Article 14

Health and reproductive rights

Ebenezer Durojaye

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.

1 Introduction

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) is the first human rights instrument that expressly articulates the rights of women and girls in Africa. Its adoption was informed by a series of activities that started with the plans of

action adopted in Dakar, Senegal, in 1994 and Beijing in 1995.[1] The significance of this chapter lies in the need to cover the gap in the literature on the rationale for the adoption of the Maputo Protocol as a whole, but more importantly, the contextual reasoning behind the adoption of the wording in article 14. Of equal importance is the need to examine the nature and scope of state party obligations and to identify emerging practices regarding the implementation of article 14 by both state parties and stakeholders. The importance of this chapter also lies in the author's attempt to map a relationship between article 14 of the Protocol and other human rights institutions.

Article 14 of the Maputo Protocol provides normative health and reproductive rights guidance. This chapter is important because it sets the broad recognition of women's and girls' right to health and reproductive health. The right to health is one of the fundamental rights crucial for women's well-being. For a continent that bears the burden of sexual and reproductive ill health, the importance of article 14 cannot be overemphasised. The Maputo Protocol complements the provision in the African Charter on Human and Peoples' Rights on the right to the highest attainable standard of health,[2] as well as the provision on health and health services in the African Charter on the Rights and Welfare of the Child.[3] While in many instances, article 14 draws inspiration from international human rights instruments such as the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Convention on Elimination of All Forms of Discrimination Against Women (CEDAW), in some instances, the provisions of the Protocol's article 14 break new ground.

A recent report indicates that the mortality rate of sub-Saharan African women is 533 per 100,000 live births annually.[4] This is exacerbated by the fact that women in Africa suffer the consequences of unsafe abortion-related issues.[5] This is an escalation from earlier statistics that indicate that while Africa accounts for about one-tenth of the world's population and 20 per cent of global births, approximately half of the mothers who die during pregnancy and childbirth are from Africa.[6] In light of the foregoing statistics, the specific aspects of reproductive rights and their known benefits remain out of reach for most populations. Some of the critical aspects of women's reproductive rights, such as family planning and the use of contraception, remain low at about 13 per cent at an unparalleled rate of 5.5 children per woman.[7] It has been noted that the ability of a woman to determine the number and spacing of children is crucial to her well-being and the realisation of her human rights.[8] This chapter offers an academic audit of article 14 of the Maputo Protocol as an important step towards improving its implementation.

1 See fourth and fifth preambular paragraph of the draft protocol, Expert Meeting on the Preparation of a Draft Protocol to the African Charter on Human and Peoples' Rights Concerning the Rights of Women, Nouakchott, Islamic Republic of Mauritania, 12-14 April 1997 (Nouakchott Draft).

2 This is in the cumulative interpretation of this is in the cumulative interpretation of arts 1(b), (e), (g), 14, 16 & 18. This is in line with the UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment 14: The Right to the Highest Attainable Standard of Health (art 12 of the Covenant), 11 August 2000, UN Doc E/C.12/2000/4 paras 1, 2, 4, 8, 9, 27, 47, 49 & 53.

3 See African Charter on the Rights and Welfare of the Child art 14.

4 L Rodriguez 'Why maternal mortality is so high in sub-Saharan Africa' (2021) Global Citizen https://bit.ly/3t0QCAo (accessed 23 June 2023).

5 S Singh 'Global consequences of unsafe abortion' (2010) 6 *Women's Health* 849-860.

6 T Ketsela 'Reproductive health in the African region. What has been done to improve the situation?' https://bit.ly/3PDFkM7 (accessed 23 June 2023).

7 Ketsela (n 6).

8 See UN Women *Progress of the world's women: families in a changing world* (2019) 56.

With regard to conceptual issues, this chapter is one of the most progressive and radical as well as controversial provisions of the instrument.[9] It is the first human rights instrument to protect the rights of women in the context of HIV. Equally, it is the first to affirm a state's obligation to ensure access to safe abortion services, albeit in designated circumstances.[10] The issues addressed in the provision respond to the realities of the African context. The concept of sexual and reproductive rights has been expounded in a non-conclusive list that includes fertility,[11] decision-making on having children, their number and their spacing,[12] contraception,[13] and self-protection against sexually transmitted infections.[14] The state is also expected to balance the right to privacy against the right to information on one's health status and the health status of one's partner, particularly if affected by sexually transmitted infections.[15] The final concept relates to the ensuring and promotion of the right to have family planning education.[16]

Various countries have not actively implemented article 14 of the Maputo Protocol. This is due to various reasons such as logistical challenges to ensure the progressive realisation of sexual and reproductive health and rights (SRHR), lack of political goodwill and the failure to prioritise SRHR. These challenges exist in instances where the state parties have not entered reservations or interpretative declarations to the implementation of the Maputo Protocol. On the other hand, some states have engaged in other drastic steps to stifle the implementation of the Maputo Protocol – and numerous examples show this. This includes the entry of reservations by Kenya and Namibia and interpretative reservations by Uganda and Rwanda.[17] In addition, as of 2022, 6 out of 55 countries in Africa outlawed abortion without any exception.[18] These are Morocco, Mauritania, Senegal, Sierra Leone, Egypt and Madagascar.[19] Consequently, as of 2022, a great percentage of African women in various countries still have restrictive abortion laws.[20] In instances where abortion is allowed, women find navigating the process to obtain a safe and legal procedure hard. In many African countries, access to sexual and reproductive health information to prevent unwanted pregnancies remains a source of contestation. Due to religious and cultural beliefs, stiff opposition to teaching comprehensive sexuality education in schools has remained a source of concern. [21] This has been associated with high rates of teenage pregnancies in the region. Cross-regional comparisons from 24 countries from East, West, Central, North and Southern African sub-regions showed a high prevalence of 21.5 per cent in East

9 See F Banda 'Blazing the trail: the African Protocol on women's rights comes into force' (2006) 50 *Journal of African Law* 72-84, see also F Viljoen 'An introduction to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women' (2009) 16 *Washington and Lee Journal of Civil Rights and Social Justice* 11-47.

10 For more on this see, E Durojaye 'An analysis of the contribution of the African human rights system to the understanding of the right to health' (2021) 21 *African Human Rights Law Journal* 751-781.

11 Maputo Protocol art 14(1)(a).

12 Maputo Protocol art 14(1)(b).

13 Maputo Protocol art 14(1)(c).

14 Maputo Protocol art 14(1)(d).

15 Maputo Protocol art 14(1)(e).

16 Maputo Protocol art 14(1).

17 L Asuagbor (2016) Status of the implementation of the African Charter on Human and Peoples' Rights on the Rights of Women (Maputo Protocol), Commissioner and Special Rapporteur on Rights of Women in Africa (African Commission on Human and Peoples' Rights) 60th meeting Commission on the Status of Women 18 March 2016, New York, paras 1-5. The United Nations Office of Legal Affairs (Treaty Handbook) defines interpretative declarations, unlike reservations, as not purporting to exclude or modify the legal effects of a treaty. Rather they serve the purpose of clarifying the meaning of certain provisions or of the entire treaty. See para 3.6.1, http:/untreaty.un.org/Englisti TreatvHandboolkyhbframeset. htm (accessed 8 March 2023).

18 M Armstrong 'Twenty-eight years of progress: legal status of abortion in African countries in 1994 and 2022' 18 May https://www.statista.com/chart/27472/abortion-legal-status-african-countries-timeline/ (accessed 23 June 2023).

19 Armstrong (n 18).

20 Armstrong (n 18). Seventeen countries have legislation that supports abortion to save the life of a woman, and nineteen countries regarding the preservation of health.

21 See for instance, E Durojaye 'Legal and human rights dilemma in sexuality education in Africa' (2016) *International Journal of Public Law and Policy* 305-316.

Africa, 9.2 per cent in Northern Africa and 18 per cent in sub-Saharan Africa.[22] Therefore, Africa is home to a large number of teenage mothers.[23]

Over three decades into the HIV/AIDS pandemic, there are concerns that new infection rates in the region are fuelled by stigma and discrimination, human rights violations and a lack of political will on the part of African governments. While significant progress has been made in addressing the epidemic, Africa remains its epicentre. Yet, efforts to ensure universal access to HIV treatment are still far from reality, given the disparities among the sub-regions.[24] This scenario, coupled with the devastating effect of COVID-19, makes it imperative for African governments to strive to live up to their obligations under article 14 of the Protocol. Emerging research shows that the economic impact of the pandemic has hit women hard because approximately 74 per cent are gainfully employed in the informal sector of the economy as street vendors and domestic workers, while they receive low pay in other formal sectors like tourism and the hospitality industry.[25]

This chapter is organised into seven sections. Following this introduction, the second section discusses the drafting history of article 14. Section 3 explores the article's relationship with other relevant treaty provisions. Section 4 discusses the evaluation of the interpretative rendering by the treaty body and relates SRHR to other rights. The fifth section engages with the nature and scope of state parties' obligations. Section 6 evaluates the measures taken by states in the implementation of the article. Section 7 presents the conclusion and recommendations. This chapter aims to give an understanding of the normative foundations of SRHR in the Maputo Protocol and evaluate the various jurisprudential developments in the interpretation of article 14.

2 Drafting history

The Nouakchott Draft[26] version of the current article 14 of the Maputo Protocol was at the Experts Meeting organised by the International Commission of Jurists and the African Commission on Human and Peoples' Rights (African Commission) in Nouakchott, Mauritania.[27] The draft article that was presented for discussion had a different text. The first draft of the article (15 as it then was) provided:

> With reference to article 16 of the African Charter on Human and Peoples' Rights, women shall benefit from the right to health on an equal footing with men. They are entitled, therefore, to exercise control over their fertility, to decide to give birth, when to give birth, chose [sic] any method of contraception, and to protect themselves against sexually transmitted diseases. State Parties shall take adequate measures to: entitle women to benefit from the right to have an abortion and to exercise this right.[28]

Two important positions were presented in the Nouakchott Draft. First, this draft pointed to five intricate aspects: equality of both men and women in accessing the right to health, discretion on the part of

22 GM Kassa, AO Arowojolu, AA Odukogbe & AW Yalew 'Prevalence and determinants of adolescent pregnancy in Africa: a systematic review and meta-analysis' (2018) 15 *Reproductive Health* 195.

23 S Mkwananzi 'It takes two to tango! The relevance and dilemma in involving men in the realisation of sexual and reproductive health and rights in Africa' in E Durojaye, G Mirugi-Mukundi & C Ngwena (eds) *Advancing sexual and reproductive health and rights in Africa: constraints and opportunities* (2021) 84.

24 UNAIDS *Global 2020 Report* (2020).

25 Office of the High Commissioner for Human Rights (2022) Covid-19 and women rights: 7 possible actions, https://bit.ly/3Rs26GU (accessed 23 June 2023).

26 Nouakchott Draft (n 1).

27 Abortion in Africa Guttmacher Institute (2021) https://www.guttmacher.org/sites/default/files/factsheet/ib_aww-africa.pdf (accessed 29 July 2022). The countries include Angola, Congo-Brazzaville, Congo-Kinshasa, Egypt, Gabon, GuineaBissau, Madagascar, Mauritania, São Tomé and Príncipe, Senegal.

28 Article 15 of the draft protocol prepared by the International Association of Jurists in collaboration with the African Commission on Human and Peoples' in Nouakchott, Mauritania, 12-14 April 1997 (ICJ Draft).

women to exercise control over their fertility, autonomous decision-making concerning childbirth and selection of mode of contraception, and mandatory protection against sexually transmitted diseases.[29] Second, the Nouakchott Draft also spoke to the need to enable the enjoyment of the right to sexual and reproductive health.[30] Such enablers include the need to facilitate access to health services for women within reasonable distances and at affordable costs.[31] In addition, the drafters proposed that states provide pre-and post-natal care and adequate nutrition during pregnancy and lactation.[32]

It is worth mentioning that this draft proposed guaranteeing women an unqualified right to abortion services. The draft took a much more expansive approach than the current provision in the Maputo Protocol, which is further discussed below. One other point to note is that the draft provision was silent on protecting women from HIV, as currently contained in the Maputo Protocol.[33] The reason for this omission is unclear, given that the HIV pandemic was already acknowledged as a threat to the lives of women at that time.

The second draft was presented at a meeting in Kigali in 1999 as article 16.[34] It provided:

1. With reference to article 16 of the African Charter, women shall have the right to health. This right includes:
   (a) the right to control their fertility;
   (b) the right to decide whether to have children;
   (c) the right to space their children;
   (d) the right to choose any method of contraception;
   (e) the right to protect themselves against sexually transmitted diseases;
   (f) the right to be informed on one's health status and on the health status of one's partner;
2. State Parties to this Protocol shall take appropriate measures to:
   (a) provide adequate, affordable and accessible health services to women especially those in rural areas;
   (b) establish pre-and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding;
   (c) protect the reproductive rights of women particularly in cases of rape and incest.[35]

This represents a significant departure from the Nouakchott Draft. First, it deviates from the focus on equality between men and women, instead setting out in detail the health and reproductive rights of a woman. It reiterates the discretion on the part of women to exercise control over their fertility, the decision to give birth, the choice in the selection of mode of contraception, and the mandatory protection against sexually transmitted diseases. In addition, the Kigali Draft introduces two important aspects: the right to decide on child spacing and the right to be informed of one's health status and that of one's partner.

Second, the Kigali Draft also refers to the need for enablers for the enjoyment of the right to sexual and reproductive health. These are framed as obligations on the part of the state. These include the need to go beyond access and affordability to adequate health services for women within rural areas, the provision of pre-and post-natal care, especially during breastfeeding, and the protection of reproductive rights in cases of rape and incest.

29 ICJ Draft (n 28) art 15.

30 As above.

31 As above.

32 As above.

33 There is a lack of documentation on the reasons that informed the first draft, and the subsequent draft.

34 Second Draft Protocol to the African Charter on Women's Rights, 26th ordinary session of the African Commission on Human and Peoples' Rights 1-15 November 1999 Kigali, Rwanda (Kigali Draft).

35 Kigali Draft (n 34) art 16.

While minor editorial changes were made to the Kigali Draft, the subsequent version upheld a woman's right to information on her health status and that of her partner, trumping concerns over the right to privacy.[36] It is argued that the drafters sought to ensure that the right to privacy was appropriately balanced against the woman's autonomy over her health and accessing information about the health condition of her partner.[37] In addition, the right to family planning was extended to include information and services.[38] In addition to establishing pre and post-natal health and nutritional services, state parties are obliged to enhance the existing ones.[39] The Kigali Draft did not provide for an obligation on states to ensure that women have access to safe and legal abortion services as a bare minimum in instances of sexual assault such as rape and incest or where their life, physical or mental health was in danger.[40] In addition, the Kigali Draft made a vague requirement on state parties to 'protect the reproductive right of women particularly in cases of rape and incest', without providing any further detail. The lack of detail in the Kigali Draft invites speculation as to what informed the unambiguous provision in the final version on this specific issue.

The Final Draft[41] drew input from government experts who proposed a few changes.[42] First, there was an overlap between clauses 13(b) and (c).[43] The merged clause read: 'the right to make decisions concerning reproduction'. Second, the experts reiterated that the right to information on the health status of one's partner would affect the right to privacy. It was proposed that the text would be retained if the application of the article was subjected to the limitation test.[44] Third, the application of the article would be limited to an 'infected' rather than an 'affected' partner.[45]

Unfortunately, a look at the drafting history does not explain the reason for the origin or the reasons for the inclusion of the various components of SRHR under article 14. This lack of detailed drafting history to use to understand the intent of the drafters is a shortcoming to understanding article 14. In contrast, articles such as article 13 are punctuated with extensive insights, such as an NGO commentary. Regarding article 14, its history simply tells us that the provision underwent various amendments. While the article is titled 'Health and Reproductive Rights', the provision also leaves open the possibility of a broad construction to include sexual health and rights.[46]

36 Revised Final Draft CAB/LEG/66.6/Rev.1, 22 November 2001 (Revised Final Draft) art 13(1)(e).

37 Revised Final Draft (n 36) art 13(1)(e).

38 As above.

39 As above.

40 As above.

41 Report of the Meeting of Experts on the Draft Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, Expt/Prot.Women/Rpt(I), Addis Ababa, Ethiopia, November 2001 (Report of the Meeting of Experts) para 86.

42 For avoidance of having large quotations on this draft, please compare the text of art 16 (quoted above) of the Second Draft Protocol to the African Charter on Women's Rights (Kigali 15 November 1999).

43 Government Experts Meetings 16 November 2001, art 13(1), and notes thereon.

44 As above.

45 As above.

46 See E Durojaye & N Murungi 'The African Women's Protocol and sexual rights' (2014) 18 *International Journal of Human Rights* 881-897.

Various moral and political controversies unfolded during the discussion of the article especially with regard to abortion. Most of the countries formed the opinion that abortion needed not to be allowed in their communities because of cultural and religious beliefs.[47] Civil society played a critical role in advancing the narrative for a stronger draft that would speak to aspects of abortion, among other things. For instance, in 2002, FEMNET raised the concern that the draft Protocol was generally weak.[48] This led to the convening of more consultation meetings by other civil society organisations such as Women in Law and Development in Africa, Equality Now and the African Centre for Democracy and Human Rights Studies in January 2003 in Addis Ababa. The author is of the view that the AU's 2004 commitment to the Solemn Declaration on Gender Equality indirectly had a bearing on the final version of article 14. This was largely because it called on member states to continue their action towards achieving gender equality and reinforcing their commitment to international and regional women's rights instruments such as the Maputo Protocol.[49]

3 Linkages to other treaty provisions

Various human rights have implications for sexual and reproductive rights. They include the rights to life,[50] dignity,[51] education and information,[52] equality and non-discrimination, and the right to full consent to and equality in marriage.[53] Within the Maputo Protocol, specific provisions have a demonstrably close relationship with article 14. For instance, the provisions on violence against women are very instructive. The wide definition of violence encapsulates aspects of physical, sexual, psychological, and economic harm that fit in neatly with any acts of the state that may stifle the enjoyment of sexual and reproductive rights.[54] In addition, the right to dignity requires states parties to adopt and implement appropriate measures to protect every woman's right, including the right to reproductive health.[55] Another important link to article 14 is the call on state parties to eliminate harmful practices that negatively affect women's human rights, such as the protection of women who are at risk of being subjected to harmful practices, abuse and intolerance.[56]

47 This was evident in the reservation to the application of the final text of the Maputo Protocol art 14(2)(c). See the discussion under sec 6 below.

48 African Women's Organizing for the Ratification and Implementation of the Maputo Protocol https://www.awid.org/news-and-analysis/african-womens-organizing-ratification-and-implementation-maputo-protocol (accessed 28 February 2023).

49 Solemn Declaration on Gender Equality in Africa (SDGEA) https://blogs.lse.ac.uk/vaw/sdgea/ (23 June 2023).

50 General Comment 14 (n 2) para 3 provides that 'the right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the right to health'.

51 General Comment 14 (n 2) para 3.

52 General Comment 14 (n 2) paras 3, 11 & 16.

53 See the Maputo Protocol art 6; Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) art 16; International Covenant on Civil and Political Rights (ICCPR) art 23(4).

54 Article 1(j) defines violence against women to include all acts perpetrated against women which cause or could cause them physical, sexual, psychological, and economic harm, including the threat to take such acts; or to undertake the imposition of arbitrary restrictions on or deprivation of fundamental freedoms in private or public life in peace time and during situations of armed conflicts or of war. The conceptualisation of violence in physical, sexual, psychological and economic contexts includes violations of sexual and reproductive health and rights.

55 Article 3(4) provides for the right to dignity.

56 Article 5(d). Article 5 provides for the right to elimination of harmful practices.

Other rights include the right to privacy;[57] the right to be free from torture or other cruel, inhuman and degrading treatment or punishment,[58] to be free from sexual and gender-based violence; from practices that harm women and girls; and the right to an effective remedy.[59] It should be noted that SRHR is potentially linked to various rights. This is briefly elucidated hereunder. First and foremost, the obligation on states parties to combat all forms of discrimination against women through appropriate legislative, institutional and other measures points to the recognition of their right to human dignity as individuals as a critical pillar in the protection of both her civil and political liberties as well as her socio-economic rights.[60] The elimination of harmful practices such as female genital mutilation goes a long way to enhance a woman's SRHR as well as the right to life that can be interfered with by such practices.[61] In equal measure, the respect of a woman's SRHR complements the protection of her right to life in the context of the quality of life that is punctuated by the provision of adequate health services and the right to decide when to have children.[62] This protection extends from areas of peace to areas with armed conflict or places of displacement and refugee host communities.[63]

These various rights provide an enabling platform that empowers and guarantees individuals and persons in relationships (especially women) to make decisions around matters of bodily integrity and family relations.[64] The right to sexual and reproductive health is interdependent with these and other related human rights.[65]

According to General Comment 22 of the Committee on Economic, Social and Cultural Rights (CESCR), the right to sexual and reproductive health is linked to the right to education, non-discrimination and equality between men and women.[66] In the same vein, the right to work[67] coupled with just and favourable working conditions[68] calls for a mandate on states to ensure employment with maternity protection and parental leave for workers.[69]

The provisions of the Maputo Protocol, in general, and article 14, in particular, are influenced by existing human rights instruments and standards. These include binding instruments such as the

57 ICCPR (n 53) art 17. This article mandates that no one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation. Clause 2 calls on the State to provide for the protection of the law against such interference and attacks.

58 ICCPR (n 53) art 23. See also the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

59 To this end, CEDAW is very instructive.

60 See Maputo Protocol arts 1 & 3.

61 See Maputo Protocol art 5. Under art 5, states parties shall prohibit and condemn all forms of harmful practices which negatively affect the human rights of women and which are contrary to recognised international standards.

62 See Maputo Protocol arts 3 & 4.

63 Article 9 calls on states parties to undertake to protect asylum seeking women, refugees, returnees and internally displaced persons, against all forms of violence, rape and other forms of sexual exploitation, and to ensure that such acts are considered war crimes, genocide and/or crimes against humanity and that their perpetrators are brought to justice before a competent criminal jurisdiction.

64 Such decisions inform the various sexual and reproductive rights that determine the size of families, where women are guaranteed safe and healthy pregnancies. This also addresses other intricate aspects such as protection against sexually transmitted infections like HIV and other sexually transmitted infections.

65 Committee on Economic, Social and Cultural Rights General Comment 22 (2016) on the right to sexual and reproductive health (art 12 of the International Covenant on Economic, Social and Cultural Rights, UU Doc E/C.12/GC/22).

66 General Comment 22 (n 65) para 9.

67 Under the ICESCR art 6.

68 Under the ICESCR art 7.

69 African Commission General Comment 2 on art 14(1)(a), (b), (c) & (f) & art 14(2)(a) & (c) of the Protocol to African Charter on Human and Peoples' Rights on the Rights of Women in Africa, adopted during the 54th ordinary session of the African Commission held in Banjul, The Gambia, 22 October-5 November 2013 para 9 (African Commission General Comment 2).

ICESCR, CEDAW and the Convention on the Rights of the Child (CRC), and the interpretation provided by the relevant monitoring bodies. In addition, decisions reached at important international meetings such as the International Conference and Population and Development[70] and the Fourth World Conference on Women 1995 have inspired the provisions of the Protocol.[71] Article 14 has a relation in both general and specific terms. Concerning the Universal Declaration of Human Rights, there is an emphasis on the recognition of the right of all persons to an adequate standard of living, including guarantees for health and well-being.[72]

The ICESCR takes on a wide spectrum of the right to health by recognising 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.'[73] As indicated earlier, states need to use progressive realisation to achieve the full realisation of this right as provided for in the CESCR in its General Comments 14 and 22.[74] In these general comments, the CESCR emphasises the need to ensure access to health care, including sexual and reproductive health care services, to all on a non-discriminatory basis.[75] The CESCR further emphasises that health care services, including sexual and reproductive health care services, must be made available, accessible, acceptable and of good quality.[76] Article 12 of the ICESCR, together with the interpretive comments, provide a good guide to developing the jurisprudence of article 14 of the Maputo Protocol. The African Commission always encourages drawing inspiration from other international law sources.[77]

Various other international instruments speak about the right to health generally. For instance, the CRC also recognises the right to health for children.[78] The CEDAW obligates states to adopt measures to guarantee women's access to health and medical care, with no discrimination whatsoever, including access to family planning services.[79] States parties to CEDAW are required to take all appropriate measures to eliminate discrimination against women in the area of health care to ensure that on a platform of equality of men and women, there is access to health care services, such as family planning.[80] The CEDAW mandates state parties to ensure that women have appropriate pregnancy and post-natal care services.[81] The CEDAW Committee has noted that failure by states to ensure health care services peculiar to women's needs will amount to discrimination under the Convention.[82]

70 UN Population Fund (UNFPA), Report of the International Conference on Population and Development, Cairo, 5-13 September 1994, 1995, UN Doc A/CONF.171/13/Rev.1.

71 United Nations, Beijing Declaration and Platform for Action, adopted at the Fourth World Conference on Women, 27 October 1995, UN Doc A/CONF.177/20 (1995) and UN Doc A/CONF.177/20/Add.1 (1995).

72 Universal Declaration of Human Rights, art 16.

73 ICESCR art 12.

74 General Comment 14 (n 2) and General Comment 2 (n 69)

75 As above.

76 As above.

77 African Charter on Human and Peoples' Rights art 60. It states that 'the Commission shall draw inspiration from international law on human and peoples' rights, particularly from the provisions of various African instruments on human and peoples' rights, the Charter of the United Nations, the Charter of the Organization of African Unity, the Universal Declaration of Human Rights, other instruments adopted by the United Nations and by African countries in the field of human and peoples' rights as well as from the provisions of various instruments adopted within the Specialized Agencies of the United Nations of which the parties to the present Charter are members'.

78 UN Convention on the Rights of the Child art 24, See also UN Committee on the Rights of the Child (CRC), General Comment 15 (2013) on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health (art 24), 17 April 2013, UN Doc CRC/C/GC/15.

79 CEDAW (n 53) art 12.

80 CEDAW (n 53) art 12(1).

81 CEDAW (n 53) art 12(2).

82 UN Committee on the Elimination of Discrimination Against Women (CEDAW), CEDAW General Recommendation 24: art 12 of the Convention (Women and Health), 1999, UN Doc A/54/38/Rev.1.

Articles 14 of the Maputo Protocol and 16 of the African Charter both provide for the enjoyment of the right to health in the context of the highest attainable standard. The normative guidance from the African Charter provides a platform for the interpretation and application of article 14 of the Maputo Protocol. States parties are expected to use 'necessary measures' and guarantee medical services. The Commission has clarified this provision through its Principles and Guidelines for the Implementation of the Economic, Social and Cultural Rights in the Charter (Nairobi Principles),[83] its Concluding Observations and its jurisprudence. In the Nairobi Principles, the Commission observes that a broad interpretation must be given to the right to health to encompass access to relevant goods and services.[84] It aligns itself with the concept of minimum core for the enjoyment of the right to health and urges states to allocate adequate resources to realise the right to health.[85] In some of its decisions, the Commission has reiterated the point that the enjoyment of the right to health goes beyond access to health care but includes provisions of relevant goods and services for the realisation of this right.[86] More importantly, the Commission has urged states to remove all barriers to the enjoyment of this right by embarking on law reforms and allocating adequate resources to the health sector.[87]

4 Concepts and definitions

Article 14 raises conceptual issues that need to be defined and or interpreted. These include the right to health, sexual and reproductive health, progressive realisation, adequate, affordable, accessible and acceptable health services, and the right to self-protection.

In its first General Comment on article 14(1)(d) and (e) of the Maputo Protocol, the African Commission explains that for women and girls to be protected from HIV infection, states must remove all barriers to women's enjoyment of their human rights and freedoms.[88] In this regard, the African Commission specifically requests states to dismantle cultural practices that undermine women's rights and ensure the adoption of laws and policies that guarantee equality for women.[89] The Commission further notes that other provisions of the Protocol must be guaranteed for women to be protected from sexually transmitted infections, including HIV. Thus, an overall context of protection of women's rights is crucial for undergirding the realisation of the rights guaranteed under article 14.

The second General Comment relates to the other provisions of article 14, where the African Commission affirms the right of women and girls to access sexual and reproductive health information and services on a non-discriminatory basis, prioritising those in rural areas.[90] The African Commission further urges states to remove all barriers to universal access to sexual and reproductive health services for women and girls, especially regarding abortion services.[91] The Commission urges states with

83 Adopted in Nairobi 2012 – The Guidelines and Principles for the Implementation of the Economic, Social and Cultural Rights in the African Charter.

84 Nairobi Principles (n 83).

85 Nairobi Principles (n 83).

86 *Purohit and Moore v The Gambia* (2003) AHRLR 96 (ACHPR 2003). See also *Free Legal Assistance Group v Zaire* (2000) AHRLR 74 (ACHPR 1995).

87 For instance, see Concluding Observations to Malawi in the Concluding Observations and Recommendations on the Initial and Combined Periodic Report of the Republic of Malawi on the Implementation of the African Charter on Human and Peoples' Rights (1995-2013), 57th ordinary session 4-18 November 2015, Banjul, The Gambia, paras 75-79.

88 African Commission General Comment 1 on art 14(1)(d) and (e) of the Protocol to African Charter on Human and Peoples' Rights on the Rights of Women in Africa, adopted during the 52nd ordinary session of the African Commission, held in Yamoussoukro, Ivory Coast, 9-22 October 2012.

89 General Comment 1 (n 88).

90 General Comment 2 (n 69).

91 General Comment 2 (n 69).

restrictive abortion laws to reform their laws to ensure access to safe abortion services within the grounds recognised under article 14.[92]

The right to health is accorded the meaning assigned to it in General Comment 22 of the Committee on Economic, Social and Cultural Rights (CESCR). It is defined as 'the highest attainable standard of health'.[93] Sexual and reproductive health amalgamates various freedoms and entitlements. These include the right to 'make free and responsible decisions and choices, free of violence, coercion and discrimination, regarding matters concerning one's body and sexual and reproductive health'.[94] The point of intersection between General Comment 22 and the Maputo Protocol's article 14 is in the reiteration of the need for access to health facilities, goods, services and information to inform the full enjoyment of the right to sexual and reproductive health.[95]

Since the right to health is a socio-economic right, the concept of progressive realisation takes centre stage. The African Commission's Principles and Guidelines on the Implementation of Socio-economic Rights offer insights on three fronts. First, it is informed by the availability of a state's resources.[96] It complements the African Charter's silence on the progressive realisation of socio-economic rights.[97] To this end, the state is expected to implement a reasonable and measurable plan subject to specific timeframes.[98] States are further reminded of the immediate realisation of some rights and the setting of achievable benchmarks and timeframes for the incremental enjoyment of rights over time.[99] Third, states are advised on various ways of raising resources, such as innovations in taxation based on an effective and fair system.[100]

It should be noted that in *Purohit and Moore v The Gambia*, the African Commission would seem to suggest that the right to health guaranteed in article 16 of the Charter is subject to progressive realisation.[101] In that case, the Commission explained that the obligation on states parties 'to take concrete and targeted steps while taking full advantage of their available resources, to ensure that the right to health is fully realised in all its aspects without discrimination of any kind', is implicit in article 16.[102]

The concept of progressive realisation takes on the understanding alluded to by the UN CESCR's General Comment 3 on the nature of state obligations. Concerning the right to sexual and reproductive health, states should take 'all appropriate means such as the adoption of legislative measures that are desirable and indispensable to establish normative guidance to promote and protect the rights of girls and women'.[103] The right to sexual and reproductive health is punctuated by availability, accessibility, affordability, acceptability and quality.[104]

92 General Comment 2 (n 69).

93 General Comment 14 (n 2) para 1.

94 General Comment 2 (n 69) para 5.

95 As above.

96 African Commission Principles on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights, para 13.

97 Principles on the Implementation of Economic, Social and Cultural Rights (n 96) para 13.

98 Principles on the Implementation of Economic, Social and Cultural Rights (n 96) para 14.

99 As above.

100 Principles on the Implementation of Economic, Social and Cultural Rights (n 96) para 15.

101 *Purohit* (n 86).

102 As above.

103 General Comment 2 (n 69) para 5.

104 General Comment 2 (n 69) paras 11-22.

5 Nature and scope of state obligations

The state has various obligations under article 14 of the Maputo Protocol, including respecting, protecting, promoting, and fulfilling African women's right to health and reproductive health.[105] State parties are mandated to recognise the rights, duties and freedoms in the Charter and adopt legislative or other measures to give effect to them.[106] The nuanced understanding of this provision may be found in some recent general comments.

As stated above, the African Commission has issued two General Comments to clarify the nature of states' obligations regarding the provisions of article 14. In the first General Comment, the Commission notes that to protect women from sexually transmitted infections, including HIV, states must ensure an enabling environment where the rights of women are respected. In the second General Comment, the Commission emphasises the need for states to remove barriers to contraceptive and abortion services for women.[107] In both General Comments, states are enjoined to repeal laws and policies that perpetuate the inequitable status of women in society in relation to men and ensure access to information and services on SRHR to all women on a non-discriminatory basis.

The provisions of article 14 impose obligations on the state to, first and foremost, ensure and promote the rights, and second, take appropriate measures. States have an obligation to ensure the respect and promotion of SRHR of women.[108] In this regard, states are mandated to take all appropriate measures in three thematic areas. First, to provide health services that are adequate, affordable, and accessible, especially in rural areas.[109] A codification of the elements of the right to health as expounded by the UN CESCR in its general comment 14.[110] Second, they must establish and strengthen health services in the three areas of pre-natal, delivery and post-natal services.[111] Third, to authorise medical abortion in instances of sexual violence or where the continued pregnancy endangers the mother's or foetus's life or health.[112]

5.1 Obligation to respect

Regarding the obligation to respect, states parties must refrain from directly or indirectly violating the right to health and reproductive health.[113] Direct violation of the right to health and reproductive health includes the failure of the state to provide contraception in health centres and a conducive environment that enables women to decide on child spacing. This obligation is rather wide, and it is argued that parameters need to be defined to ensure that a state upholds this obligation. Thus, failure by the state to enact appropriate laws that will facilitate access to sexual and reproductive health care services for women and girls will result in a breach of this obligation.

Similarly, adopting laws and policies that create barriers for women and girls' access to healthcare services will be inconsistent with the obligation to respect. For instance, where access to health care services for adolescents is conditioned on the need for parental consent, this will be regarded as a breach

105 See General Comment 1 (n 88) paras 20-25.

106 African Charter, art 1.

107 General Comment 2 (n 69).

108 Maputo Protocol art 14(1).

109 Maputo Protocol art 14(1).

110 General Comment 14 (n 2) art 12.

111 Maputo Protocol art 14(1). This forms some of the specific obligations of the State. See General Comment 2 (n 69) paras 46-51.

112 Maputo Protocol art 14(1).

113 Paragraphs 20-21 of the General Comment on art 14 of the Maputo Protocol. See General Comment 1 (n 88).

of the obligation to respect. The conceptual difficulty lies in defining the boundaries of this obligation for various reasons. First, a conducive environment must be framed around the interests of the woman and the best interests of the girl-child in the context of a child rights-based approach.[114] Second, 'an enabler concept' may be subjective depending on the cultural undertones of a given community. While access to contraception may be allowed in some communities, in others, it may be opposed for reasons based on cultural and religious grounds.[115]

States are expected to take steps to identify policies that condone stereotypes and cultures that devalue the agency and autonomy of women in making decisions concerning their sexuality since, arguably, these also constitute a direct violation of article 14.[116] Any steps by the state that hinder women's access to information on family planning and safe abortion services also violate this obligation.[117] Regarding article 14, Ngwena states that this obligation requires African states to take concrete and positive measures to realise women's sexual and reproductive health.[118] This would require states to adhere to the principle of substantive equality.

5.2 Obligation to protect

In reference to the obligation to protect, the article calls on states to take measures to prevent third parties from interfering with these rights.[119] It is documented that third parties may affect the enjoyment of the right to health and reproductive rights through various gender and cultural stereotypes attached to matters of sexual and reproductive health, in particular, abortion.[120]

The obligation to protect extends to vulnerable groups such as adolescent girls, women with disabilities, women living with HIV and women in conflict situations.[121] States parties have an obligation to formulate standards and guidelines regarding issues of consent and the involvement of third parties like parents, guardians, spouses and partners.[122] Also, adult women and adolescent girls should not require third-party consent before deciding to access health services like family planning, contraception, and safe abortion services.[123] Importantly, states are obligated to ensure that healthcare providers' attitudes do not hinder access to healthcare information and services for women and girls. Thus, judgmental attitudes by healthcare providers toward adolescent girls seeking sexual and reproductive health services will require the state's intervention. Similarly, states are required to regulate the exercise of conscientious objection by healthcare providers regarding women seeking safe abortion services and provide mechanisms for dealing with any deleterious consequences that may result from such conscientious objection.[124]

114 It is argued that the best interests' principle is not objective but rather subjective depending on the perceived best interests of the child.

115 RD Nanima 'Mainstreaming the "abortion question" into the right to health in Uganda' in E Durojaye, G Mirugi-Mukundi & C Ngwena (eds) *Advancing sexual and reproductive health and rights in Africa* (2021) 51.

116 This is evident from a reading of the Maputo Protocol art 14(1).

117 See General Comment 2 (n 69) para 42.

118 C Ngwena 'Inscribing abortion as a human right: significance of the Protocol on the Rights of Women in Africa' (2010) 32 *Human Rights Quarterly* 783.

119 See art 14(1)(d) & (e). See also General Comment on art 14, para 22 and General Comment 2 (n 69) para 43.

120 General Comment on art 14 of the Maputo Protocol para 23.

121 General Comment 2 (n 69) para 43.

122 As above.

123 As above. See generally, UN Committee on the Rights of the Child (CRC), General Comment 20 (2016) on the Implementation of the Rights of the Child During Adolescence, 6 December 2016, UN Doc CRC/C/GC/20.

124 S Nabaneh 'Abortion and conscientious objection in South Africa: the need for regulation' in E Durojaye, G Mirugi-Mukundi & C Ngwena (eds) *Advancing sexual and reproductive health and rights in Africa: constraints and opportunities* (2021) 16.

5.3 Obligation to promote

States parties have an obligation to promote the rights in article 14 through the creation of legal, social and economic conditions to enable women to exercise their rights concerning sexual and reproductive health.[125] The state is expected to use mass mobilisation and sensitisation of the public on women's health and sexual rights at community levels, training various stakeholders such as healthcare workers, religious, traditional and political leaders on the importance of this right. These measures must inform women of the right to self-protection, including the right to be informed about their own HIV status and that of their partners.[126]

5.4 Obligation to fulfil

The obligation to fulfil calls for the adoption of measures to ensure the realisation of the right.[127] It should be recalled that the right to health is a socio-economic right, which calls for engagement with the principle of progressive realisation.[128] For instance, concerning article 14(1)(d) and (e), states should adopt all the necessary measures, such as the allocation of adequate resources to realise the right to self-protection.[129] This obligation extends to the adoption of relevant laws, policies and programmes.[130] It also requires training and recruitment of skilled healthcare providers that are adequately remunerated.[131]

6 Implementation

States have adopted various measures toward the implementation of article 14. This section reviews state reports and concluding observations and evaluates the extent to which these measures align with the obligations identified above. The section concludes with a reflection on the role of different actors in implementing article 14.

6.1 Examples of state practices

Some states' practices demonstrate steps taken to implement the Maputo Protocol. Various constitutions provide for the right to health,[132] while others, like Uganda, Nigeria and Zambia, provide for the same under non-binding Principles of State Policy.[133] Other countries are still drawing up strategic plans to provide a framework for the enjoyment of the right to health.[134] In one of its Concluding Observations

125 General Comment on art 14 of the Maputo Protocol para 23. See also General Comment 2 (n 69) para 46.

126 General Comment on art 14 of the Maputo Protocol para 23.

127 General Comment on art 14 of the Maputo Protocol para 24.

128 A discussion on the relation with other provisions in other instruments is captured in sec 5 below.

129 General Comment on art 14 of the Maputo Protocol para 24.

130 General Comment 2 (n 69) para 45.

131 As above.

132 These include the Constitutions of South Africa, Kenya, Democratic Republic of Congo, Benin, Zimbabwe and Rwanda. For instance, the Constitution of the Republic of South Africa 1996 provides in sec 27 that everyone has the right to have access to health care services, including reproductive health care services and no one may be refused emergency medical treatment. The Constitution of Kenya, 2010 provides in art 43(1)(a) that every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care.

133 For instance, the Constitution of the Government of Uganda (1995) provides among its social and economic objectives that the State shall ensure that all Ugandans enjoy rights and opportunities and access to health services. See Initiative for Socio-economic Rights (ISER) 'Introduction to the right to health in Uganda: a handbook for community health advocates' (undated) https://iser-uganda.org/publication/a-handbook-for-community-health-advocates/ (accessed 20 May 2023).

134 For instance, in Sierra Leone the Heath Programme and the National Health Maternity Protection Strategic Plan of Sierra Leone address the plight of pregnant women and children aged five and below.

to the report of Malawi, the African Commission commended the government for its efforts towards addressing maternal mortality and improving post-natal care for women in hard-to-reach areas.[135] The Commission further commended the government for its efforts to domesticate the provisions of article 14 by enacting appropriate legislation such as the HIV and AIDS (Prevention and Management) Act 9 of 2018 aimed at advancing the right to health of women and girls in the country.[136] However, the Commission expresses concern about the silence of the government regarding the adoption of the Termination of Pregnancy Bill recommended by the Law Reform Commission.[137] Concerning the report of Kenya, the African Commission commended the government for improved efforts at addressing HIV/AIDS but expressed concerns regarding inadequate budgetary allocation to the health sector, which is inhibiting universal access to health care services for women and girls.[138] Thus, the Commission enjoined the government to increase allocation to the health sector. This notwithstanding, other serious challenges from a governance perspective persist. For instance, African States spend a lot on military, often to the detriment of other sectors like health.[139] Various countries spend much of their gross domestic product on military purchases with little expenditure on healthcare.[140] While it is true that some countries spend on both, more is spent on military ware.[141]

It should be noted that some of the special mechanisms of the African Commission have played an important role in ensuring a better understanding of the provisions of article 14 and states' compliance with it. Two of the special mechanisms stand out in this regard – the Special Rapporteur on Women in Africa[142] and the Committee on the Protection of the Rights of People Living with HIV (PLHIV) and Those at Risk, Vulnerable to and Affected by HIV (HIV Committee).[143] These two mechanisms were instrumental to the adoption of General Comment 1 on article 14(1)(d) and (e) of the Maputo Protocol. In addition, the Special Rapporteur on Women in Africa has continued to play a crucial role in advocating for the decriminalisation of abortion in Africa and the need for states to ensure that their laws are consistent with article 14(2)(c).[144] The Special Rapporteur on Women in Africa has issued

135 African Commission Concluding Observations and Recommendations on the 2nd and 3rd Combined Periodic Report of the Republic of Malawi on the Implementation of the African Charter on Human and Peoples' Rights (2015-2019) and Initial Report on the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women (2005-2013) adopted during the 70th ordinary session of the African Commission on Human and Peoples' Rights 23 February-9 March 2022 para 68.

136 Concluding Observations and Recommendations Malawi (n 135).

137 Concluding Observations and Recommendations Malawi (n 135) 70. The Termination of Pregnancy Bill seeks to regulate abortion and clarify the instances in which it may be allowed for instance where there is possible risk of harm to the physical and mental health of the pregnant woman; in instances of incest, rape or sexual assault, and where the foetus may likely be born with a serious disability.

138 See African Commission Concluding Observations and Recommendations on the 8th to 11th Periodic Report of the Republic of Kenya adopted at the 57th ordinary session 4-18 November 2015.

139 M Jakovljevic, Y Liu, A Cerda, M Simonyan, T Correia, RM Mariita & M Varjacic 'The Global South political economy of health financing and spending landscape – history and presence' (2021) 24 *Journal of Medical Economics* 25-33.

140 The World Bank indicates that although military spending in sub-Saharan Africa is the lowest globally, its military spending accounts for a substantial portion of both the region's gross domestic product (GDP) and overall government expenditure. It is estimated that the expenditure of 1.7 per cent of GDP by sub-Saharan Africa indicated the third highest regional military spending (and high burden globally, following North Africa (3.6% of GDP) and the Middle East (5.2% of GDP). See T Nan, W Pieter & Y Youngju *Military expenditure in sub-Saharan Africa* (SIPRI Policy Paper 48) Stockholm International Peace Research Institute (2018) 6 https://www.sipri.org/sites/default/files/2018-11/sipripp48.pdf (accessed 20 May 2023).

141 Nan et al (n 140) 6.

142 The Special Rapporteur on Rights of Women in Africa, one of the oldest mechanisms of the African Commission, was established by the African Commission at the 23rd Ordinary, which was held in Banjul, The Gambia, in April 1998.

143 The Committee on the Protection of the Rights of People Living with HIV (PLHIV) and Those at Risk, Vulnerable to and Affected by HIV was established by the African Commission on Human and Peoples' Rights with the adoption of Resolution 163 at the 47th ordinary session held in Banjul, The Gambia in May 2010.

144 For a detailed discussion on the activities of the Special Rapporteur on Women in Africa see, K Kariseb 'The responsivity of the mechanism of the Special Rapporteur on the Rights of Women in Africa in combating violence against women'

press releases[145] and embarked on mission visits to African countries to engage with policymakers and government institutions on this issue.[146] Similarly, the HIV Committee has produced a comprehensive report on HIV and the Law in Africa, which provides an overview of the nature, challenges and opportunities in addressing the HIV pandemic from a rights-based approach.[147] The report contains useful information on strategies and recommendations to different stakeholders to combat HIV and address the human rights challenges raised by HIV/AIDS. The HIV Committee has also visited some African countries to organise consultative meetings with government officials, civil society groups, and other stakeholders to address specific human rights issues in the context of HIV confronting the continent.[148]

The role of civil society groups in ensuring accountability to realise the SRHR of women and girls in article 14 cannot be overemphasised. Through advocacy, monitoring and submissions of shadow reports to the African Commission, these organisations have kept states on their toes. One of the outcomes of the efforts of these organisations is the adoption of the Reporting Guidelines for States regarding the obligation under the Maputo Protocol. Prior to that time, there was no guidance as to what the contents of state reports should be and the progress that has been made to effectively implement the provisions of the Maputo Protocol at the national level. This is particularly important in the context of sexual and reproductive rights guaranteed in article 14, which have become subject to contestation and moralisation.

Also, the efforts of civil society groups in conjunction with the Special Rapporteur on Women in Africa led to the adoption in 2017 of the Guidelines to Combat Sexual Violence and its Consequences in Africa (Niamey Guidelines).[149] The Niamey Guidelines are crucial in articulating states' obligations to realise women's rights to sexual and reproductive health in article 14. It is a known fact that violence generally results in negative consequences for the health and well-being of women. Thus, the Niamey Guidelines provide very useful and detailed steps and measures that states should adopt to prevent and punish sexual violence and rehabilitate victims of sexual violence.

(2022) 33 *Stellenbosch Law Review* 42-57. See also, E Durojaye 'The Special Rapporteur on the Rights of Women in Africa 2007-2015' (2018) 16 *Gender and Behaviour* 10700-10709.

145 See for instance, Statement of the special Rapporteur on the Rights of Women on the occasion of the Global Day of Action for Access to safe abortion, where the Special Rapporteur on Women in Africa calls for a renewed efforts on the part of African countries to address death resulting from unsafe abortion. The Special Rapporteur on Women in Africa further calls on states to intensify efforts to decriminalise abortion and remove barriers to abortion services for women during COVID-19 era: ACHPR 'Statement by the Special Rapporteur on the Rights of Women in Africa, on the Occasion of the "Global Day of Action for Access to Safe and Legal Abortion"' https://achpr.au.int/en/news/press-releases/2022-09-28/rights-women-africa-global-day-action-access-safe-legal-abortion (accessed 15 May 2023).

146 See for instance Intersession Activity Report of Hon Lucy Asuagbor presented during the 66th ordinary session of the African Commission 13 July-7 August 2020, where the Special Rapporteur on Women in Africa called for the implementation of laws to ensure safe abortion services for women and girls.

147 UNAIDS *HIV, the law and human rights in the African human rights system: key challenges and opportunities for a rights-based responses* (2018).

148 Some of the countries visited by the HIV Committee for this purpose include Kenya, Benin Republic, Namibia Uganda, Côte d'Ivoire and Cameroon.

149 ACHPR Guidelines to Combat Sexual Violence and its Consequences in Africa (2017).

6.2 Implementation of article 14, reservations and interpretative declarations

It is worth noting that 42 states have ratified the Maputo Protocol.[150] Thirteen states have cited issues relating to the normative content of the right to sexual and reproductive health rights, such as access to safe abortion, as their reason for not ratifying the Maputo Protocol.[151] This is an improvement from an initial number of 17.[152] Five states have ratified the Protocol with reservations.[153]

Concerning article 14, Cameroon stated in its reservation that the ratification of the Maputo Protocol 'should in no way be construed as endorsement, encouragement or promotion of '… abortion (except therapeutic abortion)'.[154] On the other hand, Kenya does not consider itself to be bound by article 14(2)(c) because it is 'inconsistent with the provisions of the Laws of Kenya on health and reproductive rights'.[155] A recent Court of Appeal decision in Kenya has broadened access to abortion services by affirming the right to privacy, which reduces the barriers to accessing therapeutic abortion. The court relied on General Comment 2 of the African Commission on article 14 of the Maputo Protocol[156] in holding that 'the right to therapeutic abortion, the practice of interrogation by healthcare providers, the police and/or judicial authorities is a violation of their right to privacy and confidentiality'.[157]

Some countries entered interpretative declarations, which in some cases may have the effect of limiting the implementation of the Maputo Protocol. In some instances, however, interpretive statements have the effect of broadening the scope of implementation. Uganda, for instance, extends the right of a woman to control her fertility under article 14(1)(a) by specifying that it will apply to all women regardless of marital status. In the same statement, Uganda's reservation specifies that the state's obligation under article 14(2)(c) with regard to medical abortion will only be upheld as far as it is provided for by domestic legislation.[158] It is argued that this position of non-domestication is not a valid argument for non-fulfilment.[159] While there is no judicial clarification on the import of this reservation, the Ugandan Supreme Court has held that failure by the government to ensure access to quality maternal care services to women in rural areas, which resulted in avoidable death, amounted to a breach of the obligation under international and national law.[160] According to the court, this breach of obligation violates several rights of women guaranteed in the constitution and human rights treaties, including the Maputo Protocol and CEDAW.[161] The court noted that failure to prevent maternal death undermines women's rights to life, health, dignity and non-discrimination. More importantly, the court noted that poor or inadequate health sector funding has contributed to high maternal mortality in the

150 These include Angola, Burkina Faso, Cameroon, DRC, Eswatini, Gambia, Kenya, Lesotho, Malawi, Nigeria, Mauritius, Namibia, Rwanda, Senegal, Seychelles, South Africa, Togo and Zimbabwe.

151 African Union 'Maputo Protocol Scorecard and index introduced to monitor implementation of Women's Rights' https://bit.ly/3LBsmeJ (accessed 23 June 2023).

152 These include Algeria, Botswana, Burundi, Central African Republic, Chad, Egypt, Eritrea, Ethiopia, Madagascar, Mauritius, Niger, Sahrawi Arab Democratic Republic, São Tomé and Príncipe, Somalia, South Sudan, Sudan and Tunisia.

153 These are Cameroon, Kenya, Namibia, Rwanda and South Africa.

154 See full text of the reservation in the Report of the Special Rapporteur on the status of implementation of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, Justice Lucy Asuagbor, Commissioner and Special Rapporteur on Rights of Women in Africa at the 60th meeting on the Commission on the Status of Women, 2 18 March 2016, https://bit.ly/3PFEaA0 (23 June 2023).

155 Report of the Special Rapporteur (n 154).

156 General Comment 2 (n 69).

157 Constitutional Petition *PAK and Mohammed v Attorney General* Malindi HC Const Pet No E009 of 2020 24.

158 For a detailed engagement of the abortion question in Uganda and the polarities presented by various groups, see Nanima (n 115) 51H.

159 The Vienna Convention on the Law of Treaties, art 27.

160 *Centre for Health Human Rights & Development v Attorney General* (Constitutional Petition 16 of 2011) [2012] UGSC 48 (5 June 2012).

161 *Centre for Health Human Rights & Development* (n 160).

country and amounted to discrimination against women. The court further urged the government to live up to its obligations under the Maputo Protocol and the Abuja Declaration by committing more resources to maternal health care services in the country.[162]

7 Conclusion

There is tangible progress in the implementation of the Maputo Protocol. This is evident through the increased number of countries that are reporting on the implementation of the same; more positive steps on the adoption of various laws that are positives towards the use of abortion in Africa; constitutional recognition of the right to health; increased budgetary allocation to the health sector; and the need to use civil society to support states in both reporting processes and implementation of the obligations under article 14 of the Maputo Protocol. In addition, the fact that national courts are beginning to affirm the norms and standards of the Maputo Protocol as a yardstick presents a positive development for the future. The prospects for implementation of article 14 will be significantly improved if other courts across the region emulate this development.

States could invest in various critical practical measures to enable agency and empowerment of women to have control of their fertility, decide on the spacing and number of children, family planning, and modes of contraception. This requires going beyond the use of only legislative measures to other necessary measures such as sensitisation and mass mobilisation.

Deliberate efforts to provide adequate, affordable and accessible health services should be a priority for states to ensure the progressive improvement in reproductive health and rights. For instance, abortion remains the elephant in the room with various reasons that are pro and anti-abortion that do not place the lived realities of the African woman at the centre. This should be done as a step towards the implementation of the Maputo Protocol. States need to exhibit the political will to effectively implement the provisions of article 14.

162 The Abuja Declaration was a product of a meeting of 189 Heads of State adopted the Millennium Declaration, to improve social and economic conditions in the world's poorest countries by 2015, informed by a set of eight goals devised to track its progress. Some of the critical elements of the declaration included the pledge to allocate at least 15% of their annual budget to improve the health sector. See WHO 'The Abuja Declaration: Ten years later' https://bit.ly/3cJwfD8 (accessed 23 June 2023).