in resources (Financial and Human) despite the regionalisation policy. In year 2009, a total of 1,223,964 new ANC attendees were registered in facilities implementing PMTCT services. Among those ANC clients, 1,194,172 (98%) were tested for HIV. During that period, 5.8% (70,423) of the women tested were identified as HIV infected. In the same period (January-December 2009), 84% (58,833) of the women who tested positive for HIV received ARV prophylaxis.[226] Currently, there are no figures available for reach and coverage of the MARPs, which is an indication of the weakness of the prevention programme, which tries to address everybody, but does not address the key populations with regard to stigma and discrimination, ZAPHA+ reports an existence of high level of stigma towards PLHA, including from family members.[227]

In Zambia, the percentage of adults and children with advanced HIV infection receiving antiretroviral therapy was 68% out of an estimated total population of 416,533 who were in need of ART as at December 2009. From an estimated ART need of 382,569 adults who are 15 years and older, 69% were accessing treatment while slightly fewer (62%) children (less than 15 years) were on treatment out of the estimated 33,964 in need. One of Zambia's major goals in the response to HIV and AIDS is to delay the age at which young people first have sex, until they are old enough to negotiate safe sex thereby reducing their potential exposure to HIV.

Preliminary data from the ZSBS 2009 shows that more females were likely to delay their sexual debut than the males among the age group of 15-24 years, interviewed in the survey. For the males within the ages of 15-24, 8.2% reported that they have had sexual intercourse before the age of 15 while for females in the same age group, 6.8% reported having had sex before the age of 15. The 2008 ANC Sentinel Surveillance Survey found that the HIV prevalence for the antenatal attendees aged 15-24 years will be within the same rate at 9% for the age group 15-19 years and at 16% for the age group 20-24 years. The Impact of ART and PMTCT services in Zambia, NAC (2010) highlighted a number of bottle necks and barriers to accessing ART and PMTCT services.

The increase in service demand has not matched the infrastructural development in facilities offering ART. It is difficult to talk about confidentiality in some facilities due to lack of space. Patient files are sometimes kept in two or three different places due to lack of space. In terms of quality of service, the PMTCT programme trained service providers and health workers with sufficient knowledge.

The shortage of adequate numbers of staff puts a lot of stress on the few that do work in the area, further reducing the quality of services. The other six provinces showing a reduction in HIV prevalence, the Central province is now second only to Lusaka province surpassing Copperbelt province, while the Western Province has moved from being the sixth province in 2001/2 with the most infected population to fourth in the country by 2007.

PLHIVs also have difficulty accessing critical health services, especially for those living far from major urban areas. Official estimates of the cost of treatment do not include transportation, food, and accommodation for upwards of three or more days. Neither are the personal and replacement cost of absence from work or care-giving or other responsibilities captured by this approach. Presently, these indirect costs are borne by the client or household members.

The associated costs of treatment are a factor in PLHIV missing monthly clinical appointments and collection of medication. Universal access to reproductive health services is required to respond to the needs of PLHIV of all ages, and this requires a strategy that promotes the integration of HIV and AIDS with sexual and reproductive health. With the widespread availability of ARVs, Zambia is supporting a generation of children living with HIV who are surviving longer and reaching adolescence and adulthood. Tailored sexual and reproductive health information and services are required for this group.

SUMMARY

Most of the STI interventions are being carried out through HIV and AIDS programmes in the nine countries. In terms of HIV epidemic level classification, the region remains significantly affected by HIV. In comparison to estimates in 2001, a 25% decline is observed with regards to new infections. At the same time, people dying from AIDS related causes has declined by 32%.[230]

The region has seen an improvement in the coverage for HIV testing as well as treatment. In terms of access to treatment, 56% of people eligible for HIV treatment in Sub-Saharan Africa were receiving it in 2011, and this is more than the global average of 54%. Rwanda and Zambia, in the ICPD+20 review, are countries in the region which have achieved more than 80% coverage, and Benin and Kenya have achieved more than 60% coverage of HIV treatment.[231] Stigma and discrimination continue to pose as a barrier to HIV response, treatment and care. In some countries under review, efforts are being made to integrate HIV programmes into broader health programmes.

In the nine countries, women are disproportionately affected with a high magnitude of HIV in comparison to men. Among women, younger women have a higher prevalence in comparison to the older women. The prevalence of HIV among young women is higher in comparison to young men of the same age. Among women, the HIV risk is seen to be higher among widowed and divorced women in comparison to married women. This trend needs to be examined. HIV prevalence is higher among polygamous unions in comparison with non polygamous unions. Sex workers, men who have sex with men, injectable drug users, uniformed service personnel, truckers, refugees and displaced people, mobile and cross border population, children on the street, causal labourers, students and other mobile populations

are most at risk of HIV infections. The International HIV and AIDS Alliance study which assess 56 countries on addressing stigma and discrimination at the national level, showed 90% of country activity plans included stigma and discrimination reduction programmes, fewer than 50% of such budgeted programmes. The review also indicated that countries rarely included comprehensive package of programmes to reduce stigma and discrimination in national strategies.[232]

Overall, the data shows some improvements in HIV prevention, treatment and care in the region. However, there is a need to increase domestic resources to fund HIV responses in the region to sustain efforts and improve the situation further. There is also a need to address the issue in a more holistic manner by addressing the broader social determinants as well as gender power inequalities.

3. ADOLESCENT SEXUAL RIGHTS

WHO defines adolescents as the 10-19 age group and in general terms, this period is considered a time of transition from childhood to adulthood, during which young people experience changes following puberty but do not immediately assume the roles, privileges and responsibilities of adulthood.

The ICPD PoA urges governments to address adolescent SRH issues, including unwanted pregnancy, unsafe abortion and sexually transmitted diseases, including HIV and AIDS, through the promotion of responsible and healthy reproductive and sexual behaviour, including voluntary abstinence and the provision of appropriate services and counselling specifically suitable for that age group.[233] This includes the right to sexual and reproductive health information, education and services.

Sub-Saharan Africa is characterised by diversity in the area of adolescent sexual and reproductive health and rights and a comparatively high adolescent birth rate. In many countries, customary laws and traditional norms allow marriage of girls as young as 9 years old, in rural areas where education opportunities are limited, many young women are married by age 16, many of the traditional ceremonies do not have legal papers, but families and communities are often aware of the cohabitation and sanction the relationship as a marriage.

Sexual initiation before age 15 is rare in some countries and common in other countries.[234] However, one strain runs through all this diversity, that sexual matters are private and should only be discussed by adults. Many religious, traditional and political leaders also promote norms that define sexuality as an adult activity mainly meant for reproduction and for consenting adults, emphasising purity for women and experience for men.

Yet, most of these countries also have laws that define age of marriage under statute law as between 16-18 for young women and men. Meanwhile religious leaders, service providers and policy makers, who are in the upper wealth quintiles often consider adolescent sexuality as illegal, sinful, abhorrent and outside the framework of marriage, prohibiting sexual and reproductive services and information from targeting adolescents. Defining adolescent legal age is also a challenge. Despite the above definition by WHO, many of the countries in the nine countries consider adulthood to be attained by the age of 18 years but do not have a clear definition of adolescence in their laws.[235]

The median age at first sexual intercourse in the nine countries (with the exception of Rwanda and Angola) in the age group of

Table 23:
Looking at whether comprehensive sex education is provided in schools in the nine countries

Country	Comprehensive Sexual Education in schools
Angola	Yes
Benin	No
Ethiopia	No
Kenya	No
Nigeria	No information
Rwanda	No
Sierra Leone	Limited
Zambia	Yes but faces opposition due to misinformation in curriculum

Source: Country information

women 20-49 in the nine countries is between 16-19. Recent data is not available for Rwanda[236] and Angola. We see that by age 20, most of the young girls have had sexual intercourse. It is also observed that young girls in rural areas have sexual intercourse earlier compared to young girls in urban areas. In the context where there is high generalised epidemic of HIV and high maternal mortality and morbidity rates, it is important that young adolescent girls have access to SRH information, and have safe and protected sexual experiences.

A. Comprehensive Sexuality Education

The UN Convention on the Rights of the Child states that children and young people have the right to enjoy the highest attainable health, access to health facilities (Article 24), and access to information which will allow them to make decisions about their health (Article 17), including family planning (Article 24).

Young people also have the right to be heard, express opinions and be involved in decision making (Article 12). They have the right to education which will help them learn, develop and reach their full potential and prepare them to be understanding and tolerant towards others (Article 29). Additionally, young people have the right not to be discriminated against (Article 2).

The Protocol on the Rights of Women in Africa to the African Charter on Human and People's Rights, also known as the "Maputo Protocol,"[237] condemns and prohibits sexual violence (Articles 3 and 4) and harmful practices (Article 5). Article 14, on health and reproductive rights, obliges States to provide affordable health services, including information and education, to women. Article 12, on the right to education and training, calls on States to "take all appropriate measures" to:

Eliminate all stereotypes in textbooks, syllabuses and the media, that perpetuate such discrimination [against women];

- *Protect women, especially the girl-child from all forms of abuse, including sexual harassment in schools and other educational institutions and provide for sanctions against the perpetrators of such practices;*
- *Provide access to counselling and rehabilitation services to women who suffer abuses and sexual harassment;*
- *Integrate gender sensitisation and human rights education at all levels of education curricula including teacher training*

The reclaiming and redefining rights publication by ARROW defines sexuality education as the basic education about reproductive processes, puberty and sexual behaviour. Sex education may include other information, for example about contraception, protection from sexually transmitted infections and parenthood. Sexuality education is defined as education about all matters relating to sexuality and its expression Sexuality education covers the same topics as sex education but also includes issues such as relationships, attitudes towards sexuality, sexual roles, gender relations and the social pressures to be sexually active, and it provides information about SRH services. It may also include training in communication and decision-making skills.[238] This definition is based on the definition provided by International Planned Parenthood Federation (IPPF).

Comprehensive sexuality education focuses on several issues, namely: gender, roles, norms and relationships, reproductive processes, puberty, positive sexual behaviour, sexual roles, social pressures, attitudes to sexuality, unintended pregnancies, abortion, protection from sexually transmitted infections and HIV, empowerment and respect for sexual diversity.[239] The status of providing comprehensive sexuality education is uneven in the nine countries.

Overall, there is limited data on the status of sexuality education in the region. A Guttmacher study emphasised the need for sexuality education both in school and out of school in Sub-Saharan Africa, given the magnitude of HIV, unintended pregnancies, and the vulnerabilities of adolescent and young girls. Despite policies in place, many adolescents do not receive any form of sexuality education. The entry point for most of the sexuality education curricula is through HIV and AIDS programmes. According to a 2004 survey, HIV and AIDS were part of the primary school curriculum in 19 of 20 African countries with a high prevalence of HIV. Life skills are integrated into the curricula in 17 of the 20 countries, however, implementation of the programmes have not been effective.

At the same time, school-based sex education programmes do not cater to youth (the majority of them adolescent girls and young women) who are not in school. Addressing out-of-school adolescents is another big challenge in the region. Sexuality education is not comprehensive and mostly takes a biological perspective. Religious groups and parent associations define the parameters and content for its age appropriateness. Some NGOs have established adolescent friendly reproductive health services in Tanzania and Zambia to provide the population age 10-24 with sexual and reproductive health information. Other barriers include teachers who are perpetrators of sexual harassment and violence, thus, parents are not comfortable with them handling the programmes. The low number of female teachers in rural schools and poor infrastructure also limit young women's access to quality information.[240]

In 2005 in Angola, a nationwide campaign on HIV and AIDS in secondary schools for students aged 9 to 18 was implemented by the Ministry of Education and UNICEF. The curriculum includes teachings on gender, sexuality, STDs, HIV and AIDS. Similar clubs are set up for students to be involved inside and outside of their schools.[241]

In Benin sexuality education is not taught in primary schools. Many teachers are embarrassed to even teach it in their science classes, and there is parental and ministerial opposition. There is a fear that this education would promote premarital sex. NGOs have influenced some secondary schools to teach the scientific side of sexuality. Influence from the US Mission and religion promote a side of HIV and AIDS education that encourages abstinence, being faithful and using condoms within marriage, but this presents a problem for the reality of adolescent lifestyles.[242]

The Ethiopian government has advocated a radio drama that would produce sex education for its citizens, educating them on safe practices, and on HIV and TI transmission. These radio dramas also promote women's empowerment to pursue education and health rights, and they also promote awareness of marriage abductions and other issues. This is introduced because an all-out sexual education programme does not exist in Ethiopian schools, and a more informal family and community sex education is common where adolescents are educated on sex.[243]

In Kenya, education is nationalised and does not include sexuality education. NGOs have integrated some elements into various curricula, and this is taught by proctors or in boarding schools. Sexuality education, however, has met with opposition from Muslim and Roman Catholic communities. The Boy Scout movement made a book on sexuality education that was used in school curriculums for a limited time, due to further opposition. There is even some denial that condoms add to AIDS prevention, abstinence being more reliable, and they also protest that sexuality education should only be carried out by parents. Sexuality education was traditionally carried out as part of the initiation process, or they are educated by older relatives by instruction and even sexual experimentation.[244]

In Rwanda no formal national sexuality education exists, and this responsibility is expected to be under the discretion of the child's parents. There are some abstinence-only programmes that are implemented, but many times, this leads to mis-information as a scare tactic.

VOICES FROM THE GROUND

Box 6: **Sexuality education**

A young girl , who lacked information on sexuality and access to sexual and reproductive health services was facing difficulty in her adolescent years. After attending an awareness session held by members of the YWCA Benin, she received training on SRH knowledge and leadership skills , where she learned to make her own decisions about her sexual reproductive health and not be influenced by others. She now has access to reliable information on issues related to sexual reproductive health and HIV/AIDS and actively participates in training of young women and girls. . This is Patricia's story. She is a 20 year old woman from the YWCA of Benin who is a peer educator, training young women and girls in SRH information and improving parent-adolescent SRH communication and thus reducing risky behaviour and addressing social and cultural barriers.

In Sierra Leone, peer education is used to encourage safe sex and knowledge of sexuality among the youth of Sierra Leone. Social taboos on sex prevent national education systems from letting information on sex be easily accessible. Various outside-of-school sessions on sex exist, and some students learn general information from schools, health care settings or the limited media that is available, but home education on sex and sexuality only contains limited truths on safety practices. As for youth in secondary school, providing sexuality education during that period would be considered as too late, because many girls are unfortunately exposed to sex very early on in life.

In Tanzania sexuality education is traditionally done in the female and male initiation process. However, nothing is said about contraception or prevention of STDs and HIV and AIDS. These rituals are not as common anymore. Sex education is carried out through informal teachings by mothers or friends or through past sexual experience before marriage. It is also indirectly taught through social studies, sciences and biology. In these areas of study, there is little focus on relational attitudes towards sex or moral values. It is also problematic that these indirect subjects concerning sex education are taught too late in childhood.

In 2004 Tanzania saw the introduction of HIV and AIDS education through the "Guidelines for implementing HIV and AIDS and Life-Skills Education Programmes in Schools," after the AIDS epidemic was finally noted as a big problem. This curriculum includes counselling and HIV testing, basic facts of STIs and HIV and how they are transmitted, as well as advice in approaching relationships. However, since these topics are usually scattered across multiple topics, the teaching methods are less effective.

In Zambia, sex education has undergone change in recent years, as the role of the older members of the girls' family and women traditional leaders influence is waning, but still evident through the initiation rites of girls. Women's organisations help in making the population aware of HIV and AIDS and STIs. Schools in the 1990s also adopted a system of sex education, however, some myths on sex with young virgins to protect oneself from HIV infection have been wrongly attributed to sexuality education in schools leading to some parents objecting to the curriculum. For some young people in Zambia, this knowledge about sex has contributed to behavioural changes, but in other cases it has been ineffective as they have continued with traditional ceremonies.

SUMMARY

Data from the nine countries shows the diverse context of the situation of adolescent sexual rights. Based on evidence, it is observed that by age 20, most of the young girls in the nine countries have had sexual intercourse, making them vulnerable to contracting STIs and HIV. At the same time, adolescent fertility rates are quite high in most of the countries under review. Within this context, it is very critical that adolescents and young people have access to comprehensive sexuality education and access to youth friendly SRH services.

An examination of the sexuality education curriculum in the region shows an uneven picture and there is a need to ensure that comprehensive sexuality education is provided to all adolescents and young people, both within school and out-of-school settings. The curriculum needs to be comprehensive enough and delivered by trained instructors and teachers. Access to a range of youth friendly SRH services in a non-judgemental manner also needs to be ensured, so that adolescents and young people realise their optimal sexual and reproductive health outcomes.

Table 24:
Legal age and median age at marriage

Country	Women	Men	Median age at marriage for Women (age 25-49)	Remarks
Angola	18	18	NA	Women and men who have reached aged 15 and 16 respectively may marry only under exceptional circumstances
Benin	15	18	18.5 (DHS 2006)	Exceptions under law of Dahomey and depending on ethnic group
Ethiopia	18	18	16.5(DHS 2011)	
Kenya	18	18	20.1 (DHS 2008-09)	
Nigeria	18	18	18.3 (DHS 2008)	
Rwanda	21	21	21.4 (DHS 2005)	
Sierra Leone	21	21	17.0 (DHS 2008)	Based on the Christian Marriage Act persons under age of 21 years are allowed to marry provided parental consents is given
Tanzania	18	18	18.8(DHS 2010)	Parental consent for age 14
Zambia	21	21	18.2(DHS 2007)	18.2

Source: UN Data. (2013). ***Legal Age for Marriage.***
Median age at first marriage source: Country Demographic and Health Surveys: Benin: DHS 2006; Ethiopia DHS 2011; Kenya DHS 2008-09; Nigeria DHS 2008; Rwanda DHS 2005; Sierra Leone DHS: 2008; Tanzania DHS 2010; Zambia DHS 2007.

4. SEXUAL RIGHTS

Introduction

Sexual rights are closely connected with reproductive rights and the achievement of desirable SRH outcomes is dependent on women being empowered to make decisions in the public and private spheres of life, and especially in matters related to their sexuality and reproduction. In this section, we look at critical sexual rights indicators that have a bearing on the optimal realisation of SRHR.

The WHO working definition of sexual rights is mentioned as follows: "Sexual rights embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These include the right of all persons, free of coercion, discrimination and violence, to:

- the highest attainable standard in relation to sexuality, including access to SRH care services;
- seek, receive and impart information in relation to sexuality;
- sexuality education;
- respect for bodily integrity;
- choice of partner;
- decide to be sexually active or not;
- consensual sexual relations;
- consensual marriage;
- decide whether or not, and when to have children; and pursue a satisfying, safe and pleasurable sexual life."[245]

This definition is comprehensive and in line with the ICPD PoA principles. Taking this definition into account, we examine the following key sexual rights indicators:

1. Indicators around status of laws on the legal age of marriage, arranged and forced marriages. These are meant to assess how far women are able to exercise the rights pertaining to choice of partners, decision to be sexually active or not, consensual sexual relationship and consensual marriage.
2. Indicators around traditional practices harmful to women and laws around sexual violence and trafficking, which help assess aspects of bodily integrity.
3. Indicators of sex work decriminalisation and same sex sexual relationship legislations to assess how far the rights to the highest attainable standard of health in relation to sexuality, choice of partner, consensual sexual relations and pursuit of safe , satisfying, and pleasurable sex life are pursued.

A. Early and forced marriages

Legal age of marriage and its enforcement thereof

There is a wide acknowledgment and understanding that age at marriage is an indicator of sexual rights as an early marriage would mean a woman is not likely to have a say in choosing her (sexual) partner. At the same time, age at marriage also has associations with fertility.

This section examines the laws and customs in the nine countries and how they support or violate women's sexual rights in the choice of sexual partners, and their right to be free from forced and early marriages, and consensual sexual relations and marriage.

Early marriages are a common phenomenon in Sub-Saharan Africa (38%). Sub-Saharan Africa has the second highest rate of early and forced marriages. CEDAW propounds that marriage before the age of 18 should not be allowed, and the Universal Declaration of Human Rights states that "marriage should be entered only with the free and full consent of intending spouses."

Early marriage is associated with fertility and an increase in the risk of pregnancy and maternal mortality as a result of adolescent pregnancies. Young women in early marriages have less access to reproductive health services as they will invariably be married to older partners, and have limited capacity to make healthy reproductive choices due to gender power imbalances.

In the context of forced marriages, these take place against the wishes of one or another individual, or without the full and informed consent of individuals who are getting married. This kind of marriage is also a common practice in the countries under review.[246] Abduction of girls, rape and forced marriages are a common practice in most of the countries under review, including Ethiopia.

In Table 25, we look at the legal age of marriage in the nine countries. Except for Benin, all the other eight countries have equal age of marriage for both men and women. Age at marriage may be much lower for specific population groups within the same country. This is because marriages, in all of the nine countries under review, are governed not only by the civil code, but also customary laws and religious laws with different age of marriages stipulated within these codes and laws.

In Angola, the legal age of marriage is 18 for both men and women, however, women may be married at age 15 or 16, depending on special circumstances. The marriage act states that marriage is a free choice between the man and woman, this right is protected in Articles 20 and 112 of the Family Code. The code also recognises the parental rights and obligations toward their children, and parents may decide that it is in the best interest for their minor child to establish a family through marriage upon

VOICES FROM THE GROUND

Box 7: **Early marriage- The story of Mereso Kilusu**

In the traditional Maasai communities in Tanzania early marriages are very common.

"It happened during Christmas break. My father told my school that I had died. Even if he hadn't, I would have been forced to leave when I got pregnant because that was the law at the time. I gave birth to my first child within a year. I had no professional prenatal care and no trained medical assistance during delivery. I had to depend on my husband and his other wives for guidance. It was a very painful experience. Every time I became pregnant after that I felt sick and scared. Because of all these difficult births I have a hard time controlling my bladder and it can be painful to urinate. Today, I am a mother of five at 29 years old.

In communities like mine, age is not understood as a number. Our traditional values dictate girls are meant for marriage, and when the men decide we are biologically ready, we are married. Marriage is sometimes a way of forming and cementing relationships. But it is also a way of earning money. My family received a bride price from my husband and then he took me away to become one of his wives. He beat me regularly, and so I fled back to my village. But my father and brother told me the price had been paid, this was no longer my home, I had to return.

It wasn't until six years ago that I was able to take charge of my own destiny. I ran away to Arusha and met Rebecca, a volunteer with the Young Women's Christian Association (YWCA). Through counseling, workshops and friendship, I gained more confidence in my own voice and learned to support myself.

When I returned to my village, I found an ally: one of our community leaders, named Abraham. In his own extended family girls were running away from forced marriages. He felt obliged to support them by giving them shelter and food. Quietly, he was encouraging them to go to school hoping it would be a way to get girls out of their situation. When he learned about how I was able to find support from the YWCA he was inspired. Knowing there would be places for girls to go outside their communities helped convince him they would be OK if they left their marriages.

But I love my family and my community, and I didn't want leaving to be the answer. So I set up a YWCA in my village and slowly, change is happening.Some men and boys are not happy with what I'm doing. I have to be around others all the time to protect myself from harassment. I don't know if my own father would approve if he were still alive. But many are recognizing that this is the way forward -- that girls have value beyond marriage. That we can earn money and contribute more to our communities when we stay in school.

My brother used to think I was wrong to leave my husband. But seeing how well I am doing selling traditional Maasai jewelry and clothing he is starting to respect my choice. He no longer beats me, but he still won't let me have access to any of my father's farms. Thankfully, I have supporters in my community who help give me other options to grow food for my children. I believe my relationship with my brother will get better with time. I am still working on it.

My mother is so proud. She used to fear my disobedience to my husband would reflect poorly on her and she would be cast out of the community. But now she sees I am welcome and respected and she is so happy to have me back in her life.

Likewise, passing laws provides no guarantee girls will be protected unless they have community support: 158 countries have set the legal age for marriage at 18 years but the laws are simply ignored by communities where marrying children and adolescent girls is common practice. In the fight against child marriage, the biggest battle is finding those who are ready for change and giving them the courage to speak to others. Those of us who believe in the power of girls, who have seen what they can do when they have options, we need to tell everyone we can. We need to teach girls that it's OK to say no to marrying before they are ready, and that there are places they can go if they have to run away.

We need to talk to families about different ways their girls can contribute to their livelihoods, so that marriage is not seen as the only option.We need to show community leaders examples of girls who have stayed in school, learned skills, and have helped develop their local economies. We need to convince politicians that they should pass laws to protect and empower girls, and that the people will support them if they do. And we need to share our success stories with the world. Because people need to know we are fighting for change and they can join us in their own countries and communities.

Change is possible when we believe in each other. I am living proof."

Mereso Kilusu was a child bride and is now an activist against child marriage. Her story was translated by LoeRose Mbise, of YWCA Tanzania, and edited by Marlee Wasser, of The Partnership for Maternal, Newborn & Child Health. And accessed from http://www.cnn.com/2013/03/08/opinion/child-marriage-kilusu CNN OPINION –AFRICAN VOICES

reaching the age of 16 (in the case of a male) or 15 (in the case of a female),[247] this is a challenge for young women as they are likely to be coerced into marriage by adults.

In Benin, where the age at marriage is much lower for girls (15 years) than for boys (18 years), family and marriage law is defined by the Dahomey Customary Law,[248-249] which defines women as minors, who have no legal capacity and can be inherited on death of their spouse or bartered by parents in return for assets such as livestock and land. The Dahomey Customary Law also provides for polygamy through forced and arranged marriages by fathers or older brothers, with no consent required from the woman. A law to rectify this anomaly has been pending in parliament for many years. This duality of laws explains why there is 40% more women aged 15-24 years married by age 18 compared to men in the same age group (8.6%).[250]

Ethiopia's civil code defines the legal age for both men and women as 18 years, but the median age of marriage for women is 16.5. There are three types of marriage - the civil code, customary law and religious laws, such as the Fetha Negest (Orthodox) and Sharia law. All of these other codes set a lower age of marriage for females. Fathers and brothers have a great say in the marriage of women and often set a bride price, which could be prohibitive, leading to many cases of abduction, especially when young men feel they cannot afford the cost. Abduction[251] has for many years been a traditionally legitimate way of getting a bride in southern Ethiopia.

The young men will arrange to kidnap a girl, sometimes as young as 12 years, hide her, and then rape her. This means she is considered damaged, and her family will agree to a marriage to avoid shame. Girls forced into marriage through abduction have severe reproductive health problems as they are often coerced to have sex, become pregnant early and have no access to health services because of their age and hostile environment, where they are constantly monitored to stop them from escaping or returning home. Since 2004, the Ethiopian penal code forbids girls to get married before the age of 18, and punishes marriage by abduction with up to 20 years imprisonment, however, implementation of the law has proven difficult as traditional mechanism of reconciliation tend to focus on compensation for the family rather than solace and justice for the young woman. To address the issue, UNICEF has begun a programme, encouraging families of abducted girls to go to the police and not village elders. Moreover, many girls who are abducted never go back to school.

Kenya's minimum legal age of marriage is 18 years for all and the median age of marriage for women between 25 and 45 years is said to be 20.1. However, this may not reflect the reality on the ground. Kenya has four systems of marriage - Civil, Christian, Muslim, and customary. [252] Civil and Christian marriages were introduced as part of colonial legislation and only provided for monogamous marriage, polygamy is only allowed if parties contract a marriage under customary law or are married under Islamic Law. The CEDAW Report in 2011 states that customary marriages are a recognised form of marriage in the constitution, and that there is no defined legal age of marriage.

Between 2003 and 2010, the proportion of women married, separated or widowed under age 19 declined, showing a progress towards a decrease in early marriage.[253] Key factors that have been attributed to this decline include the introduction of free basic education, and government action against the practice of child brides. The Kenyan Law Reform Commission has proposed changes to the Marriage Bill, which if passed, would consolidate existing legislation relating to marriage, and allow for the registration of marriages performed under customary law, hence, protecting the rights of many young women who are forced into undocumented unions.

Nigeria has a minimum legal age of 18 for both men and women and a median age at marriage of 18.3 years. The Child Rights Act,[254] passed in 2003, raised the minimum age of marriage to 18 for girls. However, federal law is implemented differently at the state level, and to date, only a few of the country's 36 states have begun the process of developing legislative framework. Like all other countries in Africa, Nigeria has three different legal systems operating simultaneously - civil, customary, and Islamic. State and federal governments have control over marriages that take place within the civil system, there is no registration of the customary or Islamic marriages.

Child marriage is extremely prevalent in some regions; in the Northwest region, 48% of girls were married by age 15, and 78% were married by age 18. Although the practice of polygamy is decreasing in Nigeria, 27% of married girls aged 15–19 are in polygamous marriages. In the latest DHS,[255] evidence points to an increase in age at marriage in Nigeria over the past generation.

Rwanda has a minimum legal age of 21 years for both women and men, with a median age at marriage of 21.4. Officially, any marriage undertaken by anyone below 21 is deemed to be illegal[256] and the older partner is liable for prosecution. However, most marriages are not registered. The DHS Report from 2010 stated that only 2% of women between the ages of 24-49 reported being married at the ages of 15. At age 18, the proportion is significantly higher (17%). At age 20, more than three in ten women (36%) are married; at age 22, slightly more than half of women are married (56%); by the age of 25, three quarters of the women (76%) have been married for at least a year.

Although polygamy is illegal in Rwanda, there is still over 4% of young women aged 15-19 and over 12% of women aged 45-49 in polygamous unions. The extent of polygamy differs by residence; the percentage of married women living in polygamous unions with one co-wife is 4% in urban areas compared with 8% in rural areas.

Women's level of education in Rwanda does affect the frequency of this practice: the percentage of married women with one co-wife is four times higher among women with no education (12%) than among women with a secondary education or higher (3%). The increasing legal environment around marriage is protective of women who are educated and know their rights, but it remains a challenge for young women who are not educated and cannot access legal protection if they are in relationships deemed illegal.[258]

Sierra Leone has a minimum legal age for women and men of 21 years of age, and the median age of marriage for women aged 25-49 years is 18.8. The Sierra Leone Matrimonial Act of 1960,[259] provides for three types of marriage - civil, religious, or customary. In Christian marriage, only a father's authorisation is required when the person marrying is under 21 years of age, while to undertake a civil marriage, women have to be 18 and marriage to any women under 18 years is considered forced marriage. The new act named Registration of Customary Marriage and Divorce Act of 2007 requires for the first time that customary marriages be registered and consent of both parents be given for anyone below age 18 years.

Sierra Leone has a high prevalence of early marriage. In the 2008 DHS,[260] it is indicated that 34.1% of girls aged 15-19 were married, divorced or widowed and that 22.2% of women aged 20-49 had been married by the time they were 15 years of age. Early marriage is often linked to initiation into the "bondo secret societies in adolescence, as parents are keen to marry their daughters off as soon as this has taken place."

Amnesty International [261] reports that during the civil conflict girls and young women were forced into 'marriages' with rebels fighters, and three leaders of the Revolutionary United Front were convicted of forced marriage as an inhumane act constituting a crime against humanity under the special court.

Polygamy is prohibited under the law in Sierra Leone but is legal for Muslims and is a normal practice in rural areas where many young women report being in polygamous unions. According to the 2008 DHS, overall, 37% of married women were in polygamous relationships, and in rural areas 29.7% of married girls aged 15-19 reported that their husband had more than one wife.

Tanzania's minimum legal age of marriage is 18 years for both men and women and the median age at marriage for women between ages 25-49 is 18.8. However, multiple laws based on civil, religious and customary practices allow exceptions for girls aged 14 years, under "justifiable" circumstances such as customary and religious practices.

As of 2008, it appeared that the law with regards to minimum age for marriage was under review, with a view to raising the minimum age to 18. There is a high incidence of early marriage in Tanzania that has remained unchanged over the last fifteen years. The 2004-2005 DHS found that 8.5% of married women between the ages of 20 and 49 were married before their fifteenth birthday. Tanzanian law recognises three types of marriage: monogamous, polygamous and potentially polygamous.

Zambia has a legal minimum age of marriage of 21 for both sexes and the median age at marriage for women age 25-49 years is 18.2 years. Marriage in Zambia is governed by a dual legal system of statutory and customary laws.

The Marriage Act provides for the minimum age of 16 for either male or female, under customary laws and it is legally possible with parental consent to marry a girl child who has attained puberty. The government reports that the payment of a bride price is still prevalent for statutory and customary marriages.

The UNFPA Sub analysis of 2007 Zambia DHS reports, based on 2002 data, states that 27% of girls between 15 and 19 years of age were married, divorced or widowed in Zambia, compared to 2% of boys in the same age range. In 1969, 41% of girls aged between 15 and 19 were married; divorced or widowed which indicates that societal acceptance of early marriage has declined in recent decades. Polygamy is not permitted under statutory marriages entered into under the Marriage Act.

However, polygamy is permitted and accepted as normal under customary laws in Zambia, particularly in patrilineal societies. A 2007 DHS found that 15% of married women in Zambia were in polygamous unions and that prevalence of the practice varies according to region and level of education, being more common among women in rural areas.

SUMMARY

Except for Benin, all of the other eight countries have equal age of marriage for both men and women either at 18 or 21 years. However, there is high prevalence of early and forced marriages in the countries under review. This is possible mainly because marriages in the nine countries under review are not only governed by civil laws but also by customary and religious laws. Customary and religious laws in most situations have a lower age of marriage for women than for men. Adolescent and young girls are sometimes coerced into marriage by adults as a result of parental rights and obligations.

Early and forced marriages have implications on the sexual and reproductive health of adolescent and young girls, including maternal mortality, morbidity and vulnerability to STIs and HIV. A report by Girls Not Brides on Ending Forced Marriages, notes many countries in Sub-Saharan Africa practise early and forced marriages with the belief that it will serve as a protection against HIV. There is strong evidence, particularly in Kenya and Zambia, pointing to early marriage and higher incidence of HIV infection when compared to unmarried sexually active population of the same group. The analysis in this report points to the pattern of

Table 25:
Countries stance on practice of FGM and legality of the practice

COUNTRY	PRACTICE FGM	LEGALITY OF THE PRACTICE
Angola	No	N/A
Benin	Yes	Illegal
Ethiopia	Yes	Illegal- Penal Code
Kenya	Yes	Illegal for minors under the age of 18 by the Children's Act of 2001
Nigeria	Yes	Illegal
Rwanda	No	n/a
Sierra Leone	Yes	No mention but thought to be included in the law that prohibits harmful practices on minors
Tanzania	Yes	Illegal- under the age of 18 is prohibited under the Sexual Offences Special Provision Act, 1998, and section 21 of the penal code
Zambia	No	Illegal under the penal code

Source: Data from respective countries' Gender Index

increased frequency of sexual intercourse, mostly unprotected sex, increasing the risk of HIV in the context of forced and early marriages. Above all, it violates a woman's right to choose her sexual partner.

There is a need for governments to repeal discriminatory laws against women in the context of marriages. Women's empowerment programmes should be implemented in areas of education. Sexuality educations in schools and out-of-schools are critical as a way to improve SRH education for adolescents and young people.

B. Harmful Traditional Practices

Harmful Traditional Practices (HTP) against women and children persist in Sub-Saharan Africa because individuals and communities hesitate to sacrifice what they think are important cultural activities that protect their identity and values.[262] Women, young women and girls are often victims of various forms of physical or psychological violence that infringe on their bodily or physical integrity and mental well-being due to their perceived and actual inferior status in society and the persistence of patriarchal attitudes. The linkage between SRHR and HTP is critical as some of the practices are key causes of high maternal mortality rates observed in Africa.

Many women do not have control over their fertility and face numerous obstacles in accessing reproductive health services or have undergone harmful traditional practices that have severe implications on their sexual and reproductive health rights.[263] These range from massaging the clitoris and labia of adolescents to enlarging them in southern and central Africa.[264] There is also the ironing of breasting in Cameroon to prevent early puberty and sexual activity in girls.[265]

In southern Africa, women who were sexually active before marriage or had frequent childbirth also use herbal extracts in the cervix to ensure dry sex which is thought to increase male sexual pleasure.[266] All these activities increase the vulnerability to HIV and also cause severe discomfort and infection which result in negative reproductive health outcomes. Yet, Africa has two important legal instruments, namely: The African Charter of Human and Peoples' Rights (Banjul, 1981); and The Protocol to the African Charter of Human and Peoples' Rights on the rights of Women in Africa (Maputo, 2003). States have committed themselves to outlaw all forms of traditional practices which have negative impact on the rights of women.

They have pledged to adopt legislation, and all other required measures to eradicate these practices, including; prohibition with sanctions to prevent all forms of female genital mutilations, scarification, medicalisation and paramedicalisation of female genital mutilations, and all other harmful traditional practices. States have also pledged to provide necessary support to victims of these harmful practices by giving them basic services such as health care, legal and judicial services, counselling and adequate social support as well as vocational training in order to help them become self-sufficient; protect women who were under threat of being forced to undergo harmful practices and all other forms of violence, abuse and intolerance. In spite of the coming into force of the Protocol, practical enforcement in the respective countries is not yet effective. As a case study, this work focuses

on Female Genital Mutilation (FGM) and has analysed the status of FGM. It is viewed as factors that affect young women's sexual and reproductive rights. The practices, practised by the nine countries and the laws that were implemented to protect women will be discussed.

Female Genital Mutilation (FGM)

As one of the most prevalent harmful traditional practices, FGM is illegal in most of the countries in this study, but many government do not enforce this prohibition or punish those who practise it, due to cultural and political reasons. FGM in the nine surveyed countries will be discussed below.

In Angola there is no data available on the prevalence of female genital mutilation.[267] Female genital mutilation was not practised indigenously and is against the law. It may have occurred in some immigrant communities from West African countries where it is common. There were no known government or other efforts to investigate or combat FGM.[268]

In Benin FGM is practised on girls and women from infancy up to 30 years of age (although the majority of cases occur before the age of 13, with half occurring before the age of five), and it generally takes the form of excision. Approximately 13% of women and girls have been subjected to FGM; the figure was higher in some regions, especially the northern departments, including Alibori and Donga (48%) and Borgou (59%), and among certain ethnic groups; more than 70% of Bariba and Peul (Fulani), and 53% of Yoa-Lokpa women and girls had undergone FGM. Younger women were less likely to be excised than their older counterparts.

Those who perform the procedure are usually older women who profit from it. The country outlawed female genital mutilation in 2003. DHS data from 2006 indicates that 12.9% of women aged 15-49 had been subjected to FGM. Of those women, only 15.9% had at least one daughter who had been subjected to FGM, or intended to subject their daughter to the procedure. This would indicate a marked decrease in prevalence, as UNICEF states in a 2005 report.[269] The law prohibits FGM and provides for penalties for performing the procedure, including prison sentences of up to ten years and fines of up to six million as put forward by CFA ($13,000). However, the government generally was unsuccessful in preventing the practice. Enforcement is rare due to the code of silence associated with this crime.

In Ethiopia even though the new Penal Code criminalises female genital mutilation by imprisonment of no less than three months or a fine of at least ETB 500 (USD 58), it is estimated that between 70-80% of Ethiopia's female population is subjected to the practice. Genital infibulation (the closing of the outer lips of the vulva) is also punishable by law, with imprisonment of five to ten years. To date, there have been no criminal prosecutions for practising FGM, although according to various sources, public support among women for the procedure, as well as the overall percentage of women who have experienced FGM, is declining.[270] NGOs continue to educate rural communities about the dangers of FGM and to retrain FGM practitioners in other activities. A prominent NGO, the local chapter of the Inter-African Committee, made progress in raising public awareness of the dangers of the practice, and the government cooperated with these efforts. The Ministry of Family continued an education campaign that included conferences in schools and villages, discussions with religious and traditional authorities, and the display of banners. NGOs also addressed this problem in local languages on local radio stations.[271]

In Kenya FGM is outlawed in minors under the age of 18 by the Children's Act of 2001, Section 14, but there is evidence that some communities wait until a girl has reached 18 and then subject her to the custom. The government of Kenya also forbids female genital mutilation in public hospitals and the health minister is taking steps to eradicate this practice altogether. However, FGM is far from being eliminated. It is estimated that between 30% and 40% of women have undergone FGM; the figure may be lower in urban areas but is much higher in some rural regions.[272] According to UNICEF, one-third of women between the ages of 15 and 49 had undergone FGM, and in June 2009, an obstetrician estimated that 32% of women had suffered from the procedure. Of the country's 42 ethnic groups, only four (the Luo, Luhya, Teso, and Turkana, who together constituted approximately 25% of the population) did not traditionally practise FGM. According to the Ministry of Gender and Children Affairs, in 2008, 90% of girls among Somali, Kisii, Kuria, and Maasai communities had undergone the procedure. The rates among other communities were: Taita Taveta (62%); Kalenjin (48%); Embu (44%); Meru (42%); Kamba (37%); and Kikuyu (34%). There were public awareness programmes to prevent the practice, in which government officials often participated.[273]

In Nigeria the law criminalises the removal of any part of a sexual organ from a woman or girl, except for medical reasons approved by a doctor. According to the provisions of the law, an offender is any woman who offers herself for FGM; any person who coerces, entices, or induces any woman to undergo FGM; or any person who, for other than for medical reasons, performs an operation removing part of a woman's or a girl's sexual organs. The law provides for a fine of 50,000 naira ($308), one year's imprisonment, or both, for a first offense and doubled penalties for a second conviction. The federal government publicly opposed FGM but took no legal action to curb the practice. Twelve states banned FGM, however, once a state legislature criminalised FGM, NGOs found that they had to convince the local government authorities that state laws applied in their districts. The Ministry of Health, women's groups, and many NGOs sponsored public awareness projects to educate communities about the health hazards of FGM. However, underfunding and logistical obstacles limited their contact with health care workers. The 2008 NDHS reported that 30% of

women in the country suffered FGM. While practised in all parts of the country, FGM remains most prevalent in the southern region among the Yoruba and Igbo. Infibulation, the most severe form of FGM, infrequently occurs in northern states but is common in the south.

The age at which women and girls are subjected to the practice varies from the first week of life until after a woman delivered her first child. Nevertheless, most female victims suffer FGM before their first birthday. FGM often results in obstetrical fistula (a tearing of the vaginal area as a result of prolonged, obstructed labour without timely medical intervention). Most fistulas result in the death of the baby and chronic incontinence in the woman. The social consequences of fistula include physical and emotional isolation, abandonment or divorce, ridicule and shame, infertility, lack of economic support, and the risk of violence and abuse. The absence of treatment greatly reduces prospects for work and family life, and affected women had to rely on charity.[274]

In Rwanda the law prohibits female genital mutilation, and the practice was not known to occur.[275]

In Sierra Leone there is no specific law on FGM under which a perpetrator can be charged, although police do sometimes intervene.[276] FGM is performed predominantly by women's secret societies. In secret societies, "sowies," the women who perform genital cutting, continued to advocate the practice.

According to UNICEF, approximately 90% of girls had undergone FGM. The 2007 Child Rights Act does not explicitly address FGM. However, the Ministry of Social Welfare, Gender, and Children's Affairs interprets FGM to be covered within the section of the law that prohibits subjecting anyone under the age of 18 to harmful treatment, including any cultural practice that dehumanises or is injurious to the physical and mental welfare of the child. Police occasionally detained or arrested practitioners on accusations of forced mutilation or manslaughter. [277]

In Tanzania, the law prohibits female genital mutilation (FGM), however, some tribes and families continued to practise it. Statutory penalties for performing FGM on girls under 18 range from five to fifteen years imprisonment, a fine of 300,000 TZS ($188), or both. Prosecutions were rare. Many police officers and communities were unaware of the law, victims were often reluctant to testify, and some witnesses feared reprisals from FGM supporters.

Some villagers reportedly bribed local leaders not to enforce the law in order to carry out FGM on their daughters. The media reported that others conducted the procedure in hiding, even on babies, to avoid detection by the law. According to 2005 data, the Ministry of Health estimated that 5 to 15% of women and girls underwent FGM, a decrease from a rate of 18% in 1995. The average age of FGM victims was less than 10 years. FGM was practised by approximately 20 of the country's 130 tribes and was most prevalent in the mainland regions of Arusha, Singida, Kilimanjaro, Morogoro, and Dar es Salaam. The government continued to implement the 2001-15 National Plan of Action for the Prevention and Eradication of Violence Against Women and Children, which enlisted the support of practitioners and community leaders in eradicating FGM.

The Anti Female Genital Mutilation Network (AFNET) worked with education officers in the Serengeti to increase awareness about the negative effects of FGM. AFNET worked specifically with a group of students between the ages of 10 and 13 to help them gain the confidence to refuse the practice. In April, police in the Tarime District, Mara region, called for the government to provide human rights education to combat FGM.

The Rogoro Roman Catholic Parish in nearby Masanga village continued to serve as a shelter for girls between the ages of 10 and 16 who fled from family or societal pressures to undergo FGM. In addition to supporting these children, the shelter conducted community training on the dangers of FGM, including a predilection toward fistula. Despite these efforts, residents of the Tarime district continued to perform FGM openly on mature girls.

In February, the "Women Wake Up" organisation conducted a rally against FGM in Tarime. During the campaign, young men with machetes, clubs, and other weapons marched around villages to keep out FGM activists and threatened to kill anyone who tried to prevent village girls from undergoing FGM. The media reported that the government took no action in response.[278] FGM for anyone under the age of 18 is prohibited under the Sexual Offences Special Provision Act, 1998, and Section 21 of the Penal Code, with punishments of five to fifteen years in prison.[279]

In Zambia, FGM is prohibited under the country's penal code and rarely occurred in practice. Most cases of FGM were limited to small communities of immigrants from other parts of Africa. There were no cases of FGM reported during the year 2011.[280]

C. Sexual violence against women

In this review, we look at the legislations across nine countries on rape, marital rape and sexual harassment. We also look at the indicator of the status of trafficking laws in the nine countries.

i. Anti-Rape Laws

Protection from sexual violence is critical to upholding women's bodily integrity and preserving her overall well-being. Rape is outlawed in most Sub-Saharan countries. In the nine Sub-Saharan countries under review, there are either Penal Code provisions or national legislations covering rape. The definitions of rape vary in each of the countries in the region, with comprehensive legislations in some and less so in others. The extent of punishment also varies, as do the comprehensiveness of services

Table 26:
Anti-Rape Laws in 9 countries in Africa

Country	Anti-Rape Laws
Angola	Statutory rape considered crime under Criminal Code. Rape covered under Penal Code
Benin	Rape covered under the Penal Code Draft legislation exists on Act on Punishment in Rape (2002)
Ethiopia	Whoever compels a woman to submit to sexual intercourse outside wedlock, whether by the use of violence or grave intimidation, or after having rendered her unconscious or incapable of resistance, is punishable with rigorous imprisonment from five years to fifteen years (Criminal Code 414/2004)
Kenya	Sexual Offences Act 2006. Section 3
Nigeria	The Penal Code established that the penalty for rape was 2 to 14 years imprisonment; It is a Crime under the criminal code
Rwanda	Law No 59/2008 of 10/09/2008 on Prevention and Punishment of Gender- Based Violence Article 16: Penalty for rape: Any person who is guilty with rape shall be liable to imprisonment of ten (10) years to fifteen (15) years.
Sierra Leone	Sexual Offences Act 2012
Tanzania	Sexual Offences (Special Provisions) Act of 1998
Zambia	Penal Code

Source: CRC 2011(Angola); CEDAW; the UN Secretary-General Database on Violence against Women; SIGI index

to those affected by sexual violence. The data above is mostly taken from the UN Secretary General's Database on Violence against Women.

In Ethiopia and Tanzania there are stricter penalties for sexual intercourse with minors.[281] The Sexual Offences Acts, Penal Codes and Children's Act in Tanzania and Kenya criminalise sex with persons below 18 years, however, customary law and marriage law permit marriage of girls below 18 years highlighting contradictions between different laws in the country.[282] Kenya and Zambia have policies in the health sector for delivering emergency contraception and HIV post-exposure prophylaxis to survivors.[283]

In Angola, currently there is no legislation addressing rape. According to the Social Institutions and Gender Index website, rape including marital rape is prohibited within the Penal Code and punishable up to eight years of imprisonment.[284] Statutory rape is considered a crime under the Penal Code in Angola. In Benin, there exists an Act on Punishment of Rape (2002), which is draft legislation. The Penal Code law prohibits rape (imposing sentences of one to five years in jail) but enforcement is weak and few cases are reported due to the stigma attached.[285]

In Kenya rape is covered under the Sexual Violence Act no 3 of 2006. The Sexual Offences Acts, Penal Codes and Children's Act criminalises sex with persons below 18 years, however, customary law and marriage law permit marriage of girls below 18 years highlighting contradictions between different laws in the country.[286] Kenya also has a policy in the health sector for delivering emergency contraception and HIV post-exposure prophylaxis to survivors.[287]

In Nigeria under the Criminal and Penal Codes of the various States, provision is made for the prohibition and punishment of rape, including for children.[288] Rape is defined comprehensively and includes the use of foreign objects into bodily orifice, in the Nigerian law.[289] The Violence (Prohibition) Bill 2003 presented to the National Assembly by the Legislative Advocacy Coalition on Violence against Women (LACVAW), seeks to outlaw rape, incest, etc., establish a trust fund for victims of violence and set up a Commission to aid victims. Advocacy for its passage into law is ongoing.

In Rwanda Law No 59/2008 of 10/09/2008 on Prevention and Punishment of Gender-Based Violence covers rape. Article 16 of the law sets the penalty of imprisonment of ten years to fifteen years for any person guilty of rape.[290]

In Sierra Leone the Sexual Offences Act 2012 makes provision for sexual offences, and covers persons with mental disabilities, children and married women. It also prohibits forced sex in

marital relationships. It protects children, especially the girl child, from abuse by teachers, religious and traditional leaders. The law introduces stiff minimum sentences for offenders, raising minimum jail sentences from two years to between five and fifteen years.[291]

In Tanzania, the parliament in 1998 enacted the Sexual Offences (Special Provisions) Act, which addresses sexual exploitation of women and children, incest, procuration for prostitution, trafficking of persons, cruelty to children and child prostitution. It addresses rape, molestation, indecent assault and sodomy committed against women and children. In Zambia, the Penal Code prohibits rape with heavy penalties including life imprisonment.[292] Like in Kenya, Zambia also delivers emergency contraception and HIV post-exposure prophylaxis to survivors present at health care facilities.

ii. Marital Rape

In the nine countries under review, while marital rape is increasingly considered as an offence, legislations vary. Marital rape is an offence prohibited by the Penal Code in Angola and Rwanda. According to the Social Institutions and Gender Index (SIGI), rape including marital rape is prohibited by the Penal Code in Angola.[294] This calls for imprisonment for up to eight years. No specific laws are in place addressing marital rape. (Table 27)

In Rwanda, under Article 5 of the Official Gazette of the Republic of Rwanda (2009), any person who coerces his/her spouse to sexual intercourse shall be liable to imprisonment of six months to two years. Marital rape is a criminal offence in Rwanda.[295]
In Sierra Leone, the law does not specifically recognise marital rape,[296] however, marital rape is included in proposed amendments to the Sexual Offences Act (2007).
In Ethiopia, Article 620 of the Criminal Code (2004) defines rape as occurring outside of wedlock and therefore, exempts marital rape from punishment.[297] In Tanzania, exemption is made to marital rape from punishment in the Criminal Code. The Sexual Offences Special Provisions Act (1998) retains exemption to marital rape. No specific provisions exist addressing marital rape in Benin, Kenya, Nigeria, Sierra Leone, and Zambia. Kenya and Nigeria still accept rape within marriage.[298] In Nigeria, there are no sanctions in the Penal Code against marital rape.[299] In Zambia, marital rape is not prohibited under the Penal Code.

In Tanzania the Sexual Offences Special Provisions Act (1998), amended section 130 of the Penal Code with regard to rape, but retained the marital rape exemption as follows in Section 130:

Table 27 :
Anti-marital rape laws in 9 countries in Africa

Country	Anti-Marital Rape Laws
Angola	No law on acts of violence in the family set under Criminal Law cover marital rape
Benin	Benin has adopted a number of initiatives to reform family protection. This includes the adoption, on 24 August 2004, of Act No. 2002-07 on the Personal and Family Code. This also includes a requirement of consent for both future spouses, even where they are minors but there is no specific law on marital rape. The Penal Code makes no distinction between spousal rape and other forms of rape[293]
Ethiopia	Article 620 of the Criminal Code defines rape as occurring outside of wedlock and therefore exempts marital rape from punishment (2004)
Kenya	-
Nigeria	-
Rwanda	Under Article 5 of the Official Gazette of the Republic of Rwanda (2009) - Any person who coerces his/her spouse to sexual intercourse shall be liable to imprisonment of six (6) months to two (2) years. Law No 59/2008 of 10/09/2008 on Prevention and Punishment of Gender- Based Violence (2008)
Sierra Leone	Marital rape is included in proposed amendments to the Sexual Offences Act. (2007)
Tanzania	Sexual Offences (Special Provisions) Act of 1998
Zambia	Not recognised

Source: CESCR 2008 (Angola, Benin); the UN Secretary-General Database on Violence against Women; CEDAW (Sierra Leone)

Table 28:
Anti-sexual harassment laws in 9 countries in Africa

Country	Anti – Sexual harassment
Angola	-
Benin	Law 2006-19 on Sexual Harassment
Ethiopia	Proclamation no. 414/2004 - Criminal Code of Ethiopia (2004)
Kenya	Section 21 of the Public Officers and Ethics Act 2003 Sexual Offences Act 2006 Employment Act 2008
Nigeria	DRAFT: Sexual Harassment Policy for Educational Institutions (2011) DRAFT: Sexual Harassment Policy in the Workplace (2011) Elimination of Violence Against Women in the Society Bill (2006) captures VAW in general Draft Violence (Prohibition) Bill 2003 (Draft Legislation on sexual violence
Rwanda	Law No 59/2008 of 10/09/2008 on Prevention and Punishment of Gender- Based Violence (2008)- Law on the Prevention, Protection, and Punishment of Any Gender-Based Violence promulgated in April 2009
Sierra Leone	Domestic Violence Act 2007
Tanzania	Sexual Offences (Special Provisions) Act of 1998
Zambia	Penal Code (Amendment) Act No. 15 of 2005 National Action Plan on Gender-Based Violence (2008-2013)

Source: UN Secretary General's database on violence against women

A male person commits the offence of rape if he has intercourse with a girl or woman under circumstances falling under any of the following descriptions:

(a) Not being his wife, or being his wife who is separated from him without her consenting to it at the time of sexual intercourse.

In Benin there exists no specific law on marital rape. According to the Social Institutions and Gender Index Data, the Penal Code prohibits rape (imposing sentences of one to five years in jail) but enforcement is weak. The Penal Code makes no distinction between spousal rape and other forms of rape.

In Kenya traditional rituals such as wife inheritance, and ritual cleansing[300] further impede women's rights in marriage.[301]

iii. Sexual Harassment

Three countries under review do not have a specific legislation addressing sexual harassment. For example, sexual harassment is not illegal in Angola.[302] In Nigeria, currently no laws specifically address sexual harassment, although draft laws and policies on Sexual harassment do exist in educational institutions and in the workplace, such as "Sexual Harassment Policy for Educational Institutions (2011)" and Sexual Harassment Policy in the Workplace (2011). The Elimination of Violence Against Women in Society Bill (2006) captures VAW in general and the Draft Violence (Prohibition) Bill 2003 is a draft legislation on sexual violence. (Table 28)

In Sierra Leone the Domestic Violence Act (2007) states that it addresses sexual harassment, however, in the description of the law, we do not see provisions to address sexual harassment. Benin addresses sexual harassment by means of the law 2006-19 on sexual harassment. In Kenya, sexual harassment is against the law.[303] In Tanzania, the Sexual Offences (Special Provisions Act) addresses sexual harassment.

Rwanda has the most comprehensive legislation addressing gender-based violence and this covers sexual harassment. In Rwanda, Law No 59/2008 of 10/09/2008 on Prevention and Punishment of Gender-Based Violence (2008-2009) addresses sexual harassment. This is the country's most comprehensive legislation on VAW. This bill addresses spousal violence, marital rape, sexual harassment, and sexual abuse of children in its definition of gender-based violence, and lists the occurrence of such violence as grounds for divorce. The law recommends imprisonment of six months up to two years for these crimes. Additionally, a broad support network has been set up; each police station in the nation has a gender desk, with an officer trained in gender-sensitivity, and public outreach programme.[304]

Table 29:
Anti-trafficking laws

Country	Anti-trafficking
Angola	-
Benin	Criminal laws contain provisions prohibiting trafficking among women and girls (SIGI)
Ethiopia	Constitutional provision, Constitution 1994 National Task Force on Trafficking 2004 Proclamation no. 414/2004 - Criminal Code of Ethiopia (2004) Women and Children's Trafficking Monitoring Directorate (2004)
Kenya	Anti-Trafficking in Persons Bill 2010(Draft) Sexual Offences Act 2006
Nigeria	Trafficking in Persons (Prohibition) Law Enforcement and Administration Act (2003, amended in 2005)
Rwanda	Law No 59/2008 of 10/09/2008 on Prevention and Punishment of Gender- Based Violence (2008)
Sierra Leone	Family Support Units (2010) Anti-Human Trafficking Act No.7 of 2005
Tanzania	Sexual Offences (Special Provisions) Act of 1998
Zambia	Anti-Human Trafficking Act (No. 11 of 2008) Penal Code (Amendment) Act No. 15 of 2005

Source: UN Secretary General's database on violence against women

In Ethiopia Proclamation no. 414/2004 - Criminal Code of Ethiopia (2004) addresses sexual harassment, and Zambia the Criminal Code penalises sexual harassment. The penal code, in Ethiopia, also criminalises sexual harassment with imprisonment of up to 2 years, however, the law is not effectively enforced.[305]

In Tanzania the Parliament enacted the Sexual Offences Special Provisions Act (1998), which among other things addresses sexual exploitation of women and children, incest, procuration for prostitution, trafficking of persons, cruelty to children and child prostitution. It also addresses forms of sexual abuse such as sexual harassment (Article 11), rape, molestation, indecent assault and sodomy, most of which are committed against women and children. The Act criminalised female genital mutilation.

In Zambia the Penal Code (Amendment) Act No. 15 of 2005 introduced a number of important amendments to the Penal Code, including with regard to sexual harassment, harmful practices and trafficking in children: Article 137A. (1) notes that any person who practises sexual harassment in a workplace, institution of learning or elsewhere on a child commits a felony and is liable, upon conviction to imprisonment for a term of not less than three years and not exceeding fifteen years.

D. Trafficking

At least 130,000 persons in Sub-Saharan African countries are in forced labour, including sexual exploitation as a result of human trafficking in 2009. While the Ouagadougou Action Plan to Combat Trafficking in Human Beings guides the African Union Member States in developing and reforming their policies and laws on trafficking in persons, many Sub-Saharan African countries still do not have legislation on human trafficking, or they have laws that criminalise only some aspects of human trafficking.[306]

In the nine countries under review, except for Angola, all countries have laws in place addressing trafficking – either national laws or criminal laws to address trafficking of women and girls. Trafficking for sexual exploitation is seen as a problem in Angola. Women are trafficked for sexual servitude to South Africa and other countries.[307] (Table 29)

In Ethiopia there also exist institutional mechanisms to address trafficking in women and girls. Within this institutional mechanism, the Ministry of Foreign Affairs of Ethiopia has established a Women and Children's Trafficking Monitoring Directorate and has designated "Labor Attachés" within Ethiopian Embassies abroad to deal with the issue of trafficking.[308] Trafficking of women for sexual exploitation of

women and girls seems to be a major problem that needs to be addressed. Article 597 of the Proclamation no. 414/2004 - Criminal Code of Ethiopia (2004), addresses trafficking among women and children. The Ethiopian constitution 1994 deals with trafficking a human being for whatever purpose in Article 18 (2).

In Benin trafficking is a serious issue. While the national laws do not deal directly with trafficking girls and women, criminal law contains provisions that prohibit the trafficking of women and girls.[309]

In Kenya there exists a draft Anti-Trafficking in Persons Bill 2010**.** The motion for tabling this draft legislation has been passed in Parliament and the bill is ready for tabling and debate by the Parliament. This bill has been developed in consultation with civil society organisations, and is expected to provide a legal framework for prevention and remedy of trafficking in women. At the same time, the Sexual Offences Act (2006), also addresses child trafficking in Section 13, and trafficking for sexual exploitation in Section 18.[310]

In Nigeria the Trafficking in Persons (Prohibition) Law Enforcement and Administration Act (2003, amended in 2005) addresses trafficking. At the same time, Section 34 of the 1999 Constitution makes it clear that every Nigerian citizen is entitled to respect for his/her dignity and forbids torture or inhuman/degrading treatment, slavery or servitude. Sections 223-225 of the Criminal Code, applicable in southern Nigeria, prohibit trafficking in human beings. The penal code applicable in northern Nigeria also has provisions against trafficking in humans.[311]

In Rwanda Law No 59/2008 of 10/09/2008 on Prevention and Punishment of Gender-Based Violence addresses trafficking in women. This legislation came ***into force on the 18th of August, 2005. Section 2(1) of the Act notes trafficking in persons constitutes an offence. Within this law, trafficking in persons is defined as follows: "A person engages in the trafficking in persons if he undertakes the recruitment, transportation, transfer, harbouring or receipt of persons, by means of threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person for the purpose of exploitation."*** Exploitation includes keeping a person in a state of servitude including sexual servitude; exploitation of the prostitution of another; engaging in any other form of commercial sexual exploitation, including but not limited to pimping, pandering, procuring, profiting from prostitution, maintaining a brothel, child pornography, illicit removal of human organs; and exploitation during armed conflicts.

In Tanzania the Sexual Offences (Special Provisions) Act of 1998, addresses trafficking of persons. This act also addresses sexual exploitation of women and children, incest, procuration for prostitution, cruelty to children and child prostitution.[312] Trafficking of young girls and children from rural areas to urban centres increased despite restriction in policy guidelines and the law. According to the CEDAW report, courts are now giving deterrent sentences of up to life imprisonment to sexual offenders. This development is attributed to intensive sensitisation of law enforcers on dealing with cases of violence against women under the Sexual Offences (Special Provisions) Act, (SOSPA) of 1998, which is a major achievement in addressing gender issues in recent times in Tanzania.[313]

In Zambia the Anti-Human Trafficking Act (No. 11 of 2008) addresses trafficking. This Act provides for the prohibition, prevention and prosecution of human trafficking, as well as for the filing of and dealing with matters related to human trafficking. The Act has also enabled the establishment of a Committee on Human Trafficking and provides for its powers and functions. It establishes a human trafficking fund. The Act has enabled the domestication of the Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially women and children, supplementing the United Nations Convention against Transnational Organised Crime; and provides for matters connected with or incidental to the foregoing.[314]

E. Sex Work

Sex work is often regarded as a social ill and a symbol of a society's "moral degeneration." Sex workers are seen as "vendors of vice" and reservoirs of STIs and HIV." There is a deep rooted stigma attached to this profession. The criminalisation of sex work in most societies further compounds and increases the stigma of profession; it limits access to sexual and reproductive health care, legal and social services; it inhibits access to safer sex education; use of condoms; access to STI/HIV testing and treatment; increases exploitation and abuse of sex workers by clients, partners, brothel-owners, pimps and the police. Sex workers often have no choice but to live in dangerous conditions which in fact increases the risk of contracting HIV. Decriminalising sex work creates an environment where sex workers can operate in safe environments.[315]

As a result of criminalisation policies of the state, sex workers experience stigma, discrimination, and abuse at the hands of police officers, clients, pimps and societies in general. Most African governments do not characterise violence against sex workers as an issue of violence against women. Hospitals and health centres sometimes refuse to provide sex workers with medical treatment. Police often bribe, harass and abuse sex workers. Clients assault sex workers with impunity.[316] Sex worker collectives are being formed in Cameroon, Zambia, Kenya and Senegal. However, these examples of African sex worker collectivisation are limited.[317] The illegal status of prostitution in African countries directly affects sex workers' ability to organise and demand their rights. Criminalisation of prostitution, and thus, criminalisation of sex workers leaves

Table 30:
Laws prohibiting discrimination on grounds of sexual orientation.

COUNTRY	Male to Male relationships	Female to Female relationship
Angola	Not legal	Not Legal
Benin	Legal	Legal
Ethiopia	Not Legal	Not Legal
Kenya	Not Legal	Not Legal
Nigeria	Not Legal	Not Legal
Rwanda	Legal	Legal
Sierra Leone	Not Legal	Legal
Tanzania	Not Legal	Not Legal
Zambia	Not Legal	Legal

Source: International Lesbian, Gay, Bisexual, Trans and Intersex Association (www.ilga.org)

these women without legal and health protections and further entrenches the stigma and discrimination they face.[318]

In this review, we look at current legislations around sex work. In the nine countries under review, sex work is deemed illegal in Angola, Kenya, Nigeria, Rwanda, Tanzania, and Zambia.[319]

In Ethiopia, sex work is legal for persons over 18, however, the law prohibits pimping and benefitting from sex work of others. The Penal Code Article - 634 (revised May 2005) stipulates that "whoever for gain makes a profession of or lives by procuring or on the prostitution or immorality of another, or maintains, as a landlord or keeper, a brothel, is punishable with simple imprisonment and fine." [320-321]

Though sex work is considered illegal in Kenya, it is widespread. Operating a brothel is illegal in Kenya, however, soliciting sex is not a crime. One disturbing aspect is that a 2006 study report by the UNICEF estimated that as many as 30% of minor girls ages 12 to 18 engaged in sex work.[322] Similarly, sex work is considered illegal in Nigeria and statutes at both the federal and state levels criminalise prostitution and all states that adopted Shari'a had criminalised prostitution. It is reported that police frequently used the anti-prostitution statutes as tools for harassing persons engaging in sex work.[323] The law prohibits sex work in Tanzania, however, sex work is common in the country.[324-325] In Zambia, the penal code criminalises certain conducts associated with sex work. Police routinely arrest street prostitutes for loitering.[326] In Sierra Leone, however, sex work is not prohibited by law, but sex workers are arrested and charged with loitering or vagrancy.[327]

Access to sexual and reproductive health care services remains a challenge for sex workers in the region. The levels of HIV infection have been as high as 73% in Ethiopia and 68% in Zambia. Though the HIV prevalence rates among sex workers is over represented in certain instances, barriers such as poverty, low levels of education, high prevalence of HIV and AIDS, stigma and discrimination, migration patterns, criminalisation of sex work, and political instability put sex workers at risk of contracting HIV and STIs.

This group has poor access to SRH services including the availability of condoms, lubricant, and medication supplies, including ARVs and contraceptives.[328] Sex workers are further at a disadvantage with legislations that criminalise sex work, and not recognising sex work as a legitimate occupation with no entitlements and benefits from respective states, and protection of labour regulations which apply to other workers. Decriminalisation of sex work will go a long way in providing access to SRH services for sex workers, including access to condoms and safe working environments.[329-330]

F. The Status of Diverse Sexual and Gender Identities and Recognition of their Sexual and Reproductive Rights

The situation in Africa for Lesbian, Gay, Bisexual, Trans and Intersex (LGBTI) has not seen much progress in recent years. Regionally, in Africa, thirty-six countries have laws criminalising homosexuality. Punishments include death penalty and imprisonments. The laws on homosexuality are rooted in colonial era laws, religious autonomy, political situation, cultural beliefs, family values and patriarchy.[331] In March 2011, at the second recall at the United Nations Assembly in Geneva on the

Joint Declaration to Decriminalize Homosexuality, the number of African countries, who signed, rose from six to eleven, and included Angola, Rwanda and Sierra Leone. As many as twenty-eight countries from Africa opposed the Joint Statement on Sexual Orientation and Gender Identity (SOGI). [332]

Recently, homosexuality in Africa has been blamed on the effects of colonialism and the influence of western culture on African societies. In many African societies, it is not uncommon to acknowledge same-sex relationships.[333] In this review, we look at the status of legality around male to male and female to female relationships.

According to the International Lesbian, Gay, Bisexual, Trans and Intersex Association database, male to male and female to female relationships are not legal in five of nine countries considered in this review: Angola, Ethiopia, Kenya, Nigeria, and Tanzania. In Angola, the Penal Code of September 16, 1886, as amended in 1954 (Inherited from the Portuguese colonial era), Articles 70 and 71 add security measures on people who habitually practise acts against the order of nature, stating that such people shall be sent to labour camps.[334]

In Ethiopia the Criminal Code of the Federal Democratic Republic of Ethiopia, Proclamation No. 414/2004 Article 629 Homosexual and other Indecent Acts, notes that "[w]hoever performs with another person of the same sex a homosexual act, or any other indecent act, is punishable with simple imprisonment."

In Nigeria the Criminal Code Act deems such acts as guilty of a felony, and those found quilty are liable to imprisonment for fourteen years. Several Northern Nigerian states have adopted Islamic Sharia laws, criminalising sexual activities between persons of the same sex. The maximum penalty for such acts between men is the death penalty, while the maximum penalty for such acts with a woman is a whipping and/or imprisonment.[335] In Tanzania, both male to male and female to female sexual relationships are illegal.

In Sierra Leone and Zambia male to male relationships are not legal, however, the ILGA database reports female to female relationships are legal. In Sierra Leone, Offences Against the Person Act 1861 Section 61 of the above named act, criminalises buggery and bestiality, with a penalty of life imprisonment. In Zambia's, the Penal Code Act, 1995 Edition Section 155 notes - "***Any person who - (a) has carnal knowledge of any person against the order of nature; or (b) has carnal knowledge of an animal; or (c) permits a male person to have carnal knowledge of him or her against the order of nature; is guilty of a felony and is liable to imprisonment for fourteen years. (As amended by No. 26 of 1933) Unnatural offences" Section 156. "Any person who attempts to commit any of the offences specified in the last preceding section is guilty of a felony and is liable to imprisonment for seven years" (As amended by No. 26 of 1933).***

SUMMARY

Sexual rights are closely connected to reproductive rights and the achievement of desirable SRH outcomes is dependent on women being empowered to make decisions in the public and private spheres of life, and especially in matters related to their sexuality and reproduction. The right to choice of a partner is assessed using indicators around legal age of marriage, status of early and forced marriages. While there is an increase in the age of marriages in comparison to previous demographic and health surveys in respective countries, the region has the second highest levels of early and forced marriages. Customary and religious laws where the age of marriage for girls is lower often take precedence over civil laws making child marriages acceptable within certain groups of population. Abduction and forced marriages are also common and they totally violate a woman's choice in not only choosing her sexual partner, but also decision to be sexually active or not. All these have implication on sexual and reproductive health outcomes of adolescents and young people. Traditional rituals such as wife inheritance and ritual cleaning further impede women's rights in marriage.

In terms of sexual rights and respect for bodily integrity, consensual sexual relations, the examination of indicators around rape, marital rape, sexual harassment, it is observed that rape is outlawed in most of the countries under review. However, the definition of rape varies across countries, the extent of punishment for crimes around rape, and the comprehensiveness of services post sexual violence.

Penalties also exist for sexual intercourse with minors in some of the countries. It is interesting to know that while rape is outlawed across the nine countries, marital rape is considered an offence only in two of the nine countries. Sexual harassment and trafficking legislations exists at least in draft form in all the eight countries with an exception to Angola. With respect to rights around sex work, it is deemed illegal in six of the nine countries. Access to sexual and reproductive health care services remains a challenge for sex workers in the region. Though the HIV prevalence rates among sex workers is over represented in certain instances, barriers such as poverty, low levels of education, high prevalence of HIV and AIDS, stigma and discrimination, migration patterns, criminalisation of sex work and political instability puts sex workers at risk of contracting HIV and STIs.

Sex workers have poor access to SRH services including the availability of condoms, lubricant, and medication supplies, including ARVs and contraceptives.[337] Sex workers are further at a disadvantage with legislations that criminalise sex work, and sex work not being recognised as a legitimate occupation with no entitlements and benefits from respective states, and protection of labour regulations which apply to other workers. Decriminalisation of sex work will go a long way in providing

access to SRH services for sex workers, including access to condoms and safe working environments.[338-339]

In addition to this, an increasingly hostile environment for LGBTIQ sexual and reproductive rights calls for a long and a daunting way to go before women, adolescent and young women realise their full sexual rights.

Similarly, for the nine countries of the study as in other thirty-six countries in Sub-Saharan Africa, have laws criminalizing homosexuality. Punishments include death penalty and imprisonments and the rights of people with non-conforming gender identities and sexual orientations are at stake. This has implications for these groups to access SRH services and exercise their SR rights. There is a need to ensure laws and policies respect people's rights around sexuality and reproduction. Decriminalisation is the first step towards ensuring people with non-conforming gender identities and sexual orientation lead a life free from discrimination. Universal access to SRH services for these groups needs to be ensured.

CHAPTER 5

conclusion and recommendations

CONCLUSION

The ICPD Programme of Action will be reaching its twenty year time frame in 2014. This monitoring initiative in Africa specifically in the Sub-Saharan Africa region, has aimed to look at the progress or lack of progress made in the region, specifically in the nine countries, taking into account key sexual and reproductive health and rights, and women's empowerment as well as health financing indicators. The following conclusions are based on the findings of this research and monitoring indicators.

There have been significant changes in Africa since 1994 in the political landscape with many democracies spreading and the political empowerment of women growing. Also, we see a new generation of young African women with political power rising and Rwanda leading globally in female parliamentarian participation.

The region has also shown progress towards the Millennium Development Goals with gains in education, child survival, and health indicators such as HIV and Malaria. However, this progress is painstakingly slow and remains uneven with fewer people enjoying the benefits of progress and many people who are poor and marginalised continuing to stay in the same conditions.

All the nine countries under review have signed all international human rights instruments including CEDAW, and have put place some mechanisms to domesticate CEDAW provisions in national laws and policies. While there are these positive actions at the national level, there is a long way to go in actually implementing the laws, policies and frameworks pertaining to women's empowerment in the nine countries. Barriers include the strong persistence of patriarchal attitudes and deep-rooted stereotypes regarding the roles and responsibilities of women and men in society, which are discriminatory to women. Inadequate human and financial resources also prevent the implementation of programmes promoting the advancement of women and gender equality. The nine countries under review have also signed on to regional agreements such as The Solemn Declaration on Gender Equality in Africa; The African Charter on Human and Peoples' Rights on the Rights of Women in Africa, Maputo Protocol 2003, and the Abuja Declaration, where heads of state of AU countries met and pledged to set a target of allocating at least 15% of their annual budget to improve the health sector.

Developments in the region's health sector include a shift towards increased privatisation in the health sector. Countries in the region are making efforts to meet the target set in the Abuja Declaration of allocating at least 15% of their annual budget to health. In the nine countries under review, Rwanda and Zambia have met the 15% target of Abuja. Rwanda, Tanzania and Zambia show comparatively higher total expenditure on health as percentage of GDP. These countries also have consistently greater government expenditure on health as percentage of total government expenditure and comparatively lower private expenditure on health as a percentage of total expenditure. Some of the reproductive health indicators such as contraceptive prevalence and maternal mortality in these two countries are comparatively improving. Since the region has high dependence on donor funds, governments have to seriously think about increasing domestic resources to improve the health sector.

In the nine countries under review, seven of them have a total fertility rate above 5.0. These trends of comparatively higher fertility rates are characteristic of trends of higher fertility seen across Sub-Saharan African countries. Overall, CPR for any method in the eight countries is not very encouraging for married women and ranges between 51.6% (Rwanda) to 8.2% (Sierra Leone). The reliance is mostly on three methods: injectable, traditional methods and pills. Traditional methods having a higher failure rate may not meet married women's need to control her fertility resulting in greater numbers of unintended pregnancies and higher fertility. It is interesting to see sexually active women use of contraception ranging between 61.0% in Nigeria – 33.6% in Sierra Leone. This points to the high use of contraception among sexually active unmarried women, who want to avoid pregnancy before marriage, and also avoid HIV and STI infection as the condom is the most predominant method of contraception among sexually active unmarried women. The use of contraception is also influenced by characteristics such as education, place of residence, and wealth.

In the nine countries under review, none of the countries are likely to achieve the ICPD target of maternal mortality level of 75/100,000 live births by 2015. Rwanda, among the nine countries under review, has shown significant progress in reducing the MMR from 1400 in 1995 to 540 in 2008. An examination of all the maternal health services in Rwanda shows consistent improvements in skilled birth attendants and antenatal care. Rwanda also has comparatively lower adolescent birth rates. Other factors such as a holistic approach with the focus on universal coverage, increase in the health workforce and their skills, performance-based financing, community-based health insurance, and better leadership and governance have also added to the improvements in the reduction of maternal mortality in Rwanda. Although, maternal mortality has reduced to a greater extent over time in Sierra Leone, with relatively better antenatal and postnatal care, the maternal deaths in Sierra Leone are still very high. Based on the DHS data, Fistula is a condition affecting about 1% of women. More studies need to be done on this issue to accurately measure its magnitude.

Every country in Africa has at least one ground on which abortion is permitted. In many countries, additional procedural requirements are required to be met before an abortion can be legally performed. This includes gestational limits, mandatory

waiting periods, parental and spousal consent, third party authorization, the categories of health providers permitted to perform abortions, the types of medical facilities where abortions may be performed and mandatory counselling. Abortion law has been reformed in Ethiopia, Benin and Kenya since ICPD. Africa accounts for 14% of maternal deaths (29,000) due to unsafe abortion in 2008 according to WHO. In the nine countries studied, abortion is restrictive and permitted only to save the life of a woman in Angola. In five countries, Kenya, Nigeria, Rwanda, Sierra Leone and Tanzania, abortion is permitted to save a woman's life, to preserve physical health and to preserve mental health. In Benin and Ethiopia, abortion is permitted on additional grounds including in cases of rape or incest and foetal impairment. Zambia permits abortion on more liberal grounds including socio-economic reasons; however, abortion is not permitted on grounds of rape or incest, only upon request. Decriminalisation and expanding the grounds on which abortion is permitted and access to safe abortion services in the region will reduce maternal mortality and morbidity.

The lack of early detection programmes for cancers at the primary health-care level results in late diagnosis, catastrophic complications, disabilities and premature death. Low public sector availability of technologies and medicines leads people with non-communicable diseases to the private sector, where services are frequently unaffordable. Up to 80% of cancer patients have no access to radiotherapy and countries have no operating radiotherapy services in Africa. There is a clear need to expand the number of high quality population-based cancer registration systems, as these registries provide reliable, evidence and population-based information on cancer incidence, prevalence and mortality. There is also a need to improve the quality of care and survival for cancer patients.

In the area of STI interventions, these are mostly being carried out through the HIV and AIDS programmes in the nine countries. In terms of HIV epidemic level classification, Angola, Benin, Ethiopia, Kenya, Nigeria, Rwanda, Sierra Leone, Tanzania and Zambia have a generalised level of HIV epidemic. Angola, Ethiopia, Kenya, Nigeria, Rwanda, Tanzania, and Zambia are countries with the largest number of pregnant women with HIV in 2009.[340] In the nine countries, women are disproportionately affected with a high magnitude of HIV in comparison to men. Among women, younger women have a higher prevalence in comparison to the older women. The prevalence of HIV among young women is also higher in comparison to young men of the same age. Among women, the HIV risk is seen to be higher among widowed and divorced women in comparison to married women. This trend needs to be further examined. HIV prevalence is higher among polygamous unions in comparison with non polygamous unions. Sex workers, men who have sex with men, injectable drug users, uniformed service personnel, truck drivers, refugees and displaced people, cross border populations, children on the street, causal labourers, students and other mobile populations are most at risk of HIV infections.

Data from the nine countries shows the diverse context of the situation of adolescent sexual rights. Based on the evidence, it is observed that by age 20, most young women and girls in the nine countries have had sexual intercourse and begun childbearing. They are also vulnerable to contacting STIs and HIV. At the same time, the adolescent fertility rates are quite high in most of the countries under review. Within this context, it is critical that adolescents and young people have access to comprehensive sexuality education and access to youth friendly SRH services. An examination of the sexuality education curriculum in the region shows an uneven picture and there is a need to ensure comprehensive sexuality education is provided to all adolescents and young people, both within school and out of school settings. The curriculum needs to be comprehensive enough and delivered by trained instructors and teachers. Access to a range of youth friendly SRH services in a non-judgemental manner also needs to be ensured, so that adolescents and young people realise their optimal sexual and reproductive health outcomes.

With the exception of Benin, all of the other eight countries have equal age of marriage for both men and women either at 18 and 21 years. However, a high prevalence of early and forced marriages remains in the countries under review. This is mainly because marriages in the nine countries are not only governed by civil laws but also by customary and religious laws. Customary and religious laws in most situations have a lower age of marriage for women than for men. Adolescent and young girls are sometimes coerced into marriage by adults as a result of parental rights and obligations. Early and forced marriages have implications on the sexual and reproductive health of adolescent and young girls, including maternal mortality, morbidity and vulnerability to STIs and HIV. There is strong evidence, particularly in Kenya and Zambia, pointing to early marriage and higher incidence of HIV infection when compared to the unmarried sexually active population of the same group. There is a need for governments to repeal discriminatory laws against women in the context of marriages.

Sexual rights are closely connected with reproductive rights and the achievement of desirable SRH outcomes is dependent on women being empowered to make decisions in the public and private spheres of life, and especially in matters related to their sexuality and reproduction. While there is an increase in the age of marriages in comparison to previous demographic and health surveys in respective countries, the region has the second highest levels of early and forced marriages. Abduction and forced marriages are also common and completely violate a woman's choice in not only choosing her sexual partner, but also her decision to be sexually active or not. Traditional rituals such as wife inheritance, ritual cleaning further impede women's rights in marriage.

In terms of sexual rights, respect for bodily integrity and consensual sexual relations, in examining indicators around rape,

marital rape and sexual harassment, it is observed that rape is outlawed in most of the countries under review. However, the definition of rape varies across countries as does the extent of punishment for crimes around rape, and the comprehensiveness of services post sexual violence. Penalties also exist for sexual intercourse with minors in some of the countries. It is interesting to know while rape is outlawed across the nine countries, marital rape is considered an offence only in very few countries. Sexual harassment and trafficking legislation exists at least in draft form in all the eight countries with the exception of Angola.

With respect to rights around sex work, sex work is deemed illegal in six of the nine countries. Access to sexual and reproductive health care services remains a challenge for sex workers in the region. Though the HIV prevalence rates among sex workers is over represented in certain instances, barriers such as poverty, low levels of education, high prevalence of HIV and AIDS, stigma and discrimination, migration patterns, criminalisation of sex work and political instability put sex workers at higher risk of contracting HIV and STIs. This group has poor access to SRH services including the availability of condoms, lubricant, and medication supplies, including ARVs and contraceptives. Sex workers are further at a disadvantage with legislation that criminalises sex work, and because sex work is not recognised as a legitimate occupation, there are no entitlements and benefits from respective states,nor protection of labour regulations which apply to other workers. Decriminalisation of sex work will go a long way in providing access to SRH services for sex workers, including access to condoms and safe working environments.

Homosexuality is criminalised in the most countries in the region. Punishments include the death penalty and imprisonments, and the rights of people with non-conforming gender identities and sexual orientations are at stake. This has implications for this group of persons to access SRH services and exercise their sexual and reproductive rights.

RECOMMENDATIONS

To improve the situation in the countries and in Sub-Saharan Africa as a whole there is a need for the governments in the region to ensure accountability to the right to health for women, young women and girls by implementing targeted programmes addressing these gaps. Additionally, regional and international legal commitments need to focus rights of the most marginalised groups of women, young women and girls, in poor urban households, rural areas, those living with HIV survivors of violence, child brides, women living with HIV, and sexual minorities. To fulfil their responsibilities to these groups, governments in Sub-Saharan Africa need to address the following areas:

1. Laws and Policies

Governments should develop robust laws and polices that ensure women, young women and girls are protected from social and environmental barriers, including poverty, which contributes to early sexual debut and unprotected sexual activity among young women and girls. It is also important to provide universal access to sexual and reproductive health services, and to provide accurate information and opportunities for them to make informed decisions on their sexuality in a positive and responsible manner.

Government and partner agencies should protect and promote the sexual reproductive rights of all women, young women and girls, by providing them with access to universal, equitable comprehensive and affordable reproductive health services, which also include accurate information to enable them to assert the right to make a decision on their sexuality free from coercion, violence, discrimination and stigma.

Governments must repeal and review laws that are barriers to justice for survivors of sexual violence and promote laws that protect women, young women and girls from sexual violence and harassment at home, work and in public spaces.

2. Financing

Governments must implement the Abuja Declaration of allocating at least 15% of their annual budget to improve the health sector.

Governments must also direct resources for building the capacity of health workers and service providers to facilitate women, young women and girls to fulfil their sexual and reproductive health rights.

Governments must, in collaboration with other stakeholders, provide comprehensive SRH services that include maternity care, contraception, safe and legal abortion, HIV and STI prevention, treatment, care and counselling to all women including young women and girls ensuring they are non judgemental and quality services that are responsive to the needs of both young women and girls in and out of school. Women, young women and girls should be included in decision making processes where decisions for allocating resources for reproductive health services are made in order to uphold theirrights.

Governments should establish a fund for building skills andknowledge of youth who are peer educators and counsellors fotargetting young people in and out of school on SRHR and HIV.

3. Enabling Environments

Governments should ensure that every person, particularly women, young women and girls have access to evidence and rights based reproductive health information as well as address policy gaps on comprehensive sexuality education, and ensure its inclusion in education curriculum.

Governments should ensure all women, young women and girls, have access to education and training which will increase their opportunities for employment and livelihood. Governments need to review marriage laws, and prohibit and outlaw child marriages through better law enforcement and public education.

Governments should collaborate with development partners to provide resources for NGOs, FBOs and CBOs to educate, mobilise, and train communities to address socio-cultural dynamics, norms and values that restrict women, young women and girls from accessing sexual and reproductive health and rights and services.

Governments in collaboration with NGOs, FBOs, and CBOs should fund gender and behavioural change programmes for youth and create safe spaces for them to dialogue on sexuality and life skills based reproductive health which will enhance their role as leaders and change agents in reducing risk to HIV, early and unintended pregnancies and other negative reproductive health outcomes.

Governments should address laws on diverse sexual identities from a rights based perspective that enables marginalised groups in the category to access sexual reproductive health services.

Governments are also encouraged to address legislation that criminalises sex work from a rights based approach that enables sex workers and trafficked women and girls to access services.

4. Data

Governments need to develop and strengthen partnerships with organisations in developing evidenced-based policies and programmes, and tracking and implementation of regional and global SRHR indicators including ICPD.

Governments should develop robust monitoring systems that will track the impact of their programmes on the sexual and reproductive health and rights of women, young women and girls, particularly on rights based ICPD Indicators, such as unmet need for contraception, unintended pregnancies, fertility rates, abortion, child and maternal mortality rates disaggregated by all background characteristics.

ANNEX

Table 31:
Status of Major International Human Rights Instruments

COUNTRY	(CEDAW)	ICESR	CRC	ICCPR	CAT
Angola	1986	1992	1990	1992	yes
Benin	Signed 1981 Ratified 1992	1992	1990	1992	Yes
Ethiopia	Signed 1980 Ratified 1981	1993	1991	1993	Yes
Kenya	1984	1972	1990	1972	Yes
Nigeria	Signed 1984 Ratified 1985	1993	Signed 1990 Ratified 1991	1993	Yes
Rwanda	Signed 1988 Ratified 1988	1975	Signed 1990 Ratified 1991	1975	Yes
Sierra Leone	Signed 1980 Ratified 1985	1996	1990	1996	Yes
Tanzania	Signed 1980 Ratified 1985	1976	Signed 1990 Ratified 1991	1976	Yes
Zambia	1991	1984	Signed 1990 Ratified 1991	1984	yes

Source: Office of the High Commissioner for Human Rights

Table 32:
Status of Regional Human Rights Instruments

COUNTRY (Country status on ratification and implementation)	SOLEMN DECLARATION	MAPUTO PROTOCOL (signing without reservation on article 14 relating to right to health and control of reproduction).	ABUJA DECLARTION (commitment to spend 15% of national budget on health including SRHR)
Angola	Yes	Yes	No
Benin	No	Yes	No
Ethiopia	Yes	No	No
Kenya	No	Yes	No
Nigeria	Yes	Yes	No
Rwanda	Yes	Yes but with reservation on article 14	Yes
Sierra Leone	No	No	No
Tanzania	No	Yes	Yes
Zambia	No	yes	Yes

Source: African Union

Table 33:
Current Expenditure Status

Consolidated National Health Accounts for Sub-Saharan Countries		
Name of Country	2005	2010
Angola		
Total expenditure on health as % of Gross domestic product	2	3
General government expenditure on health as % of total expenditure on Health	74	82
General government expenditure on health as % of total government expenditure	4	7
Private expenditure on health as % of total expenditure on health	26	18
Out-of-Pocket expenditure as % of private expenditure on health	100	100
Benin		
Total expenditure on health as % of Gross domestic product	5	4
General government expenditure on health as % of total expenditure on Health	50	50
General government expenditure on health as % of total government expenditure	11	10
Private expenditure on health as % of total expenditure on health	50	51
Out-of-Pocket expenditure as % of private expenditure on health	95	93
ETHIOPIA		
Total expenditure on health as % of Gross domestic product	4	5
General government expenditure on health as % of total expenditure on Health	61	54
General government expenditure on health as % of total government expenditure	10	13
Private expenditure on health as % of total expenditure on health	39	46
Out-of-Pocket expenditure as % of private expenditure on health	81	80
KENYA		
Total expenditure on health as % of Gross domestic product	4	5
General government expenditure on health as % of total expenditure on Health	42	44
General government expenditure on health as % of total government expenditure	8	7
Private expenditure on health as % of total expenditure on health	58	56
Out-of-Pocket expenditure as % of private expenditure on health	77	77
NIGERIA		
Total expenditure on health as % of Gross domestic product	7	5
General government expenditure on health as % of total expenditure on Health	29	38
General government expenditure on health as % of total government expenditure	6	4
Private expenditure on health as % of total expenditure on health	71	62
Out-of-Pocket expenditure as % of private expenditure on health	96	95
RWANDA		
Total expenditure on health as % of Gross domestic product	7	10
General government expenditure on health as % of total expenditure on Health	56	50
General government expenditure on health as % of total government expenditure	16	20
Private expenditure on health as % of total expenditure on health	44	50

Consolidated National Health Accounts for Sub-Saharan Countries		
Name of Country	2005	2010
SIERRA-LEONE		
Total expenditure on health as % of Gross domestic product	14	13
General government expenditure on health as % of total expenditure on Health	13	11
General government expenditure on health as % of total government expenditure	8	6
Private expenditure on health as % of total expenditure on health	87	89
Out-of-Pocket expenditure as % of private expenditure on health	84	90
UNITED REPUBLIC OF TANZANIA		
Total expenditure on health as % of Gross domestic product	4	6
General government expenditure on health as % of total expenditure	47	67
General government expenditure on health as % of total expenditure on Health	9	14
Private expenditure on health as % of total expenditure on health	53	33
Out-of-Pocket expenditure as % of private expenditure on health	70	42
ZAMBIA		
Total expenditure on health as % of Gross domestic product	7	6
General government expenditure on health as % of total expenditure on Health	55	60
General government expenditure on health as % of total government expenditure	15	16
Private expenditure on health as % of total expenditure on health	45	40
Out-of-Pocket expenditure as % of private expenditure on health	61	67

Source: World Health Organization (WHO). (2009, February). ***National Health Accounts*** (latest updates are available at http://www.who.int/nha/en/)

Table 34:
Out-Of-Pocket (OOP) Expenditure as a percentage of Private Health Expenditure (PHE) and Translated in PPP $

Country	PHE (2010)	OOP (2010)	PHE in PPP $	OOP in PPP $
Angola	17.5%	100.0%	29.0	29.0
Benin	50.5%	92.7%	33.0	30.5
Ethiopia	46.5%	80.1%	24.0	19.2
Kenya	55.7%	76.7%	44.0	33.7
Nigeria	62.1%	95.3%	75.0	71.4
Rwanda	49.9%	44.4%	60.0	26.6
Sierra Leone	88.7%	89.5%	95.0	85.0
Tanzania	32.7%	41.7%	27.0	11.2
Zambia	39.7%	66.7%	36.0	24.0

Source: WHO National Health Accounts[341]

Table 35:
Countries Government views and policies

COUNTRY	GOVERNMENT VIEWS AND POLICIES
ANGOLA	
Population Size and Growth:	
View on growth	Satisfactory
Policy on growth	Maintain
Fertility and Family Planning	
View on fertility level	Too High
Policy	Maintain
Access to contraceptive methods	Direct Support
Adolescent Fertility -Level of Concern -Policies and programmes	 Major Concern Yes
BENIN	
Population Size and Growth:	
View on growth	Too High
Policy on growth	Lower
Fertility and Family Planning	
View on fertility level	Too High
Policy	Lower
Access to contraceptive methods	Direct Support
Adolescent Fertility -Level of Concern -Policies and programmes	 Major Concern Yes

COUNTRY	GOVERNMENT VIEWS AND POLICIES
ETHIOPIA	
Population Size and Growth:	
View on growth	Too High
Policy on growth	Lower
Fertility and Family Planning	
View on fertility level	Too High
Policy	Lower
Access to contraceptive methods	Direct Support
Adolescent Fertility -Level of Concern -Policies and programmes	 Major Concern No
KENYA	
Population Size and Growth:	
View on growth	Too High
Policy on growth	Lower
Fertility and Family Planning	
View on fertility level	Too High
Policy	Lower
Access to contraceptive methods	Direct Support
Adolescent Fertility -Level of Concern -Policies and programmes	 Major Concern Yes
NIGERIA	
Population Size and Growth:	
View on growth	Too High
Policy on growth	Lower
Fertility and Family Planning	
View on fertility level	Too High
Policy	Lower
Access to contraceptive methods	Direct Support
Adolescent Fertility -Level of Concern -Policies and programmes	 Major Concern Yes

COUNTRY	GOVERNMENT VIEWS AND POLICIES
BENIN	
Population Size and Growth:	
View on growth	Too High
Policy on growth	Lower
Fertility and Family Planning	
View on fertility level	Too High
Policy	Lower
Access to contraceptive methods	Direct Support
Adolescent Fertility -Level of Concern -Policies and programmes	 Major Concern Yes
RWANDA	
Population Size and Growth:	
View on growth	Too High
Policy on growth	Lower
Fertility and Family Planning	
View on fertility level	Too High
Policy	Lower
Access to contraceptive methods	Direct Support
Adolescent Fertility -Level of Concern -Policies and programmes	 Major Concern Yes
SIERRA LEONE	
Population Size and Growth:	
View on growth	Too High
Policy on growth	No intervention
Fertility and Family Planning	
View on fertility level	Too High
Policy	Lower
Access to contraceptive methods	Direct Support
Adolescent Fertility -Level of Concern -Policies and programmes	 Major Concern Yes

COUNTRY	GOVERNMENT VIEWS AND POLICIES
UNITED REPUBLIC OF TANZANIA	
Population Size and Growth:	
View on growth	Too High
Policy on growth	Lower
Fertility and Family Planning	
View on fertility level	Too High
Policy	Lower
Access to contraceptive methods	Direct Support
Adolescent Fertility -Level of Concern -Policies and programmes	 Major Concern Yes
ZAMBIA	
Population Size and Growth:	
View on growth	Too High
Policy on growth	Lower
Fertility and Family Planning	
View on fertility level	Too High
Policy	Lower
Access to contraceptive methods	Direct Support
Adolescent Fertility -Level of Concern -Policies and programmes	 Major Concern Yes

Source: World Population policies 2009

Table 36:
TFR based on background characteristics

Country	TFRs based on Background Characteristics
ANGOLA (DHS 2006-2007)	
Highest Education Level	
Secondary or Higher	2.5
No Education	7.8
Household Wealth Index	
Highest	2.8
Lowest	8.0
Residence	
Urban	4.5
Rural	7.8
BENIN (DHS 2006)	
Highest Education Level	
Secondary or Higher	3.7
No Education	6.4
Household Wealth Index	
Highest	4.8
Lowest	7.0
Residence	
Urban	4.9
Rural	6.3
ETHIOPIA (DHS 2011)	
Highest Education Level	
Secondary or Higher	1.6
No Education	5.8
Household Wealth Index	
Highest	2.8
Lowest	6.0
Residence	
Urban	2.6
Rural	5.5
KENYA (DHS 2008-2009)	
Highest Education Level	
Secondary or Higher	3.1
No Education	6.8
Household Wealth Index	
Highest	2.9
Lowest	7.0
Residence	
Urban	2.9
Rural	5.2
NIGERIA (DHS 2008)	
Highest Education Level	
Secondary or Higher	4.2
No Education	7.3
Household Wealth Index	
Highest	4.0
Lowest	7.1
Residence	
Urban	4.7
Rural	6.3

Country	TFRs based on Background Characteristics
RWANDA (DHS 2010)	
Highest Education Level	
Secondary or Higher	3.0
No Education	5.4
Household Wealth Index	
Highest	3.4
Lowest	5.4
Residence	
Urban	3.4
Rural	4.8
SIERRA- LEONE (DHS 2008)	
Highest Education Level	
Secondary or Higher	3.0
No Education	5.8
Household Wealth Index	
Highest	3.2
Lowest	6.3
Residence	
Urban	3.8
Rural	5.8
UNITED REPUBLIC OF TANZANIA(DHS 2010)	
Highest Education Level	
Secondary or Higher	3.0
No Education	7.0
Household Wealth Index	
Highest	3.2
Lowest	7.0
Residence	
Urban	3.7
Rural	6.1
ZAMBIA (DHS 2007)	
Highest Education Level	
Secondary or Higher	7.1
No Education	8.2
Household Wealth Index	
Highest	3.4
Lowest	8.4
Residence	
Urban	4.3
Rural	7.5

Source: DHS data

Table 37:
Most recent current % of contraceptive use by currently married women compared to % of contraceptive use by sexually active unmarried women.

	Currently Married Women	Sexually Active Unmarried Women
BENIN		
Any method	54.9	17.0
Any modern method	29.4	6.1
Any Traditional Method	25.2	10.6
Not Currently Using	45.1	83.0
ETHIOPIA		
Any method	28.6	56.7
Any modern method	27.3	52.3
Any Traditional Method	1.2	4.2
Not Currently Using	71.4	43.3
KENYA		
Any method	45.5	50.3
Any modern method	39.4	45.1
Any Traditional Method	5.3	4.8
Not Currently Using	54.5	49.7
NIGERIA		
Any method	61.0	14.6
Any modern method	42.4	9.7
Any Traditional Method	11.6	4.1
Not Currently Using	39.0	85.4
RWANDA		
Any method	51.6	41.1
Any modern method	45.1	40.3
Any Traditional Method	6.4	0.8
Not Currently Using	48.4	58.9
SIERRA LEONE		
Any method	33.6	8.2
Any modern method	24.5	6.7
Any Traditional Method	5.0	0.2
Not Currently Using	66.4	91.8

	Currently Married Women	Sexually Active Unmarried Women
TANZANIA		
Any method	34.4	50.6
Any modern method	27.4	44.7
Any Traditional Method	6.1	4.6
Not Currently Using	65.6	49.4
ZAMBIA		
Any method	40.8	47.3
Any modern method	32.7	43.3
Any Traditional Method	3.0	6.8
Not Currently Using	52.7	59.2

* No Data on CPR available for Angola
Source: Benin DHS, 2006; Ethiopia DHS, 2011; Kenya DHS, 2008-09; Nigeria DHS, 2008; Rwanda Interim DHS, 2011; Sierra Leone DHS, 2008; Tanzania DHS, 2010; Zambia DHS, 2007 [342]

Table 38:
Skilled health attendants at birth

Country	% skilled health worker (doctors, nurses, midwives and other cadres of health workers	ICPD/ICPD +10 ICPD targets for 2015 met? 90% of births should be assisted by skilled attendants
Angola	49.4 (2009)	No
Benin	74 (2006)	No
Ethiopia	10.0 EDHS (2011)	No
Kenya	43.8 (2009)	No
Nigeria	38.9 (2008)	No
Rwanda	69.0 RDHS (2010)	No
Sierra Leone	42.4 (2008)	No
Tanzania	50.6 (2010)	No
Zambia	47 (2007)	No

Source: Millennium Development Goals Official Data Base, Ethiopia DHS, 2011.

Table 39:
Antenatal care

Country	At least one visit		Four visits		
	1995-2003	2008-2010	2000	2005	2007
Angola	65.6 (2001)	79.8 (2007)	-	-	-
Benin	80.3 (1996)	84.1 (2006)	61.6 (2001)	60.5 (2006)	-
Ethiopia	26.7 (2000)	33.9 (2011)	10.4 (2000)	12.2 (2005)	-
Kenya	88.1 (2003)	91.5 (2009)	60.8 (1999)	52.3 (2003)	47.1 (2009)
Nigeria	63.6 (1999)	57.7 (2008)	47.3 (1999)	47.4 (2003)	44.8 (2008)
Rwanda	91.5 (2000)	98.0 (2010)	10.4 (2000)	13.3 (2005)	35.4 (2010)
Sierra Leone	67.9 (2000)	86.9 (2008)	-	-	56.1 (2008)
Tanzania	48.8 (1999)	87.8 (2010)	69.9 (1999)	61.5 (2005)	42.7(2010)
Zambia	83.1 (1999)	93.7 (2007)	71.6 (2002)	60.3 (2007)	-

Source: Millennium Development Goals Indicators

Table 40:
Strategic plans set up by the individual countries

COUNTRY	STRATEGIC PLANS
Angola	The National Poverty Strategy plan prioritizes HIV and AIDS prevention and control. The 2011-2014 National Strategic plan is based on: -Optimization of prevention programmes -Improve ART/At/PMTCT and care services -Reduce new infections -Monitoring strategic information, behavioural research and research in vulnerable populations
Benin	2011 Strategic Plan is based on: -Coordination ,Partnership and Mobilization of Resources -Prevention and promotion of testing -Access to care and treatment -Strengthening strategic information: Monitoring epidemiological, behavioural research and promotion -Monitoring and evaluation
Ethiopia	HIV and AIDS programme is integrated in the Poverty Reduction Strategy 2011-2015, National multi-sectoral strategic plan (SPM II) to respond to HIV is based on: -Creating an enabling environment through capacity building -Intensifying HIV prevention -Increasing access to and improving quality of chronic care and treatment -Intensifying mitigation efforts against the epidemic -Strengthening the generation -Using strategic information for action -targeting interventions with a focus on MARPS

COUNTRY	STRATEGIC PLANS
Kenya	the Kenya National HIV and AIDS Strategic Plan for 2009/10- 2012/13 (KNASP III) is based on: -Health sector HIV service delivery -Sectoral streaming of HIV -Community-based HIV programmes -Governance and strategic information
Nigeria	National HIV and AIDS Strategic Plan (NSP) 2010-2015 is based on: -Behaviour change Prevention of new infections Sustaining the momentum in HIV treatment care and support Address gender inequality, knowledge, management and research to improve interventions
Rwanda	Vision2020- Development strategy that highlights HIV Economic Development and Poverty Reduction Strategy- Multi-sectoral action on HIV and AIDS Health Sector Strategic Plan II (2008-2012)-Aims to strengthen institutional capacity to ensure that health care is accessible to the entire population
Sierra Leone	PMTCT Scale-UP Plan PMTCT technical guidelines National Prevention Strategy for HIV 2011-2015 National Behaviour Change Communication and Advocacy Strategy 2011-2015 Key pillar activities: 5 strategic documents that guide the national response to HIV The recent strategic plan was developed to strengthen toward the tracking and assessment of the endemic
United Republic of Tanzania*	The most recent documented strategic plan had four thematic areas: Enabling environment Prevention Care and treatment Impact mitigation
Zambia	2011-2015 SNDP, HIV and AIDS and Gender were the major cross-cutting issues in all the programmes of the plan The 2011-2015 NASF articulates four national priorities: -Intensify Prevention -Accelerate the provision of universal access to comprehensive and quality treatment, care and support. -Mitigate the socio-economic impacts of HIV and AIDS -Strengthen the capacity -Prevention of sexual transmission of HIV and STIs -PTMCT -Counselling and testing -Prevention of HIV in health care setting -Prevention of infection in MARPS

* Source from The Prime Minister's Office, The United Republic of Tanzania. ***Tanzania For AIDS.***
Source: UN AIDS Progress reports.

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