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Your Health, Your Choice, Your Rights:

International and Regional Obligations on Sexual and Reproductive Health and Rights

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CONTENTS

Background on Nature and Scope of Sexual and Reproductive Health and Rights

Sexual and reproductive health and rights are grounded in a range of human rights guarantees, protected in international and regional human rights treaties and in national laws and constitutions.
In 1994, States around the globe under the auspices of the UN at the International Conference on Population and Development (ICPD) recognized this:

> Reproductive rights embrace certain human rights that are already recognized 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 from discrimination, coercion and violence. (Programme of Action of the ICPD, para. 7.3, Cairo, Egypt, September 5-13, 1994).

States agreed that population, development and human rights are inextricably linked and that empowering women and meeting people's needs for education and health, including reproductive health, are necessary.

Years later the Millennium Development Goals and now the Sustainable Development Goals have followed suit in recognizing the importance of reproductive rights to the realization of poverty reduction, particularly for those persons belonging to groups most vulnerable to poverty.

Human Rights Key to Sexual and Reproductive Health and Rights

Sexual and reproductive rights are grounded in a range of fundamental human rights guarantees, protected in national constitutions and in international and regional human rights treaties. They include the rights to life, to dignity, to health, to education and information, to equality and non-discrimination, the right to decide the number and spacing of children, the right to privacy, to consent to marriage and equality in marriage, the right to be free from torture or other cruel, inhuman and degrading treatment, to be free from sexual and gender based violence, from practices that harm women and girls, and the right to an effective remedy.

They rest on the recognition of empowering and guaranteeing to couples and individuals the right to make decisions about the size of their families, and providing them with the information and eans to do so, to ensure women have safe and healthy pregnancies, and to address issues concerning HIV and other STIs. These are grounded in the ability to exercise self-determination and bodily autonomy free of discrimination, coercion and violence. The UN Treaty Monitoring Bodies and other international and regional human rights bodies, including the African Commission on Human and Peoples' Rights (ACHPR) monitor State compliance with treaties and provide interpretive guidance to States in general comments on how to implement their obligations. The ACHPR General Comment 2 and the CESCR General Comment No 22 underscore the interdependence and indivisibility of rights and that the civil and political rights components of sexual and reproductive rights cannot be separated from the socioeconomic components.

UN and African regional human rights law lay down minimum obligations, which States are bound to respect. By becoming parties to international and regional treaties, States assume obligations and duties under international law to respect, protect and fulfill human rights. The obligation to respect means that States must refrain from interfering with or curtailing the enjoyment of human rights. The obligation to protect requires States to protect individuals and groups against human rights abuses. The obligation to fulfill means that States must take positive action to facilitate the enjoyment of basic human rights. Through ratification of international and regional human rights treaties, States undertake to put into place domestic measures and legislation compatible with their treaty obligations and duties. States can however protect rights beyond these minimum standards.

The UN and African human rights treaty bodies, including the African Commission on Human and Peoples' Rights (ACHPR) and the UN Committee on Economic, Social and Cultural Rights (CESCR) issue authoritative interpretative guidance in general comments that aid states in their implementation of human rights treaties and achieve their objective. General Comments clarify the content of a given right and the nature of state obligations in relation to this right, including measures that all countries should take to ensure that specific rights or issues covered by the treaty are realized. General comments are particularly important for providing interpretive guidance in areas where human rights remain unprotected as is the case with women's reproductive health.[2]

[1] The Committee on Economic, Social and Cultural Rights, General Comment No. 22 (2016) on the right to sexual and reproductive health, paras. 9 and 10; African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, paras 2 and 30.

The Maputo Protocol and the International Covenant on Economic Social and Cultural Rights

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) is an African regional treaty affirming women's reproductive autonomy as a human right. Fifty one of the 54 African Union member states have signed the Maputo Protocol and thirty-seven countries have thus far ratified it and are bound to its provisions.[3]

The African Commission on Human and Peoples' Rights (ACHPR) adopted General Comment No 2 to interpret provisions of Article 14 of the Protocol to the African Charter on the Rights Women (the Maputo Protocol). Article 14 of the Maputo Protocol and its corresponding General Comment 2, relate to women's rights to control their fertility, contraception, family planning, information and education, and abortion. ACHPR's General Comment 2 covers Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c). It is important to note that the ACHPR has another general comment covering the provisions of Article 14 (1) (d) and (e) of the Maputo Protocol, dealing with women and HIV.[4]

The Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa

Article 14: Health and Reproductive Rights

1. States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes:

a) the right to control their fertility;
b) the right to decide whether to have children, the number of children and the spacing of children;
c) the right to choose any method of contraception;
d) the right to self protection and to be protected against sexually transmitted infections, including HIV/AIDS;
e) the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices;
f) the right to have family planning education.

2. States Parties shall take all appropriate measures to:

a) provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas;
b) establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding;
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.

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[1] Charles G.Ngwena, Eunice Brookman-Amissah, Patty Skuster, Human rights advances in women's reproductive health in Africa, International Journal of Gynecology and Obstetrics (2015), http:// dx.doi.org/10.1016/j.ijgo.2015.02.001.

[2] African Union, List of Countries which have signed, ratified, acceded to the Protocol to the African Charter on Human and Peoples' rights on the Rights of Women in Africa, http://www.achpr.org/instruments/women-protocol/ratification/ (accessed on 6 April 2017).

[3] General Comments on Article 14 (1) (d) and (e) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2012).

ACHPR General Comment 2 does not set out to create new human rights standards but rather to draw explicitly as well as implicitly from existing UN international human rights law and authoritative guidance.[5] The General Comment clarifies obligations of the State that build on existing human rights standards developed under UN treaties such as the International Covenant on Civil and Political Rights, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the International Covenant on Economic, Social and Cultural Rights.[6] It reaffirms the normative content of the right to health as interpreted by the Committee on Economic, Social and Cultural Rights (CESCR) in General Comment 14.[7] to the specific contexts of the rights to fertility control, contraception, family planning education, and abortion that are guaranteed under the Protocol. In this way, the General Comment consolidates international human rights best practices in an African regional context. [8]

Since the adoption of ACHPR General Comment 2, the CESCR has adopted a General Comment specifically on the right to sexual and reproductive health, General Comment 22. It applies the rights framework set forth in General Comment 14 on the right to the highest attainable standard of health generally to the specific area of sexual and reproductive health, much like the ACHPR's General Comment 2. Although the CESCR has previously addressed sexual and reproductive health in its General Comment 14, [9] the Committee issued the new comment in 2016 in light of constant, severe violations of the right to sexual and reproductive health care, and to highlight the various barriers that impede enjoyment of this right. CESCR's General Comment 22 explains States' duties and provides guidance to ensure the right to sexual and reproductive health, as an integral part of the right to health protected by Article 12 of the International Covenant on Economic, Social and Cultural Rights. The General Comment reinforces the long-standing recognition in international law that sexual and reproductive rights are not only an integral part of the general right to health but are fundamentally linked and interdependent to the enjoyment of many other human rights, including the rights to education, work and equality, as well as the rights to life, privacy and freedom from torture, and individual autonomy.

General Comments from other UN treaty monitoring bodies are also relevant. These include Children's Rights Committee General Comment No. 20 (2016) on the implementation of the rights of the child during adolescence, Children's Rights Committee General Comment No.15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health, the Committee on the Rights of Persons with Disabilities, General Comment 3 on Article 6 women and girls with disabilities (2016), and the Committee on the Elimination of Discrimination against Women (CEDAW) General Recommendation 24 on women and health (1999).

[5] Charles G. Ngwena, Eunice Brookman-Amissah, Patty Skuster, Human rights advances in women's reproductive health in Africa, International Journal of Gynecology and Obstetrics (2015).

[6] African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para. 30.

[7] African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para. 6.

[8] Charles G. Ngwena, Eunice Brookman-Amissah, Patty Skuster, Human rights advances in women's reproductive health in Africa, International Journal of Gynecology and Obstetrics (2015).

[9] The Committee on Economic, Social and Cultural Rights, General Comment No. 14 (2000) on the right to the highest attainable standard of health (art. 12), paras. 2, 8, 11, 16, 21, 23, 34 and 36.

Availability, Accessibility, Acceptability, and Quality (AAAQ)

General Comments 2 and 22 identify four central components of the right to health, including sexual and reproductive health: availability, accessibility, acceptability, and quality.[10]

- **Accessibility** requires the State to ensure access to health services in a non-discrimination basis and in ways that are physically accessible, economically accessible, and in which information is accessible.
- **Availability** of health services requires that States must ensure that there are an adequate number of functioning health care facilities, services, good and programs to serve the population including essential drugs as defined by the WHO Model List of Essential Medicines which includes, contraception and emergency contraception, for example.
- **Acceptability** requires that health facilities, services and goods must be respectful of the culture of individuals, including the needs of minorities, and different genders and age-groups, and designed to respect medical ethics, including confidentiality and informed consent.
- **Quality** requires that reproductive healthcare must be of good quality, meaning that it is scientifically and medically appropriate, which requires skilled (trained) medical personnel, scientifically approved and unexpired drugs and equipment.

Equality and Non-discrimination

The Maputo Protocol was adopted for the specific purpose of promoting gender equality and eliminating discrimination against women in the African region. Its aim is substantive equality, nondiscrimination, and human dignity for women and girls. ACHPR's General Comment 2 and CESCR's General Comment 22 calls on States to take measures that guarantee equality and non-discrimination in health care. States have an obligation to take all appropriate measures to eliminate discrimination both in law and in practice. This obligation is subject to immediate application, even in circumstances where states face extreme resource constraints; low-cost, targeted programs must be adopted in order to protect vulnerable members of society.[13]

The General Comments detail the indispensability of sexual and reproductive rights for women's right to make meaningful and autonomous decisions about their lives and health. Noting that gender equality requires that women's specific health needs are met,[14] both General Comments reaffirm that States are obliged to attend not just to legal and policy barriers but also cultural, social, religious, and economic barriers that hinder women's realization of their rights.[15] ACHPR's General Comment 2 notes that the right to dignity and to non-discrimination enshrines the freedom to make decisions without interference by State or non-state actors, including influences based on religion or ideology.[16] CESCR General Comment 22 recognizes that gender-based stereotypes play a role in fueling violations of the right to sexual and reproductive health, including assumptions and expectations of women being subordinate to men and of women's role as only caregivers and mothers and requires states to eliminate such gender stereotypes.

ACHPR's General Comment 2 calls for States to address gender disparities, patriarchal attitudes, harmful

[10] Originally set forth in the Committee on Economic, Social and Cultural Rights, General Comment No. 14 (2000) on the right to the highest attainable standard of health (art.12), para 12.

[11] African Commission on Human and Peoples' Rights. Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2003), para. 3.

[12] Charles G. Ngwena, Eunice Brookman-Amissah, Patty Skuster, Human rights advances in women's reproductive health in Africa, International Journal of Gynecology and Obstetrics (2015).

practices, prejudices of health care providers, discriminatory laws and policies in relation to sexual and reproductive health.[18] In light of the specific stigma associated with contraception and abortion, ACHPR General Comment 2, calls on States to sensitize and educate communities, religious leaders, and traditional and political leaders, as well as health care professionals on sexual and reproductive rights.[19]

Both General Comments recognize how sexual and reproductive health care has been disproportionately and discriminatorily denied to certain vulnerable groups, including adolescent girls, women with disabilities, women living with HIV and women living in conflict. For marginalized and underserved populations, the right to non-discrimination is at the core of their right to access comprehensive reproductive health care, as reproductive health policies and programs have historically neglected their Human rights obligations include ensuring accountability, which in turn, helps guide States in meeting their human rights commitments and providing an opportunity to improve laws, policies and practices.[21] Key to ensuring accountability are strong mechanisms for budgeting, monitoring and evaluation and ensuring the participation of affected communities in the development of policies and programs. Financial and budgetary allocation is critical to the realization of rights and ensuring accountability as recognized by the General Comments. ACHPR's General Comment 2 notes that the State must fulfil its duty by allocating sufficient and available resources for the full implementation of the rights guaranteed in the Maputo Protocol.[22]

Accountability is also important as it may provide avenues of redress for victims of violations and deter future violations. Redress is achieved through a variety of processes and institutions that vary from country to country, and include both national and international mechanisms. Examples include courts, national human rights institutions, professional disciplinary proceedings and international and regional human rights bodies' state reporting processes and individual complaint mechanisms. Ensuring access to justice is a human right that is featured in both General Comments.[23]

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[13] The Committee on Economic, Social and Cultural Rights, General Comment No. 22 (2016) on the right to sexual and reproductive health; The Committee on Economic, Social and Cultural Rights, General Comment No. 3 (1990) on the nature of States parties' obligations (Art. 2, para. 1); The Committee on Economic, Social and Cultural Rights, General Comment No. 14 (2000) on the right to the highest attainable standard of health (art. 12), para. [18].

[15] African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, paras. 22, 24, 27; The Committee on Economic, Social and Cultural Rights, General Comment No. 22 (2016) on the right to sexual and reproductive health, para. 29, 35, 48.

[16] African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, paras. 24-26, (explicitly noting also that the right to be free from discrimination includes deprivation of health services by providers for reasons of conscientious objection).

[17] The Committee on Economic, Social and Cultural Rights, General Comment No. 22 (2016) on the right to sexual and reproductive health, paras. 27, 31, 35, 36.

[18] African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para. 60

[19] African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para. 44.

specific needs. More information is provided in section on marginalized populations.[20]

Select SRHR Issues

The issues addressed in this paper relate to State obligations in relation to ACHPR's General Comment 2, relating to fertility control, contraception, and family planning. The issues covered are maternal health, contraception, abortion, comprehensive sexuality education and issues facing adolescents and youth. Each section begins with the situation on the continent with regards to that issue, it is then followed by State obligations in relation the Maputo Protocol and to UN treaties, particularly ACHRP's General Comment 2 and CESCR's General Comment.[22]

Equality and Non-discrimination

While significant progress has been made on reducing maternal mortality in the past, since the 1990s a number of countries in Sub-Saharan Africa have their levels of maternal mortality, the numbers of women dying from pregnancy-related causes remain unacceptably high. About 830 women die from pregnancy or childbirth-related complications around the world every day. It was estimated that in 2015, roughly 303,000 women died during and following pregnancy and childbirth. In almost all developing countries women face significant obstacles, including delays in seeking care, reaching healthcare facilities and receiving treatment. Poor women in remote areas are the least likely to receive adequate health care. This is especially true for regions with low numbers of skilled health workers. Approximately, three quarters of maternal deaths in Sub-Saharan Africa result from severe bleeding, infections, high blood pressure during pregnancy and unsafe abortion. These causes are generally preventable if they are identified and properly managed in a timely manner. The proportion of women who become pregnant before age 15 years varies enormously within regions, for example, the rate in Rwanda is 0.3% versus 12.2% in Mozambique.

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[20] African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para. 43; The Committee on Economic, Social and Cultural Rights, General Comment No. 22 (2016) on the right to sexual and reproductive health, paras. 2, 31.
[21] Cottingham, Jane, et. al., Using human rights for sexual and reproductive health: improving legal and regulatory frameworks. Bulletin of the World Health Organization 2010; 88:551-555.
[22] African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para. 45; See also Article 26 of the African Commission on Human and Peoples' Rights. Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2003).
[23] African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, paras 29, 50, 62; The Committee on Economic, Social and Cultural Rights, General Comment No. 22 (2016) on the right to sexual and reproductive health, para. 64.
[24] African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, paras 29, 50, 62; The Committee on Economic, Social and Cultural Rights, General Comment No. 22 (2016) on the right to sexual and reproductive health, para. 64.

Contraceptive Information and Services

On average, adolescents between 15-19 years old face twice the risk of dying during pregnancy or childbirth compared to women over 20 years old, while adolescents under the age of 15 face five times the risk. In addition, for every woman that dies of pregnancy and childbirth complications, at least 20 more women suffer long-term illness related to unintended pregnancy or recent childbirth.
The high rates of maternal mortality and morbidity on the continent, as in other parts of the world, reflects inequities in access to health services both within and between countries, and highlights the gap between rich and poor.[25]

Lack of access to quality maternal health care is now recognized as human right issue and in need of enhanced government accountability. Maternal mortality implicates the rights to health, the right to life, and to be free from discrimination amongst other human. Both the CESCR and the ACHPR General Comments address various State obligations in relation to the provision of maternal health care. General Comments 2 and 22 and other treaty standards link high rates of maternal mortality to lack of a well-functioning health system and to comprehensive reproductive health services, particularly restrictive abortion laws and the resulting unsafe or illegal abortion, adolescent childbearing, and inadequate access to contraceptives.[26] In fact, one of the main impetus behind the development of ACHPR's General Comment 2 were the unacceptably high rates of maternal mortality on the continent.[27] Under human rights law, States have an obligation to provide adequate interventions to prevent maternal mortality, including appropriate maternal health services that meet the distinct needs of women and are inclusive of marginalized groups.[28]

General Comments 2 and 22 and other UN human rights standards require States to have in place comprehensive policies and programs to address sexual and reproductive rights,[29] including reduce their maternal mortality rates, including by ensuring among others, access to birth assistance, prenatal care, emergency obstetric care, and post abortion care, including for complications resulting from unsafe abortions. General Comments 2 and 22 recommends that States should allocate adequate financial resources so that they can provide comprehensive care, remove barriers to such health care, such as high costs and inadequate infrastructure, and ensure that essential medicines for pregnancy-related complications are registered and available.[30] CESCR General Comment 22 notes that States must address the underlying determinants of healthy pregnancy, including potable water, nutrition, education, sanitation, and transportation.[31] The CEDAW Committee has made clear that States must take measures to ensure that the life and health of the pregnant woman are prioritized over protection of the fetus.[32]

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[25] World Health Organization, maternal mortality fact sheet Nov 2016. http://www.who.int/mediacentre/factsheets/fs348/en/: WHO Adolescent pregnancy, http://www.who.int/maternal_child_adolescent/topics/maternal/adolescent_pregnancy/en/; UNFPA, Adolescent Pregnancy: A Review of the Evidence (2013), https://www.unfpa.org/sites/default/files/pub-pdf/ADOLESCENT%20PREGNANCY_UNFPA.pdf; UNFPA State of the World Population 2013, Motherhood in Childhood: Facing the challenge of adolescent pregnancy (2013) http://www.unfpa.org/publications/state-world-population-2013.

[26] The Committee on Economic, Social and Cultural Rights, General Comment No. 22 (2016) on the right to sexual and reproductive health, paras. 10, 28, 45; African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, Preface and paras. 19, 23, 39.

[27] African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, Preface; Charles G.Ngwena, Eunice Brookman-Amissah, Patty Skuster, Human rights advances in women's reproductive health in Africa, International Journal of Gynecology and Obstetrics (2015).

Access to contraceptive information and services enables individuals and couples to determine whether and when to have children. It also contributes to the achievement of their health and increases their autonomy and well-being.[32] Contraceptive information and services are important in preventing pregnancies, including those resulting from sexual violence, and in preventing sexually transmitted infections and HIV transmission. Despite the importance of modern contraception to the health and lives of women, the number of women with unmet contraceptive need in Africa excluding North Africa increased from 50 million in 2008 to 53 million in 2012.[34] It is especially high among groups such as adolescents, migrants, urban slum dwellers, refugees and women in postpartum period.[35] In 2012 among women of reproductive age (15–49) 42% said they wanted to avoid pregnancy, but only 17% were using a modern contraceptive method—roughly the same proportion as in 2008.[36] Common reasons for not using contraceptives included lack of access to methods that meet users' needs; concerns and misinformation about health and side effects; lack of comprehensive sexuality education; opposition from a partner or on religious grounds; and problems obtaining family planning services generally, including being unable to afford contraceptives. In addition, the prevalence of sexual violence on the continent is high. For example, the lifetime prevalence of physical and/or sexual intimate partner violence in Africa is 36.6%.

The health effects of sexual violence are devastating and include the impact of unsafe abortion, vulnerability to HIV and other sexually transmitted infections, anxiety, low birth weight and premature birth, to name a few. ACHPR, in its General Comment 2 recognizes that one of the consequences of unmet contraception need is a commensurately high rate of unintended pregnancies, including adolescent pregnancies. Women with unintended pregnancies who want to terminate their pregnancies but are faced with restrictive laws and/or practices are likely to resort to unsafe abortion, resulting in a higher rate of maternal mortality and morbidity. For example, evidence shows that fully meeting all need for modern contraceptive methods in Sub-Saharan Africa would result in a 29% decline in maternal mortality.

UN human rights bodies have framed the lack of access to modern contraception as violating the rights to non-discrimination and to health, denial of access to emergency contraception in cases of sexual violence, as violating numerous human rights, including the right to health and the right to be free from inhuman and degrading treatment.

ACHPR's General Comment 2 calls on States parties to provide complete and accurate information and a range of choice of contraceptive methods, by training health care providers to provide information on risks, benefits of and alternatives to various contraceptive methods. It also calls for public information campaigns on contraceptives and to

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[28] The Committee on Economic, Social and Cultural Rights, General Comment No. 22 (2016) on the right to sexual and reproductive health, para. 45.
[29] African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para. 45.
[30] African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para 62; The Committee on Economic, Social and Cultural Rights, General Comment No. 22 (2016) on the right to sexual and reproductive health, para.13.
[31] The Committee on Economic, Social and Cultural Rights, General Comment No. 22 (2016) on the right to sexual and reproductive health, paras. 7, 8, 12.
[32] CEDAW Committee, L.C. v. Peru, (2011).
[33] Singh S and Darroch JE, Adding It Up: Costs and Benefits of Contraceptive Services—Estimates for 2012, New York: Guttmacher Institute and United Nations Population Fund (UNFPA), 2012.
[34] Guttmacher Institute, Costs and Benefits of Investing in Contraceptive Services in Sub-Saharan Africa (2012), https://www.guttmacher.org/fact-sheet/costs-and-benefits-investing-contraceptive-services-sub-saharan-africa
[35] United Nations, Department of Economic and Social Affairs, Population Division, Trends in Contraceptive Use Worldwide 2015, http://www.un.org/en/development/desa/population/publications/pdf/family/trendsContraceptiveUse2015Report.pdf
[36] Singh S and Darroch JE, Adding It Up: Costs and Benefits of Contraceptive Services—Estimates for 2012, New York: Guttmacher Institute and United Nations Population Fund (UNFPA), 2012.

ensure all information on contraceptives is accessible to all women and girls including ensuring that it is available in languages and formats accessible and understandable to women and girls with disabilities.
Both General Comments note that states must ensure access to medications on the WHO Essential Medicines List, which include hormonal contraception and emergency contraception. They have recommended that States eliminate obstacles to accessing contraception, include high costs, marital status requirements, and third-party authorization. Sexually active young women often face obstacles to accessing contraceptives and health services, increasing the risk of unintended pregnancy and unsafely performed abortions. Young men also need information and services so they can be partners in preventing unintended pregnancies.[45] **Confidential and child-sensitive counseling services should thus, also be implemented, and adolescents should have access to information and medical services without parental consent, in accordance with their maturity.**

The General Comments emphasize the obligation of States to ensure that the use of contraceptives is voluntary and fully informed. Human rights bodies recognize that forced and coercive sterilization of women violates the rights to non-discrimination; health; determine the number and spacing of one's children; and be free from cruel, inhuman, and degrading treatment. **General Comment 2 specifically notes that States have an obligation to prevent involuntary sterilization of groups that have been directly or indirectly targeted:**

> 'State parties should ensure that the necessary legislative measures, administrative policies and procedures are taken to ensure that no woman is forced because of her HIV status, disability, ethnicity or any other situation, to use specific contraceptive methods or undergo sterilization or abortion. The use of family planning/contraception and safe abortion services by women should be done with their own informed and voluntary consent. '[46]

UN treaty body standards emphasize the State obligation to investigate and prosecute instances of involuntary sterilization and to provide redress, including compensation, to people who are forcibly sterilized. States should provide training on patients' rights in order to prevent involuntary sterilizations.

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[37] Singh S and Darroch JE, Adding It Up: Costs and Benefits of Contraceptive Services—Estimates for 2012, New York: Guttmacher Institute and United Nations Population Fund (UNFPA), 2012.
[38] World Health Organization, Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence (2013), http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf?ua=1
[39] World Health Organization, Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence (2013), http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf?ua=1
[40] World Health Organization, Safe Abortion: Technical and Policy Guidance for Health (2012), page 90.
[41] Guttmacher Institute, Costs and Benefits of Investing in Contraceptive Services in Sub-Saharan Africa (2012), https://www.guttmacher.org/fact-sheet/costs-and-benefits-investing-contraceptive-services-sub-saharan-africa
[42] See UNFPA and Center for Reproductive Rights, The Right to Contraceptive Information and Services for Women and Adolescents (2010) https://www.unfpa.org/sites/default/files/resource-pdf/Contraception.pdf; Center for Reproductive Rights Violations as Torture or Ill-treatment https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Reproductive_Rights_Violations_As_Torture.pdf; CAT Committee, Concluding Observations: Peru, para. 15, U.N. Doc. CAT/C/PER/CO/5-6 (2013)
[43] African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para. 28.
[44] African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para. 28.

Namibia: Involuntary sterilization of HIV positive women

In L.M. and Others v. the Government of the Republic of Namibia, the Namibian High Court ruled that medical practitioners in State-run hospitals involuntarily sterilized three women living with HIV. While all three women in this case signed consent forms for sterilization, the court determined that they did so without the necessary information to make an informed decision, as they did not receive adequate counseling and one was told that medical treatment would be withheld if she did not sign the consent form. The Court relied, in part, on Namibia's international human rights obligations to find these violations, and criticized the underlying stereotypes and paternalism which fuel such violations.[47]

Specifically, the Court recognized the paternalistic beliefs of the health care providers in failing to secure the women's informed consent to sterilization: "[t]he doctors … appeared to have formed the opinion that sterilisation was the best option available to the respondents, presumably because - as one of the doctors put it in relation to the third respondent - BTL [bilateral tubal ligation or sterilization] would offer a 'final solution' to the respondents' predicament .. With great respect, this attitude smacks of medical paternalism." [48]

Moreover, the Court elaborated on the doctors' paternalistic assumptions about the patient, noting that, "[s]he was, for example, described by one of the doctors as being 'unreliable concerning her life care' and that it was felt that she is 'best helped if she never falls pregnant again'.[49] While the Court, unfortunately, did not address the specific HIV dimensions related to the decision to sterilize the women, the Court recognized the detrimental consequences of such paternalism and underscored the importance of securing the patients' informed consent to the procedure of sterilization as a matter of autonomy and self-determination, which applies to all women, including HIV positive women, as in this case:

"There can be no place in this day and age for medical paternalism when it comes to the important moment of deciding whether or not to undergo a sterilisation procedure. The principles of individual autonomy and self- determination are the overriding principles towards which our jurisprudence should move in this area of the law. These principles require that in deciding whether or not to undergo an elective procedure, the patient must have the final word. Unlike some life-saving procedures that require intervention on a moment's notice, sterilisation allows time for informed and considered decisions. … [H]ealth professionals are under an obligation to assess the patient and point out the risks involved in particular procedures so as to enable the patient to make an informed decision and give informed consent. They may also make recommendations as to the management and/or treatment of a patient's condition based on their professional assessment. However, the final decision of whether or not to consent to a particular procedure rests entirely with the patient."[50]

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[45] UNFPA, Status Report, Adolescents and Young People in Sub-Saharan Africa, Opportunities and Challenges (2012), http://www.prb.org/pdf12/status-report-youth-subsaharan-Africa.pdf.
[46] African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para. 47.
[47] Government of the Republic of Namibia v. LM and Others, Case No. SA 49/2012, [2014] NASC 19 (3 November 2014) (Namibia, Supreme Court); see also UNFPA and Center for Reproductive Rights, ICPD and Human Rights: 20 years of advancing reproductive rights through UN treaty bodies and legal reform (2013).

Abortion and Post-Abortion Care

Unsafe abortion* is one of the largest causes of maternal mortality and morbidity globally. In Africa, of the 6.4 million abortions carried out in 2008, only 3% were performed under safe conditions. Globally, the number of deaths from unsafe abortion reduced from 69 000 in 1990 to 56 000 in 2003, and 47 000 in 2008. Almost all abortion-related deaths worldwide occur in developing countries, with the highest number occurring in Africa: close to 62% of unsafe abortion-related mortality (29 000 women) globally occurs in the African region. high.[52] In Africa, according to the most recent estimates, at least 9% of maternal deaths (16,000) annually were due to unsafe abortion.[53]

WHO recognizes that unsafe abortions occur primarily in countries with restrictive legal regimes in law or in practice. African countries have some of the most restrictive abortion laws in the world. As of 2015, an estimated 90% of women of childbearing age in Africa live in countries with very restrictive abortion laws, where abortion is only allowed on grounds of health or life of the woman or totally prohibited. According to WHO, legal status and availability of lawful abortions influences the safety of abortions, ACHPR's General Comment 2 also recognizes this.[54]

It is not only the legal indications for abortion that are important. Economic status, age, geographical location and restrictive regulations exacerbate obstacles to women seeking legal abortions.[55] Even where abortion may be legal, many women do not have access to services due to cumbersome administrative requirements or ignorance of the law by both women and health care providers.[56] Limitations on types of health workers authorized to perform abortions and prohibitions on the use of medical abortion and other modern methods of abortion can also have significant impact on accessibility, especially in rural locations. Lack of budgetary prioritization of reproductive health and maternal health services is also a significant barrier, as abortion is a central component of reproductive health care. This has particular impact on poor women.

While other human rights instruments infer abortion from broader human rights, Maputo Protocol is the only international or regional human rights treaty that **explicitly** articulates in the provisions of a treaty, the right to abortion for several indications. **Under Article 14 (2) (c) of the Maputo Protocol, States Parties are called upon to take all appropriate measures to "protect the reproductive rights of women by authorizing 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".**
This provision recognizes the critical benefits that ensuring access to abortion has on women, their families and communities on a continent burdened by extremely high maternal mortality and morbidity.

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[48] Government of the Republic of Namibia v. LM and Others, Case No. SA 49/2012, [2014] NASC 19 (3 November 2014) (Namibia, Supreme Court), paras. 103-104.
[49] Government of the Republic of Namibia v. LM and Others, Case No. SA 49/2012, [2014] NASC 19 (3 November 2014) (Namibia, Supreme Court), para. 105.
[50] Government of the Republic of Namibia v. LM and Others, Case No. SA 49/2012, [2014] NASC 19 (3 November 2014) (Namibia, Supreme Court), para. 106.
* World Health Organization definition: An unsafe, or clandestine, abortion is a procedure meant to terminate an unintended pregnancy that is performed by an individual without the necessary skills, or in an environment that does not conform to the minimum medical standards, or both. World Health Organization. Unsafe abortion: global and regional estimates of the incidence of abortion and associated mortality in 2008. Geneva: World Health Organization; 2011.
[51] World Health Organization. Unsafe abortion: global and regional estimates of the incidence of abortion and associated mortality in 2008. Geneva: World Health Organization; 2011.

> As described by African legal scholar Professor Charles Ngwena, '... by inscribing abortion in the Protocol the drafters have ensured that unmet abortion needs are given voice at the highest regional, juridical level and that the violation of abortion rights by the nation-state cannot be insulated from human rights scrutiny by the African Charter treaty bodies.'

Both General Comments make the connection between restrictive abortion laws and high rates of unsafe abortion and maternal mortality. **These general comment and other UN treaty body standards condemn absolute bans on abortion as being incompatible with international human rights norms and have urged states to eliminate punitive measures for women and girls who undergo abortions and for health care providers who deliver abortion services. Treaty monitoring bodies have called on States to decriminalize and ensure access to abortion, as well as to release women who are in prison due to criminal abortion laws. Human rights bodies have clearly indicated that denying women access to abortion in certain circumstances violates the rights to health, privacy and to be free from cruel, inhumane and degrading treatment, amongst other rights.**

ACHPR General Comment 2 and UN standards also urge states to interpret exceptions to restrictive abortion laws broadly to incorporate, for example, mental health conditions as a threat to their health. ACHPR General Comment 2 explicitly urges States to adopt the WHO definition of health when interpreting abortion provisions:

> 'When assessing the risks to a pregnant woman's health, health must be interpreted according to the WHO definition, namely: "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The reasons put forward by the woman seeking an abortion must be taken into account.'[58]

Human rights bodies have noted that where abortion is legal, States must ensure that it is available, accessible (including affordable), acceptable, and of good quality. General Comment 2 recognizes that because of the criminalization of abortion and the resulting stigma, many abortion laws on the continent are not being fully implemented, resulting in denying women their right to abortion and risking their health and lives.[59]

Both General Comments urge States to also abolish other barriers to accessing safe abortion services, such as third-party authorization requirements, including spousal authorization, lack of available providers, and to enact clear guidelines and ensure awareness by health providers and others on the conditions under which abortion is legal. ACHPR's General Comment 2 specifically calls on States to take into account WHO Safe Abortion guidance, which calls for expanded access to safe abortion through authorizing mid-level providers to perform abortions. This will ensure access to abortion in rural areas.[60] CESCR General Comment 22 in line with ACHPR General Comment 2 dictate that States should ensure that women's access to and the availability of abortion and other sexual and reproductive health services are not hindered by conscientious objection.[61] CESCR General Comment 22 notes that States should monitor the practice and implement mechanisms to ensure that women systematically receive timely referrals to another service provider.[62]

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[52] World Health Organization, Maternal Mortality Fact Sheet (2016), http://www.who.int/mediacentre/factsheets/fs348/en/
Guttmacher Institute, Abortion in Africa, Incidence and Trends (2016), https://www.guttmacher.org/fact-sheet/facts-abortion-africa.
[53] World Health Organization, Safe Abortion: Technical and Policy Guidance for Health (2012); African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para. 19.
[54] African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, paras. 38, 39.
[55] African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para. 38; African Union and Ipas, Interpreting and Implementing Existing Abortion Laws in Africa (2013).
[56] Charles G. Ngwena, Eunice Brookman-Amissah, Patty Skuster, Human rights advances in women's reproductive health in Africa, International Journal of Gynecology and Obstetrics (2015).

Regardless of the legal status of abortion, ACHPR General Comment 2 and CESCR General Comment 22 have made clear that States must ensure women receive confidential and adequate post-abortion care. **Post-abortion care must not be conditioned upon admissions by women that will be used to prosecute them for undergoing the procedure illegally, as this may amount to cruel, inhuman, and degrading treatment.** General Comment 2 calls on states to decriminalize abortion, noting:

> 'The right to be free from discrimination also means that women must not be subjected to criminal proceedings and should not incur any legal sanctions for having benefited from health services that are reserved to them such as abortion and post-abortion care. Furthermore, it entails that the health personnel should not fear neither prosecution, nor disciplinary, or others for providing these services, in the cases provided for in the Protocol.' [63]

Case Study: Ethiopia's Abortion Law Reform and Ensuring Access to Safe Abortion

Prior to 2005, Ethiopia permitted abortion only when there was a 'grave or imminent danger to the woman. After liberalizing Ethiopia's abortion law in 2005, a woman is also allowed to obtain an abortion on numerous other grounds. The reform has resulted in expansion of safe abortion care and post abortion care across the health system and is an important step towards reducing maternal mortality due to unsafe abortions.

After passage of the law, the government implemented programs designed to train health care providers including midlevel health workers, to equip facilities and expand the services they offer and to integrate abortion care into broader reproductive health services. The reform of the law and such program and policy efforts to implement it have resulted in significant improvements in access to abortion and post-abortion care in the country. A new study reveals that, although many abortion procedures continued to occur outside health facilities, often under unsafe conditions, the number of abortions that took place in health facilities nearly doubled between 2008 and 2014. Contraceptive access has also improved in recent years, in part due to increased attention to post abortion contraceptive counselling. In 2014, 40% of married women in Ethiopia were using a modern method of contraception, up from 27% in 2011. Of the women who received abortion care at health facilities in 2014, 77% left the facility with a modern contraceptive method. Ethiopia's national abortion rate remains lower than the rates in most other countries in the East Africa region.

While Ethiopia has made significant progress in improving access to safe abortion services, additional improvements are still necessary. Calls have been made to ensure efforts continue to focus on expanding the health care workforce and infrastructure, scaling up services and educating women about the legal status of abortion.

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[58] African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para. 38.
[59] African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, Preface and paras. 19, 37-40,
[60] African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, paras. 58, 61.
[61] African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para. 26; The Committee on Economic, Social and Cultural Rights, General Comment No. 22 (2016) on the right to sexual and reproductive health, para 43.

Comprehensive Sexuality Education

In order to make informed decisions about contraception, family planning and abortion, individuals need accessible, quality, comprehensive information on sexual and reproductive health, including effective contraceptive methods. However, inadequate counseling tools and services, limited or the absence of sexuality education in and out of schools, and the complete absence of or misinformation about the safety and effectiveness of contraceptives and other issues concerning reproduction and sexuality prevent individuals, including adolescents, from using reproductive health services.[65]

Every year, adolescents account for 16 percent of all births in in Africa excluding North Africa. Adolescent pregnancies and childbirth pose serious health risks. Adolescents between the ages of 15 and 19 have twice the risk of dying due to pregnancy-related complications compared to women in their twenties, while girls under the age of 15 have times the risk of pregnancy-related deaths worldwide. Pregnancy also compels girls to drop out of school or result in expulsion by school authorities.[66] Evidence shows that information on sexual and reproductive health, including sexuality education in school can help prevent pregnancy and help adolescents to delay their sexual debut, and prevent sexually transmitted infections, including HIV.[67]

Right to Information on Sexual and Reproductive Health

Both General Comments emphasize that complete and accurate information is central to the enjoyment of the right to health, including sexual and reproductive health, that includes the provision of information by trained health care staff with regards to contraceptives, abortion and family planning as well as information provided in schools and to the public, in general. They both emphasize that information must be accessible, and must be provided in a manner understandable to the individual, taking into account their age, disability status, language, for example.[68]

General Comments 2 and 22 and other UN standards recognize that sexuality education contributes to the prevention of HIV/AIDS, teenage pregnancy, unwanted pregnancies, abortion, and maternal death. These and other human rights bodies have made clear that States should ensure that all adolescents have access to information on sexual and reproductive health. ACHPR's General Comment 2 stresses

> 'the importance of information and education on family planning / contraception and safe abortion for women, especially adolescent girls and young people. State parties must ensure provision of comprehensive information and education on human sexuality, reproduction and sexual and reproductive rights. The content must be based on clinical findings, rights-based, without judgment and take into account the level of maturity of adolescent girls and the youth…'[69]

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[62] The Committee on Economic, Social and Cultural Rights, General Comment No. 22 (2016) on the right to sexual and reproductive health, para. 43.
[63] African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para. 32.
[64] Guttmacher Institute, Induced Abortion and Post Abortion Care in Ethiopia (2016) https://www.guttmacher.org/fact-sheet/induced-abortion-ethiopia.
[65] The Committee on Economic, Social and Cultural Rights, General Comment No. 22 (2016) on the right to sexual and reproductive health, paras. 28, 63; African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para.28, 51, 52.
[66] UNFPA State of the World Population 2013, Motherhood in Childhood: Facing the challenge of adolescent pregnancy (2013) http://www.unfpa.org/publications/state-world-population-2013.
[67] UNFPA State of the World Population 2013, Motherhood in Childhood: Facing the challenge of adolescent pregnancy (2013) http://www.unfpa.org/publications/state-world-population-2013.
[68] African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para. 28; The Committee on Economic, Social and Cultural Rights, General Comment No. 22 (2016) on the right to sexual and reproductive health, paras. 19, 47, 63.

The ACHPR notes that sexual and reproductive rights issues must be included in school programs, including in private and faith -based schools, throughout education, including in primary, secondary and tertiary levels and have programs that reach those out of school.[70] Similarly, CESCR's General Comment 22 and other UN standards note that sexual and reproductive health information should be comprehensive, unbiased, and scientifically accurate. They note that sexuality education programs should include information on preventing unwanted pregnancy, sexual and reproductive health and rights, risks of unsafe abortions, the legality of abortion, and preventing STIs, including HIV. Sexuality education should also aim to transform cultural views about adolescents' need for contraception and other taboos regarding adolescent sexuality. Such programs also should not reinforce stereotypes or prejudice, and should not include discriminatory information based on sexual orientation and/or gender identity.[71]

Marginalized Populations

Individuals belonging to marginalized and underserved populations often face barriers, in law or in practice, in accessing or in receiving sexual and reproductive health services. These barriers can sometimes be discriminatory and illegal under international law and national laws and constitutions. Both the UN and The African human rights systems prohibit discrimination. The Maputo Protocol focuses on discrimination against women and the CESCR includes discrimination against women, including in accessing sexual and reproductive health care. (see section above on equality and non-discrimination).

Both General Comments recognize how sexual and reproductive health care has been disproportionately and discriminatorily denied to certain vulnerable groups, including persons with disabilities and lesbian, gay, bisexual, transgender, and intersex (LGBTI) individuals, migrants, refugees, people living with HIV, people living in rural areas, and young people. The CESCR and the Maputo Protocol and their corresponding General Comments urge states to recognize that persons belonging to these groups require special attention for the realization and respect of their sexual and reproductive health and rights and to ensure that they are receiving adequate, appropriate, accessible, and quality care that responds to their particular needs.

ACHPR General Comment 2 calls on states parties to:

> '...take all appropriate measures to remove the obstacles such as those arising from marital.[72]

[69] African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para. 51
[70] African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para. 52.
[71] The Committee on Economic, Social and Cultural Rights, General Comment No. 22 (2016) on the right to sexual and reproductive health, paras. 19, 47, 63.
[72] The Committee on Economic, Social and Cultural Rights, General Comment No. 22 (2016) on the right to sexual and reproductive health, paras. 30, 31; African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para. 43.

status, age, disability as well as economic and geographic barriers faced by women who want access to family planning/contraception and safe abortion services, especially young women, teenage girls, women living with disabilities and women in situations of conflict, displaced or refugee women, as well as rural women.'[73]

These obligations include making accommodations to ensure that the barriers faced by vulnerable groups in accessing health facilities can be overcome, such as structural changes to make them accessible for people with physical disabilities or making information available in languages and formats needed by the community, or ensuring the availability and accessibility of services in rural areas.[75] In some countries on the continent, maternal mortality is up to three times higher in rural areas.[75] In addition, some people face compounded discrimination based on their various identities or characteristics. For example, certain groups of women are subjected to abusive treatment, such as HIV positive pregnant women (see box above on coercive sterilization practices). CESCR General Comment 22 advises States to adopt comprehensive strategies to address multiple discrimination against women belonging to such marginalized groups.[76] This includes the obligation to eliminate stereotypes, which can drive discrimination against these groups, including through public awareness-raising campaigns, training of health care providers on diversity and tolerance; and through sanctions when violations occur. [77]

Adolescent and Youth Autonomy

Adolescents, in particular, face numerous barriers in exercising their sexual and reproductive autonomy. In marriage and access to sexual and reproductive health services, for example, adolescents face numerous obstacles, including stigmatization of their sexuality, and laws and policies that discriminate based on age or mandate parental consent for reproductive health services, and their overall low social status. The resulting lack of autonomy hinders access to confidential health care and comprehensive sexuality education, encountering barriers to contraceptive access, for example. It also subjects them to harmful practices, such as child and forced marriage or female genital mutilation.

Across the continent, adolescent birth rates remain very high in many countries. 67% of married adolescent women who want to avoid pregnancy, are not using any method of contraception, and 12% are using a traditional method. Each year, births to adolescents aged 15 to 19 account for 16 per cent of all births. The youngest adolescents are the most likely to experience complications or death due to pregnancy and childbearing. Adolescents account for 14% of all unsafe abortions that occur in the developing world. In Sub-Saharan Africa, the proportion is 25%.[79] In fact, pregnancy-related deaths are the leading cause of death for adolescent girls in sub Saharan Africa.[80] Furthermore, adolescents who become pregnant are likely to have lower educational attainments, in part due to policies in some countries permitting or mandating expulsion of pregnant students.

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[73] African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para. 61.

[74] The Committee on Economic, Social and Cultural Rights, General Comment No. 22 (2016) on the right to sexual and reproductive health, paras. 16, 19, 63.

[75] Alkema L, Chou D, Hogan D, Zhang S, Moller AB, Gemmill A, et al. Global, regional, and national levels and trends in maternal mortality between 1990 and 2015, with scenario-based projections to 2030: a systematic analysis by the UN Maternal Mortality Estimation Inter-Agency Group, Lancet. 2016; 387 (10017): 462-74.

[76] The Committee on Economic, Social and Cultural Rights, General Comment No. 22 (2016) on the right to sexual and reproductive health, paras. 30, 31.

[77] The Committee on Economic, Social and Cultural Rights, General Comment No. 22 (2016) on the right to sexual and reproductive health, paras. 27, 31, 35, 36.

[78] Guttmacher Institute and IPPF, Facts on the Sexual and Reproductive Health of Adolescent Women in the Developing World, https://www.guttmacher.org/sites/default/files/pdfs/pubs/FB-Adolescents-SRH.pdf.

ACHPR General Comment 2 recognizes the vulnerability to maternal mortality faced by adolescent girls.[82] The Comment emphasizes that particular attention be paid to preventing interference by third parties, recognizing that adolescent girls are particularly vulnerable. The 'obligation entails the formulation of standards and guidelines containing the provision that the consent and involvement of third parties, including but not limited to, parents, guardians, spouses and partners, is not required when adult women and adolescent girls want to access family planning/contraception and safe abortion services in the cases provided for in the Protocol.'[83]

CESCR General Comment 22 also recognizes that the right to sexual and reproductive health requires States to ensure that all adolescents have the same right to access health care without third party authorization, whether that is a spouse or a parent, and whether the adolescent is married or unmarried.[84] Human rights bodies recognize that children are more likely to use health services that are friendly and supportive, that give them the opportunity to participate in decisions affecting their health, that are confidential and non-judgmental, and that do not require parental consent nor are discriminatory.[85]

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[79] Guttmacher Institute and IPPF, Facts on the Sexual and Reproductive Health of Adolescent Women in the Developing World, https://www.guttmacher.org/sites/default/files/pdfs/pubs/FB-Adolescents-SRH.pdf.
[80] Patton GC. Global patterns of mortality in young people: a systematic analysis of population health data. The Lancet, 2009, 374(9693):881–92.
[81] UNFPA State of the World Population 2013, Motherhood in Childhood: Facing the challenge of adolescent pregnancy (2013) http://www.unfpa.org/publications/state-world-population-2013.
[82] African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para. 39.
[83] African Commission on Human and Peoples' Rights, General Comment 2 (2014) on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c), to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para. 43.
[84] The Committee on Economic, Social and Cultural Rights, General Comment No. 22 (2016) on the right to sexual and reproductive health, para. 41; Additionally, the U.N. Committee on the Rights of the Child, which monitors state compliance with the Convention on the Rights of the Child, has noted that states parties should consider 'the introduction of a legal presumption that adolescents are competent to seek and have access to preventive or time-sensitive sexual and reproductive health commodities and services.' It has urged states to consider allowing children to consent to certain medical treatment without the consent of a parent or guardian, including sexual and reproductive health services such as contraception and safe abortion, Children's Rights Committee General Comment No. 20 (2016) on the implementation of the rights of the child during adolescence, para 39.
[85] See for example, Report of the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on the right to health of adolescents (2016).

Conclusion

It is critical that States take measures to ensure that their domestic laws and policies are in line with these international and regional human rights standards. States must ensure that their laws, policies and practices protect sexual and reproductive health and rights, with particular attention to ensuring autonomy, non-discrimination, and equality. They also have an obligation to ensure their implementation, including taking measures to ensure access to sexual and reproductive health care based on these principles and that sexual and reproductive health information and services are available, accessible, acceptable, and of good quality, and that accountability measures are in place which enable the development of effective laws, policies and practices, and which guarantee an effective remedy when violations do occur.

States should take measures such as:

- Ratifying and domesticating the Maputo Protocol and ensuring its full implementation, including Article 14;
- Ensuring laws and policies, and their implementation prohibit discrimination in the provision of reproductive health services, including repealing laws that criminalize services that only women need and taking into consideration the specific needs of marginalized populations;
- Ensuring women and girls have access to the full range of maternal health services, including safe abortion services both in law and in practice;
- Removing barriers to accessing contraception, including emergency contraception, and safe abortion services, such as parental or spousal authorization requirements;
- Ensuring laws and practices respect the right to informed consent in reproductive health care services, especially for marginalized populations, with particular safeguards against involuntary sterilization;
- Guaranteeing that comprehensive reproductive health care is affordable and geographically and physically accessible;
- Guaranteeing all, including adolescents, the right to full and accurate information on sexual and reproductive health and rights, including formal sexuality education;
- Respecting privacy and confidentiality in the provision of sexual and reproductive health care, including adolescents;
- Ensuring there are adequate budgetary allocations for the full implementation of laws and policies on sexual and reproductive health;
- Ensuring the broad participation of key stakeholders in the formulation, implementation and monitoring of laws, including relevant government bodies and ministries, and external stakeholders such as civil society, women groups and the marginalized groups being impacted;
- Consistently monitoring and evaluating laws and policies to ensure their implementation and attainment of their desired aims, including by collecting disaggregated data and putting in place rigorous mechanisms for monitoring and evaluation;
- Ensuring that individuals harmed by human rights violations have access to appropriate and adequate remedies and take measures to prevent human rights violations from recurring, and to hold those responsible for the violations to account.

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