ASSESSING THE

sexual and reproductive health, & rights of women and girls

IN FRAGILE AND CONFLICT-AFFECTED COUNTRIES IN AFRICA

CASE STUDIES

SUDAN, SOUTH SUDAN, CENTRAL AFRICAN REPUBLIC, MALI, ETHIOPIA AND NIGERIA

URGENT ACTION FUND + AFRICA
FOR WOMEN'S HUMAN RIGHTS

RWB
RESEARCHERS WITHOUT BORDERS

ASSESSING THE SEXUAL AND REPRODUCTIVE HEALTH, & RIGHTS OF WOMEN AND GIRLS IN CONFLICT-AFFECTED COUNTRIES IN AFRICA.

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ACRONYMS

AAH	Action Against Hunger
ADE	Association pour le Développement et la Santé
AFJC	Association des Femmes Juristes de Centrafrique
AMBEF	Association Malienne pour le Bien -Etre Familial
APROSOFEC	Association pour la Promotion de la Santé de la Femme et de l'Enfant en Centrafrique
ARH	Adolescent Reproductive Health
ARHFP	Association for Reproductive Health and Family Planning
CAR	Central African Republic
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
CHAI	Clinton Health Access Initiative
CPC	Coalition of Patriots for Change
DHS	Demographic and Health Survey
EHS	Essential Health Services
FGAE	Family Guidance Association of Ethiopia
FGM	Female Genital Mutilation
GBV	Gender -Based Violence
HEWs	Health Extension Workers
ICESC	International Covenant on Economic, Social and Cultural
ICPD	International Conference on Population and Development
IDPs	Internally Displaced Persons
IMC	International Medical Corps
IPPF	International Planned Parenthood Federation
IRC	International Rescue Committee
IUDs	Intrauterine Devices
JWN	Juba Wo men's Network
KOICA	Korea International Cooperation Agency
MHNT	Mobile Health and Nutrition Team
MHPSS	Mental Health and Psychosocial Support
MoH	Ministry of Health
MOWCYA	Ministry of Women, Children, Youth Affairs Offices
MOWSA	Ministry of Women and Social Affairs
MSF	Medecins Sans Frontieres
MSI	Marie Stopes International
MTI	Medical Teams International
NASCP	National AIDS/STI Control Program
NWHPU	National Women's Health Policy Unit

NGOs	Non-Governmental Organi sations
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PEP	Post Exposure Prophylaxis
PLW	Pregnant and Lactating Women
POC	Protection of Civilians
PSI	Population Services International
RECAOLSA	Réseau Centrafricain des Associations et ONG de Lutte contre le Sida
RHRC	Reproductive Health for Refugees Consortium
RSF	Rapid Support Forces
SDG	Sustainable Development Goal
SFPA	Sudanese Family Planning Association
SNNP	Southern Nations, Nationalities and People
SOPs	Standard Operating Procedures
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SSWHA	South Sudan Women's Health Association
STIs	Sexually Transmitted Infections
UNDP	United Nations Development Fund
UDHR	Universal Declaration of Human Rights
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
VAPP	Violence Against Persons Prohibition
WAT	Women Association of Tigray
WGFS	Women and Girls' Friendly Spaces
WHI	Women's Health Initiative
WHO	World Health organization
YEPAD	Youth Empowerment for Peace and Development

1.0 INTRODUCTION

In 2021, 18 out of 49 states in Sub Saharan Africa were in active armed conflict with fatalities 19 per cent higher than in 2020. The conflicts were shaped by the presence of armed groups and criminal networks, election related violence, water insecurity and the growing impact of climate change[1]. West Africa hotspots included Burkina Faso, Mali, Niger, and Nigeria due to attacks by armed groups operating across borders. In the Central Africa region large-scale violence continued in the eastern Democratic Republic of Congo as external and Congolese armed groups engaged in multiple armed conflicts. In East Africa, 9 of the 22 states were involved in active conflict in 2021, with 5 countries including Ethiopia, Mozambique, Somalia, South Sudan and Sudan with sharp escalations of violence. The violence led to more than 9.6 million people being internally displaced and more than 4.7 million people becoming refugees. Grave human rights violations against civilians continued to be committed in the region, while at least 33.8 million people were severely food insecure[2].

Conflicts impact the health and wellbeing of communities. The impact of conflict on health infrastructure and work force has been well documented. Women's sexual and reproductive health and rights (SRHRs) are negatively affected by conflict[3]. Research indicates that the destruction of infrastructure, state and other armed actors' control over women's reproduction and limited access to maternal and reproductive health care impacts the SRHRs of women and girls in conflict settings[4]. Reproductive insecurities contribute to high mortality for women during conflict and post conflict periods and impede their inclusion in decision making[5] [6]. Women's bodily integrity and reproductive health is deeply politicized and securitized. In addition, existing cultural and religious practices and norms limit women's reproductive freedom. Several studies have shown how rebel groups control women's reproduction, including forced pregnancy and marriage[7], and imposed abortions or contraceptives[8]. Restricted access to family planning and health care initiatives lead to an increase in unwanted pregnancies and unsafe abortions[9]. These actions indicate that SRHR is not incidental to conflict but integral to military tactics and strategies, shaping women's experiences of conflict and post conflict periods[10].

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[1] SIPRI Year Book 2022: Armaments, Disarmament and International Security. https://www.sipri.org/yearbook/2022/07

[2] SIPRI Year Book 2022: Armaments, Disarmament and International Security. https://www.sipri.org/yearbook/2022/07

[3] Hedström J, Herder T. Women's sexual and reproductive health in war and conflict: are we seeing the full picture? Glob Health Action. 2023 Dec 31;16(1):2188689. doi: 10.1080/16549716.2023.2188689. PMID: 36927249; PMCID: PMC10026773.

[4] Ibid

[5] Singh NS, Aryasinghe S, Smith J, Khosla R, Say L, Blanchet K. A long way to go: a systematic review to assess the utilisation of sexual and reproductive health services during humanitarian crises. BMJ Glob Health. 2018;3:e000682

[6] Davies SE, Harman S. Securing reproductive health: a matter of international peace and security. Int Stud Q. 2020;64:277–284

[7] Hedström J. Reproducing revolution: a feminist political economy analysis of the conflict in Kachinland. Melbourne: Monash University; 2018.

[8] Carsten P, Levinson R, Lewis D, et al. Nigeria military ran secret mass abortion program in war on Boko Haram. Reuters.com [Internet]. Available from: https://www.reuters.com/investigates/special-report/nigeria-military-abortions/

[9] Urdal H, Che CP. War and gender inequalities in health: the impact of armed conflict on fertility and maternal mortality. Int Interact. 2013;39:489–510

[10] Hedström J, Herder T. Women's sexual and reproductive health in war and conflict: are we seeing the full picture? Glob Health Action. 2023 Dec 31;16(1):2188689. doi: 10.1080/16549716.2023.2188689. PMID: 36927249; PMCID: PMC10026773.

There is limited research on the reproductive health and rights of women in conflict settings in Africa, the aim of this research is therefore to assess the sexual and reproductive health and rights of women and girls in fragile and conflict affected countries in Africa, looking at Sudan, South Sudan, Central African Republic, Mali, Ethiopia, and Nigeria.

The research reviewed existing literature review through the analysis of various reports from humanitarian organizations, academic research and online news articles to respond to the research objectives. The research seeks to identify legal instruments for the promotion and protection of SRHR of women at global, regional and national levels, examine policy implementation gaps including availability and sufficiency of SRHR services; and provide recommendations to improve the protection of the SRHRs of women and girls in these fragile countries.

Policy Frameworks on Reproductive Health and Rights

The Universal Declaration of Human Rights (UDHR) provides the basis for all rights including the right to health. The UDHR specifies the various rights that complement the right to health as follows:
"Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, and housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age, or other lack of livelihood in circumstances beyond his control"[11].

Following rapid population growth, the International Covenant on Economic, Social and Cultural (ICESC) rights came into force. The Covenant recognizes the right of everyone to enjoy the highest attainable standard of physical and mental health. The ICESC listed the steps required to achieve the full realization of this right to include; provision for the reduction of the stillbirth rate and of infant mortality, and for the healthy development of the child; the improvement of all aspects of environmental and industrial hygiene; the prevention, treatment and control of epidemic, endemic, occupational and other diseases; and the creation of conditions which would assure to all medical service and medical attention in the event of sickness. However, the resolution did not recognize reproductive health[12].

Several attempts by global institutions to curb population growth and ensure the right to health, brought the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) into force. It guarantees the right to health[13]. The CEDAW recognizes the reproductive health rights of women; guaranteed access to health services relating to family planning and ante-natal and post-natal practices[14]. However, it was not until the 1994 Cairo International Conference on Population and Development (ICPD) that reproductive health rights of women were recognized as part of human rights[15].

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[11] Article 25(1), Universal Declaration of Human Rights, adopted and proclaimed by General Assembly resolution 217(111) of 10 December 1948
[12] Article 12, International Covenant on Economic, Social, and Cultural Rights, adopted and opened for ratification and accession by General Assembly Resolution 2200A(XXI) of 16 December 1966, which entered into force on 3January 1976, in accordance with Article 27.
[13] Article 12 of the Convention on the Elimination of all forms of Discrimination Against Women, adopted by the UN General Assembly Resolution 34/180 of 18 December 1979, entered into force on 3 September 1981
[14] Ibid
[15] The Cairo Programme of Action, 1994.

The ICPD defined reproductive health as 'a state of complete physical, mental and social well-being and not merely absence of disease or infirmity, in all matters relating to the reproductive system, and to its functions and processes'. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed about and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of birth control which are not against the law.

The ICPD also highlighted the right of access to appropriate health-care services that will enable women to safely go through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. Of central importance are the rights to autonomy and privacy in making sexual and reproductive decisions, as well as the rights to informed consent and confidentiality in relation to health services. ICPD provided the framework for sexual and reproductive health and rights (SRHR) to be included in national health policies[16] and outlined states obligation to provide unhindered access to sexual and reproductive health (SRH) services[17].

The United Nations Sustainable Development Goal recognizes maternal health as a global priority. The SDG contains a number of targets related to reproductive health. Specifically, target 3.7 calls for ensuring universal access to sexual and reproductive health-care services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes by 2030.

Likewise, target 5.6 calls for ensuring universal access to sexual and reproductive health and reproductive rights. Other targets in the 2030 Agenda related to reproductive health include reducing the global maternal mortality ratio to less than 70 per 100,000 live births (target 3.1); ending preventable deaths of newborns and children under 5 years of age (target 3.2); and eliminating all harmful practices, such as child, early and forced marriage as well as female genital mutilation (target 5.3). Meeting the targets related to reproductive health can contribute positively to the achievement of other goals and targets of the 2030 Agenda, including those related to poverty, health, education and gender equality[18]. In the same way, United Nations Security Council Resolution 1325 on Women, Peace and Security stresses that sexual and reproductive health assistance for survivors of conflict related sexual violence is an important component of peace building.

[16] Hadi M. Historical development of the global political agenda around sexual and reproductive health and rights: a literature review. Sex Reprod Healthc 2017;12:64–9. 10.1016/j.srhc.2017.03.005

[17] Berro Pizzarossa L. Here to stay: the evolution of sexual and reproductive health and rights in international human rights law. Laws 2018;7:29. 10.3390/laws7030029

[18] Reproductive Health Policies. 2017. United Nations Economic and Social Affairs. https://www.un.org/en/development/desa/population/publications/pdf/policy/reproductive_health_policies_2017_data_booklet.pdf

Considering the various efforts made at international level towards the reproductive health rights of women, African countries demonstrated their commitment to advancing these rights at the regional level – by adopting the African Charter on Human and People's Rights[19],which provides that:

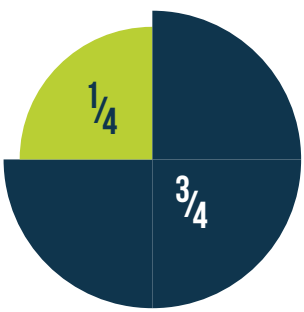
Every individual shall have the right to enjoy the best attainable state of physical and mental health and that State Parties to the present Charter shall take all the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick[20].

Subsequently, African countries adopted the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa[21]. The Protocol complements the African Charter on Human and People's Rights and contains express provisions in relation to health and the reproductive health rights of women. It is expected that countries in Africa would follow the steps of the African Union and domesticate these protocols through their national laws and policies to guarantee the sexual and reproductive health and rights of women and girls. The extent to which this has been done is evaluated in each of the country case studies to throw more light into the sexual and reproductive health and rights of women and girls in conflict settings in Africa.

[19] Adopted in Nairobi on 27 June1981 and entered into force on 21 October1986.
[20] Article 12 of the African Charter on Human and People's Rights, adopted at Nairobi on 26 June 1981, and entered into force on 21October 1986, in accordance with Article 63.
[21] Adopted by the African Union in July 2003 and came into force in November2005.

CASE STUDY OF:

SUDAN.



It is estimated that
over three-quarters
of married women have little to no decision-making power within the household.

The war in Sudan has led to displacement of women and children to crowded internal displaced people's camps or to neighboring countries as refugees.

2.0 SUDAN

2.1 Background

Sudan has witnessed some of the longest conflicts in Africa and the situation remains fragile. Most recently, Sudan has been grappling with heightened insecurity and a rise in demonstrations. Demonstration events more than doubled in 2022 compared with the number recorded in 2021, reflecting ongoing opposition to the military regime and support for a civilian government. In addition to the popular unrest, armed conflict involving state and non-state armed groups across the country has increased. Over half of the political violence events reportedly involved identity militias. Ongoing turmoil in the Sudanese capital, Khartoum, has contributed to the escalation of the conflict, after a military coup d'état in October 2021 put the country on an uncertain path. Against this backdrop, the December 2022 signing of a political framework agreement is hoped to end the political stalemate and move Sudan toward a civilian government[22].

In August 2020, the Sudanese transitional government signed the Juba Agreement for Peace in Sudan with key rebel groups, which provided for transitional security arrangements in Darfur. These included a permanent ceasefire, the reintegration of rebel forces into national security forces, disarmament, military and security reforms[23]. However, the agreement failed to halt the deadly clashes in the region. The power vacuum resulting from the 2021 military coup and the presence of several armed groups including the Sudanese Armed Forces, the semi-autonomous Rapid Support Forces (RSF), and rebel groups in periphery states, particularly Blue Nile, West Kordofan, and West Darfur, has contributed to an escalation of inter-communal violence and facilitated an increase in the number of ethnic militias[24].

The war in Sudan has led to displacement of women and children to crowded internal displaced people's camps or to neighboring countries as refugees. Human Rights Watch reported rape of women and girls by armed men with impunity[25]. The violation of women's rights in Sudan is not limited to conflict periods. Sudan's repressive and discriminatory laws undermine women and girls' rights across the country and diminish their ability to take decisions pertaining to their health and wellbeing.

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[22] ACLED, March 2023. Context Assessment: New Political Deal Amid Rising Disorder in Sudan. https://acleddata.com/2023/03/03/context-assessment-new-political-deal-amidst-rising-political-disorder-in-sudan/

[23] Denis Dumo, 'Sudan signs key peace deal with key rebel groups, some hold out,' Reuters, 31 August 2020; International Institute for Democracy and Electoral Assistance, 'The Juba Agreement for Peace in Sudan: Summary and Analysis,' 21 April 2021

[24] Jack Jeffery and Samy Magdy, 'Sudan officials: Tribal clashes kill 170 in country's south,' Associated Press News, 20 October 2022; Alan Boswell, 'A Breakthrough in Sudan's Impasse?,' International Crisis Group, 12 August 2022

[25] Jehanne Henry. Dispatches: Sudan's War on Women and Girls. October 12, 2015. https://www.hrw.org/news/2015/10/12/dispatches-sudans-war-women-and-girls

2.2 The Status of Sexual and Reproductive Health and Rights of Women in Sudan

The sexual and reproductive health and rights (SRHR) of women in Sudan are a crucial but vastly overlooked issue. Women in Sudan face numerous challenges when it comes to making autonomous decisions about their sexual and reproductive health. Too often, their voices are silenced, their health is compromised, and their rights are overlooked. The consequences are dire. Women often find themselves in situations where they are unable to make the best decisions possible for their health, resulting in preventable physical and emotional struggles.

In Sudan, it is estimated that over three-quarters of married women have little to no decision-making power within the household, making it difficult for them to access critical sexual and reproductive healthcare[26]. The reproductive health needs of women in Sudan include maternal health care, family planning, comprehensive sexuality education, reproductive cancers, and safe abortion. Access to contraception and family planning programmes is highly limited and the cost of these services is often beyond the reach of most women in the country[27]. Limited access to information and resources means that women are more likely to suffer from complications during pregnancy, childbirth, and postpartum[28]. The inequity in access to sexual and reproductive health care in Sudan is further exacerbated by the prevalence of gender-based violence and discrimination[29].

2.3 National and Local Legal Instruments on Sexual and Reproductive Health and Rights in Sudan

The sexual and reproductive rights of women in Sudan are protected by several regional and international legal instruments[30]. These instruments provide a framework for ensuring that women in Sudan have access to comprehensive sexual and reproductive health services and information. They also provide for women's freedom from discrimination and violence related to their sexual and reproductive health. By ratifying these legal instruments, Sudan has committed to protecting the sexual and reproductive rights of women and ensuring that women have access to comprehensive sexual and reproductive health services and information.

[26] Ghonim, E. (2018). Women's autonomy in household decision-making: A study of married women in Sudan. African Journal of Reproductive Health, 22(3), 57-65.
[27] Mukhtar, W., Abdelhalim, I. M., & Elhassan, E. (2020). Access to family planning services in Sudan: A systematic review. Reproductive Health, 17(1). https://doi.org/10.1186/s12978-020-0961-8
[28] Kanawati, A., Mertens, K., Ahmed, M., & De Regt, M. (2018). Understanding sexual and reproductive health needs and rights in Sudan: A qualitative investigation. Global Health Action, 11(1), 1488607. https://doi.org/10.1080/16549716.2018.1488607
[29] Fadul, E. E., Ali, M. E., & Elzaki, M. E. (2018). Gender-based violence and women's health: A call for prevention and health promotion in Sudan. International journal of women's health, 10, 595–602. https://doi.org/10.2147/IJWH.S167562

[30] United Nations. (1979). Convention on the Elimination of All Forms of Discrimination Against Women. Retrieved from https://www.un.org/womenwatch/daw/cedaw/cedaw.htm

Some of these legal instruments include:

1. **The Interim National Constitution of Sudan, 2005 which provides for equality and non-discrimination, including on the basis of gender and the right to health, including sexual and reproductive health[31]. The Personal Status Act of 1991 governs the regulation of personal status issues such as marriage, divorce, and inheritance. It includes provisions that protect women's right to health and to seek medical treatment, including sexual and reproductive health services[32].**

2. **The Sudan Population Act of 2002 provides for the promotion and protection of reproductive health and family planning services. It also requires the government to provide access to information and services for the prevention of sexually transmitted infections, including HIV/AIDS[33]. The Criminal Code of 1991 criminalizes gender-based violence and sexual abuse, including rape and sexual harassment, and provides for the protection of women's bodily autonomy and sexual integrity[34].**

3. **These legal instruments provide a framework for the protection of sexual and reproductive rights of women in Sudan. However, their implementation remains a challenge, as women still face significant barriers in accessing comprehensive sexual and reproductive health services and information, as well as facing discrimination and violence related to their sexual and reproductive health.**

2.4 Factors Undermining Implementation of the Legal Frameworks

The government of Sudan has made several legal and policy commitments to sexual and reproductive health and rights (SRHR), including the ratification of various international and regional agreements. However, translating these commitments into concrete actions has been challenging due to several factors. These include political instability, limited resources, cultural barriers, and weak enforcement mechanisms.

One of the major obstacles is the lack of political will and commitment to SRHR issues. It is a common concern identified by various researchers[35] that despite the existence of legal frameworks that support SRHR, policymakers and politicians often prioritize other issues, such as national security and economic development. This low prioritization results in insufficient budget allocation and resource mobilization for SRHR programmes and services.

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[31] Government of Sudan. (2005). Interim National Constitution of Sudan, 2005. Retrieved from https://www.refworld.org/pdfid/42f8cefd4.pdf
[32] Government of Sudan. (1991). Personal Status Act of 1991. Retrieved from https://www.refworld.org/pdfid/4f0f69f72.pdf
[33] Government of Sudan. (2002). Population Act of 2002. Retrieved from https://www.refworld.org/docid/3f7d4d1c4.html
[34] Government of Sudan. (1991). Personal Status Act of 1991. Retrieved from https://www.refworld.org/pdfid/4f0f69f72.pdf
[35] Guttmacher Institute

Another obstacle is the conservative cultural and religious norms that exist in Sudan, which often limit women's access to reproductive health services and information. For example, the prevalence of female genital mutilation (FGM) remains high in Sudan, despite it being criminalized. A report by the United Nations Population Fund (UNFPA) states that 87% of Sudanese women aged between 15 and 49 years have undergone FGM[36].

Furthermore, Sudan has been going through a turbulent political transition in recent years, which has made implementation of policies and programmes difficult. For instance, the government's ability to implement the national strategy for reproductive health has been hampered by the ongoing conflicts in Darfur, Blue Nile, and South Kordofan regions. In addition, the country's economic crisis has made it challenging for the government to allocate sufficient resources towards sexual and reproductive health programmes[37].

In addition to these challenges, there is also a lack of awareness and education on SRHR issues, particularly among marginalized and rural communities[38]. This results in a lack of demand for SRHR services, which further perpetuates the underfunding and inadequate allocation of resources to SRHR programs.
In conclusion, the government of Sudan faces several challenges in implementing legal and policy commitments on sexual and reproductive health and rights. To make progress in this area, the government needs to address the root causes of these challenges, such as political instability and weak enforcement mechanisms, while also engaging with communities to overcome cultural barriers.

2.5 National and International Sexual and Reproductive Health Service Providers

Sexual and reproductive health services are provided by a range of organizations and providers in Sudan, including the government and non-governmental organisations (NGOs). The government is responsible for providing essential sexual and reproductive health services to women through its health care system. Some of the key government agencies and bodies that provide these services include the Ministry of Health, which is the primary agency responsible for overseeing the delivery of health services in Sudan, including sexual and reproductive health services (Ministry of Health, Sudan)[39]. The National Population Council is the main governmental body responsible for coordinating the implementation of policies and programmes related to population, reproductive health, and family planning in Sudan (National Population Council, Sudan)[40]. The Federal Ministry of Social Welfare, Women and Children is responsible for implementing policies and programs aimed at improving the status of women and children in Sudan, including addressing their sexual and reproductive health needs (Federal Ministry of Social Welfare, Women and Children, Sudan)[41].

[36] Sudan Tribune. (2021). UNFPA says 87% of Sudanese women aged 15-49 undergo FGM. Retrieved from https://sudantribune.com/article69008/
[37] United Nations Population Fund. (2019). Sudan: Reproductive Health at a Glance. Retrieved from https://sudan.unfpa.org/sites/default/files/pub-pdf/Sudan-RHAG-2019.pdf
[38] World Health Organization. (2017). Sexual and Reproductive Health in Sudan: An Overview. Retrieved from https://www.who.int/reproductivehealth/publications/monitoring/SRHR-Sudan.pdf
[39] Ministry of Health, Sudan. (n.d.). Ministry of Health. Retrieved from http://www.moh.gov.sd/
[40] National Population Council, Sudan. (n.d.). National Population Council. Retrieved from http://www.population.gov.sd/
[41] Federal Ministry of Social Welfare, Women and Children, Sudan. (n.d.). Federal Ministry of Social Welfare, Women and Children. Retrieved from https://mssd.sd/

The National AIDS Council is responsible for coordinating the national response to the HIV/AIDS epidemic in Sudan, including the provision of comprehensive sexual and reproductive health services to women and men living with HIV/AIDS[42].

In addition to the government, several civil society organizations and international development partners in Sudan also provide sexual and reproductive health services to women. Some of these organizations include International Medical Corps (IMC) a non-profit humanitarian organization that provides health care services, including sexual and reproductive health services, to vulnerable communities[43]. UNFPA works to improve the health and well-being of women and girls, including their sexual and reproductive health[44].

Marie Stopes International (MSI) provides family planning and reproductive health services, including maternal health care, to women[45]. Population Services International (PSI) works to improve the health and well-being of women and children, including their sexual and reproductive health[46]. International Planned Parenthood Federation (IPPF), Sudanese Family Planning Association (SFPA), Al-Tahadi Women's Center and Women's Health Initiative (WHI) provide family planning services, comprehensive sexuality education, safe abortion and maternal health services in Sudan.

2.6 Gaps in Access to Sexual and Reproductive Health Services

Despite the efforts of the government and civil society organizations to provide sexual and reproductive health services to women in Sudan, significant gaps remain in access to these services. Some of the key challenges include:

1. The health care infrastructure in Sudan, especially in rural and conflict-affected areas, is insufficient and lacks basic facilities and resources required for providing sexual and reproductive health services. For example, there is a shortage of health facilities such as clinics and hospitals, ill-equipped facilities without basic medical equipment and supplies, limited availability of essential medicines and reproductive health commodities, a lack of skilled healthcare personnel, limited access to transportation, and inadequate data collection and management systems. These limitations make it difficult to provide basic sexual and reproductive health services, including maternal and newborn health care, family planning, comprehensive sexuality education, and safe abortion services, to the population[47].

2. High levels of poverty and economic insecurity. Many women cannot afford the cost of reproductive health services, or lack the means to travel to health care facilities[48].

[42] Sudan National Aids Council Programme. https://www.unaids.org/sites/default/files/country/documents/ce_SD_Narrative_Report[1].pdf
[43] International Medical Corps. (2020). About IMC. Retrieved from https://internationalmedicalcorps.org/about-us/
[44] UNFPA. (n.d.). UNFPA in Sudan. Retrieved from https://www.unfpa.org/sudan
[45] Marie Stopes International. (2020). About MSI. Retrieved from https://mariestopes.org/about-us/
[46] Population Services International. (2020). About PSI. Retrieved from https://www.psi.org/about-psi/
[47] USAID. (2019). Health in Sudan. Retrieved from https://www.usaid.gov/sudan/health
[48] UNFPA. (n.d.). UNFPA in Sudan. Retrieved from https://www.unfpa.org/sudan

3 Social and cultural attitudes towards sexuality and reproductive health are often conservative in Sudan and limit women's ability to access services and make informed decisions about their health. (UNFPA, n.d.)

4 High levels of violence and insecurity, particularly in conflict-affected areas, make it difficult for women to access sexual and reproductive health services and puts them at risk of gender-based violence. (UNFPA, n.d.)

In order to close these gaps and ensure that women in Sudan have access to the sexual and reproductive health services they need, there is a need for continued investment in health care infrastructure, increased efforts to address poverty and economic insecurity, and a more proactive approach to addressing social and cultural barriers.

2.7 Recommendations

To address the gaps in the protection of sexual and reproductive rights of women in Sudan, a number of measures need to be taken.

1 The government must enforce laws and policies that protect the sexual and reproductive rights of women, and hold those who violate these rights accountable. This will require a stronger rule of law, increased political will, and greater efforts to combat corruption. (HRW, 2016)[49]

2 Access to comprehensive and accurate information about sexual and reproductive health, as well as access to services that can help women protect their rights, must be improved, especially in rural and conflict-affected areas. This will require increased investment in health care infrastructure, as well as greater efforts to address poverty and economic insecurity. (UNFPA, n.d.)[50]

3 To address the threat posed by violence and insecurity, the government must take steps to increase the safety and security of women, and provide women with access to services that can help them recover from the impacts of violence. (UNFPA, n.d.)

[49] HRW. (2016). Sudan: Women's Sexual and Reproductive Rights Abused. Retrieved from https://www.hrw.org/news/2016/05/11/sudan-womens-sexual-and-reproductive-rights-abused
[50] UNFPA. (n.d.). UNFPA in Sudan. Retrieved from https://www.unfpa.org/sudan

Addressing social and cultural attitudes towards sexuality and reproductive health is critical to ensuring that women are able to fully exercise their rights. This will require greater efforts to educate communities, particularly men and boys, about the importance of these rights, and to challenge harmful practices, such as female genital mutilation. (UNFPA, n.d.)

4

2.8 Conclusion

The case of Sudan indicates that while conflict contributes to lack of access to SRH services that impacts on women's health the intersection of cultural and religious norms makes it more difficult for women and girls to obtain their reproductive health and rights despite the many laws and policies in place. Addressing the gaps in the protection of the sexual and reproductive rights of women in Sudan will require a multi-faceted approach that involves the government, civil society organizations, and the international community. Sustainable peace is a prerequisite for the protection of women's rights and more so their SRHRs. There is a need for post conflict peace building to ensure a robust reproductive health services plan, as well as programmes to address cultural norms that inhibit women's access to reproductive health services. By taking these measures, it is possible to ensure that women in Sudan are able to fully enjoy their rights, and to create a safer and more just society for all.

CASE STUDY OF:

SOUTH SUDAN.

45%

GIRLS MARRIED BEFORE 18

AND **7%** MARRIED BEFORE THEY TURNED 15.

Prevailing cultural norms limit women's participation in decision making at all levels.

3.0 SOUTH SUDAN

3.1 Background

The outbreak of conflict in December 2013 in South Sudan was led to massive loss of life, destruction, and displacement that impacted the region. This followed over 50 years of conflict and instability in the region, as well as significant development needs. Despite the signing of the Revitalised Peace Agreement in 2018 which led to a cessation of hostilities, the impact of conflict and breakdown in services continue to have severe consequences for a country where human development ranks among the worst in the world. In 2022, the country will enter its tenth year of protracted conflict. This has resulted in 8.3 million people needing humanitarian assistance, 2.3 million refugees, 1.7 million internally displaced people, 34,000 living in protection of civilian (POC) sites, 1.4 million and 483,000 women children suffering malnutrition[51]. The health system is weak, with severe shortages of health workers and poorly functioning health facilities[52].The country experienced a climate emergency in 2021 with the worst flooding the South Sudan has seen in nearly 60 years. This affected eight of the country's ten states, and over 800,000 people.

Gender relations in South Sudan are shaped by decades of conflict and the related social and economic realities. Prevailing cultural norms limit women's participation in decision making at all levels. Early marriage is also common, with 45% of girls married before their 18th birthday (and 7% married before they turned 15). These rates have increased since the start of the conflict[53]. Women disproportionately bear the burden of morbidity and mortality related to sexual and reproductive health, with a maternal mortality ratio of 789 deaths per 100,000 live births[54]. According to the United Nations Population Fund[55] the country has one of the highest maternal mortality rates in the world.

Research shows that 82% of women and 81% of men agreed that 'women should tolerate domestic violence in order to keep their families together'. The majority, 68% of females and 63% of males, also agreed that 'there are times when a woman deserves to be beaten'. Women (47%) were more likely than men (37%) to agree that 'it is okay for a man to hit his wife if she won't have sex with him' . Even in a happy marriage, women are at risk in South Sudan, which has one of the highest maternal mortality rates in the world at 14% [56].

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[51] Concerned Worldwide. The South Sudan Crisis, explained:5 things you need to know in 2022. https://www.concern.net/news/south-sudan-crisis-explained

[52] Ministry of Health, Republic of South Sudan. Health Sector Development Plan 2012–2016. South Sudan: Ministry of Health; 2012

[53] Concerned Worldwide. Gender Equality in South Sudan: What we know in 2022. https://www.concern.net/news/gender-equality-in-south-sudan

[54] World Health Organisation. Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva: World Health Organisation; 2015

[55] United Nations Population Fund. (2021). South Sudan. Retrieved from https://esaro.unfpa.org/en/countries/south-sudan

[56] Scott et al. An assessment of gender inequitable norms and gender-based violence in South Sudan: a community-based participatory research approach. Conflict Health. 2013 Mar 6;7(1):4. doi: 10.1186/1752-1505-7-4. PMID: 23497469; PMCID: PMC3599371.

3.2 The Status of Women's Sexual and Reproductive Health and Rights in South Sudan

Armed conflict has had a significant impact on the availability and accessibility of sexual and reproductive health and rights (SRHR) services in South Sudan. The ongoing civil war in South Sudan has created a heightened sense of insecurity, which has increased the need for SRHR services. However, the lack of resources, infrastructure, and healthcare personnel has hindered the delivery of these services, exacerbating existing gender-based inequalities and leading to an increase in gender-based violence [57].

In addition, the conflict has had a negative impact on maternal health outcomes, with an increase in maternal mortality rates. The lack of access to SRHR services, including family planning, maternal and child health services, and treatment for sexually transmitted infections (STIs) and HIV/AIDS, has further exacerbated the situation. The displacement of people due to the conflict has also disrupted regular healthcare providers, limiting access to essential services [58]. The conflict in South Sudan has resulted in the displacement of millions of people and widespread human rights abuses. It is crucial to address the SRHR needs of women in South Sudan comprehensively and equitably to promote their health and well-being [59].

Furthermore, the implementation and enforcement of laws and policies aimed at promoting SRHR in South Sudan remains limited due to the ongoing conflict, limited resources, among other challenges. The status of women's SRHR in South Sudan is characterized by limited access to family planning services, high maternal mortality rates, limited comprehensive sexual and reproductive health education, and vulnerability to sexual violence. Traditional practices such as female genital mutilation and early marriage also impact women's reproductive health and their ability to make informed decisions about their bodies.

3.3 National Legal Instruments on Sexual and Reproductive Health and Rights in South Sudan

The legal instruments that protect the sexual and reproductive rights of women in South Sudan include:

[57] Murphy, M., Roberts, L., Oram, S., & Devries, K. (2019). Exploring barriers to accessing sexual and reproductive health services during conflict in South Sudan. BMJ Global Health, 4(5), e001676. https://doi.org/10.1136/bmjgh-2019-001676
[58] Ibid
[59] United Nations. (n.d.). South Sudan: Background. Retrieved from https://www.un.org/peacekeeping/missions/unmiss/background.shtml

1. The Constitution of the Republic of South Sudan 2011 which recognizes the rights of women to equality and to access health services, including reproductive health services. Article 32 states that every person has the right to health care and Article 38 states that every person has the right to the highest attainable standard of health [60]. The Sexual Offences Act 2008 criminalizes sexual violence, including rape and sexual harassment. The act also provides for the protection and rehabilitation of victims of sexual violence [61].

2. The Marriage Act 2014 sets the minimum age of marriage at 18 years old and requires the free and full consent of both parties to a marriage [62]. The Child Act 2008 defines a child as a person under 18 years of age and provides for their protection and well-being, including the right to health care and education [63]. The Health Care Act 2016 provides for the regulation of health care services and the protection of the right to health care, including reproductive health services [64].

3. The National Health Policy [65] prioritizes maternal health and family planning services. The Reproductive Health and Rights Policy calls for the provision of reproductive health service. The HIV/AIDS Prevention and Control Act provides for the protection of women's rights in the context of HIV/AIDS

3.4 Factors Undermining the implementation of Legal Instruments on Sexual and Reproductive Health and Rights.

A combination of political, economic, and sociocultural factors contribute to the challenges faced by the government of South Sudan in translating legal and policy commitments on SRHR into action. These limited factors include:

1. Ongoing conflict and insecurity: South Sudan has been dealing with a protracted civil war since gaining independence in 2011, characterized by violence, displacement of people, and human rights abuses (United Nations, n.d.). This conflict has had a devastating impact on the delivery of health services, with many healthcare facilities destroyed or closed down, healthcare workers leaving the country, medical supplies and medicines in short supply [66] . As a result, the conflict has led to limited access to critical health services, including sexual and reproductive health services, maternal and child health services, and treatment for infectious diseases such as HIV/AIDS and tuberculosis [67].

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[60] Constitution of the Republic of South Sudan 2011, https://www.constituteproject.org/constitution/South_Sudan_2011.pdf
[61] Sexual Offences Act 2008, https://www.refworld.org/pdfid/4b817c7b2.pdf
[62] Marriage Act 2014, https://www.refworld.org/pdfid/5b96a01a4.pdf
[63] Child Act 2008, https://www.unicef.org/southsudan/media/4826/file/Child%20Act%202008.pdf
[64] Health Care Act 2016, https://www.nhsrc.sd/en/laws/Health%20Care%20Act.pdf
[65] South Sudan National Health Policy and Strategic Plan 2016-2021, https://apps.who.int/iris/handle/10665/259443
[66] United Nations Population Fund. (2021). South Sudan. Retrieved from https://esaro.unfpa.org/en/countries/south-sudan
[67] Murphy, M., Roberts, L., Oram, S., & Devries, K. (2019). Exploring barriers to accessing sexual and reproductive health services during conflict in South Sudan. BMJ Global Health, 4(5), e001676. https://doi.org/10.1136/bmjgh-2019-001676

2 Limited resources and infrastructure: The government of South Sudan faces significant challenges in terms of resource acquisition, allocation and infrastructure development, which can make it difficult to deliver essential health services to those in need [68].

3 Sociocultural factors such as gender inequality, early marriage, and stigma around SRHR issues create significant barriers to the implementation of policies and programs aimed at improving access to these services. For example, early marriage increases the risk of complications during pregnancy and childbirth, and limits educational and economic opportunities for women, making it difficult for them to access SRHR services [69]. Similarly, stigma around SRHR issues, particularly contraception and abortion, can lead to a reluctance to seek these services, and makes it challenging for healthcare providers to deliver these services in a sensitive and non-judgmental manner [70].

4 Policies and programmes that aim to improve access to SRHR services in South Sudan are affected by sociocultural factors. For example, programmes aimed at improving access to family planning services face resistance due to cultural norms around large family sizes and the perceived importance of childbearing for women [71]. Similarly, efforts to address gender-based violence, which can have negative impacts on SRHR, may face resistance due to traditional gender norms and beliefs around domestic violence and women's rights [72].

5 The lack of political will can be seen in the government's failure to allocate adequate resources and implement programmes that promote and protect women's SRHR, including access to maternal health care and family planning services. For example, while South Sudan's health policies prioritize maternal and child health services, the implementation of these policies has been limited due to a lack of political will and resources.

6 Similarly, while South Sudan has made some progress in advancing women's rights and SRHR, further action is needed to fully implement policies and programmes. For instance, the government's National Strategic Plan on Gender-Based Violence (GBV) aims to prevent and respond to GBV, including sexual violence. However, implementation of the plan has been limited, and GBV remains a significant problem in the country due to a lack of resources and political will [73].

[68] United Nations Population Fund. (2021). South Sudan. Retrieved from https://esaro.unfpa.org/en/countries/south-sudan
[69] United Nations Population Fund. (2021). South Sudan. Retrieved from https://esaro.unfpa.org/en/countries/south-sudan
[70] Murphy, M., Roberts, L., Oram, S., & Devries, K. (2019). Exploring barriers to accessing sexual and reproductive health services during conflict in South Sudan. BMJ Global Health, 4(5), e001676. https://doi.org/10.1136/bmjgh-2019-001676
[71] Murphy, M., Roberts, L., Oram, S., & Devries, K. (2019). Exploring barriers to accessing sexual and reproductive health services during conflict in South Sudan. BMJ Global Health, 4(5), e001676. https://doi.org/10.1136/bmjgh-2019-001676
[72] United Nations Population Fund. (2021). South Sudan. Retrieved from https://esaro.unfpa.org/en/countries/south-sudan
[73] Ibid

3.5 National and International Actors providing Sexual and Reproductive Health Services

A number of organizations and actors are providing sexual and reproductive health services to women in South Sudan, including government health facilities and clinics, although their capacity is limited due to ongoing conflict, limited funding, and other challenges. International actors and local non-governmental organizations (NGOs), provide reproductive health services and support in areas where government services are limited. Community-based organizations, such as women's groups and youth organizations provide education, counselling, and support related to sexual and reproductive health.

Some of the conflict specific sexual and reproductive health services available to women in South Sudan include emergency obstetric and neonatal care; prevention and management of sexual and gender-based violence; HIV testing, counselling, and treatment; family planning and contraception services and antenatal and postnatal care

In South Sudan, the government is responsible for providing sexual and reproductive health services to women through various government agencies and bodies, including:

Ministry of Health which is responsible for the overall coordination and management of the health sector in South Sudan including maternal and child health services, family planning, and care for survivors of sexual violence [74]. National AIDS/STI Control Program (NASCP) [75] is responsible for the prevention and control of HIV/AIDS and sexually transmitted infections (STIs) in South Sudan. It provides education and services for sexual and reproductive health, including testing and counselling for HIV/AIDS.

National Women's Health Policy Unit (NWHPU) [76] is responsible for developing and implementing policies to improve the health and well-being of women and girls in South Sudan. It provides and coordinates sexual and reproductive health services, including maternal and child health services, family planning, and care for survivors of sexual violence. Similarly, the State Ministry of Health is responsible for the provision of health services in each of the ten states of South Sudan. Additionally, a number of international organizations and actors are providing sexual and reproductive health services to women. They include;

1. **United Nations Population Fund (UNFPA) [77] is providing comprehensive reproductive health services, including family planning and maternal health services, in South Sudan. It is also supporting the strengthening of the health system and the training of health workers. International Rescue Committee (IRC) [78] offers comprehensive sexual and reproductive health services, including maternal health services, family planning, and care for survivors of sexual violence.**

[74] Ministry of Health, Republic of South Sudan, "Health System in South Sudan," 2021, https://www.moh.gos.sd/index.php/our-services/health-system
[75] National Aids/STI Control Program (NASCP), "National AIDS/STI Control Program (NASCP)," 2021, https://www.nascp.org/
[76] National Women's Health Policy Unit (NWHPU), "National Women's Health Policy Unit (NWHPU)," 2021, https://nwhpu.org/
[77] United Nations Population Fund (UNFPA), "South Sudan - UNFPA country profile," 2021, https://www.unfpa.org/south-sudan-unfpa-country-profile
[78] International Rescue Committee (IRC), "South Sudan: Sexual & Reproductive Health," 2021, https://www.rescue.org/country/south-sudan/sexual-reproductive-health

2 United Nations Children's Fund (UNICEF) [79] is working to improve maternal and child health, including providing support for the prevention and response to sexual violence against women and girls. Medecins Sans Frontieres (MSF) [80] is providing comprehensive sexual and reproductive health services, including maternal health services and care for survivors of sexual violence. World Health Organization (WHO) [81] extends support to the government of South Sudan in strengthening the health system and improving access to health services, including sexual and reproductive health services.

3 Marie Stopes South Sudan provides family planning, maternal and child health, safe abortion services, comprehensive sexuality education and support for survivors of sexual and gender-based violence. International Planned Parenthood Federation (IPPF) offers a range of reproductive health services, including family planning, maternal health, and HIV and AIDS services, through its local partners in South Sudan.

4 IPAS is global non-profit organization that works to prevent deaths and injuries from unsafe abortion, and to ensure access to safe abortion services, post-abortion care, and comprehensive sexuality education. Reproductive Health for Refugees Consortium (RHRC) provides comprehensive reproductive health services, including family planning and maternal health services, to refugees and internally displaced persons in South Sudan.

5 These are just a few of the many civil society organizations working to provide sexual and reproductive health services to women in South Sudan. Despite the challenges posed by ongoing conflict and limited resources, local organizations also play a critical role in ensuring that women have access to essential sexual and reproductive health services and in promoting their rights. Local organizations that provide sexual and reproductive health services to women in South Sudan include:

A Association for Reproductive Health and Family Planning (ARHFP) is a local organization that works to promote reproductive health and family planning services, as well as prevent and respond to gender-based violence. South Sudan Women Empowerment Network (SSWEN), a local network of women's organizations provides comprehensive sexual and reproductive health services, including maternal healthcare, family planning, as well as support for survivors of sexual and gender-based violence.

B Youth Empowerment for Peace and Development (YEPAD) provides comprehensive sexuality education, as well as services related to family planning, maternal health, HIV/AIDS prevention and treatment. Juba Women's Network (JWN) promotes gender equality, women's rights, and access to reproductive health services, including maternal health and family planning. South Sudan Women's Health Association (SSWHA) provides reproductive health services, including family planning and maternal health services, as well as support for survivors of sexual and gender-based violence.

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[79] United Nations Children's Fund (UNICEF), "South Sudan: Maternal, Newborn and Child Health," 2021, https://www.unicef.org/southsudan/mnch

[80] Medecins Sans Frontieres (MSF), "South Sudan," 2021, https://www.msf.org/south-sudan

[81] World Health Organization (WHO), "South Sudan: Health System Review," 2017, https://apps.who.int/iris/bitstream/handle/10665/257921/9789241565196-eng.pdf?sequence=1&isAllowed=y

3.6 Gaps in Access to Sexual and Reproductive Health Services

South Sudan faces significant gaps in providing sexual and reproductive health services, with limited access to contraception, maternal and child health services, sexual education, and treatment for sexually transmitted infections (STIs) and HIV/AIDS. Gender-based violence and harmful traditional practices, such as female genital mutilation and child marriage, also impact women's access to sexual and reproductive health services.

17% of women in South Sudan use modern methods of family planning[82]. This is due to limited availability, accessibility, cultural and religious opposition, and insufficient training for healthcare personnel. Additionally, South Sudan has one of the highest maternal mortality rates in the world, with an estimated 889 maternal deaths per 100,000 live births in 2020[83]. Women in South Sudan face numerous barriers to accessing maternal health services, including a lack of trained health workers, poor road infrastructure, and conflict.

Furthermore, 35% of women in South Sudan have basic knowledge of reproductive health, leaving them vulnerable to sexually transmitted infections (STIs), including HIV/AIDS, and unintended pregnancies[84]. The prevalence of gender-based violence in South Sudan, particularly in conflict-affected areas, also limits access to comprehensive sexual violence services, including medical and psychological care, and legal protection.

[82] World Health Organization. (2017). South Sudan: WHO statistical profile. Retrieved from https://www.who.int/gho/countries/ssd.pdf?ua=1
[83] United Nations Population Fund. (2021). State of World Population 2021: My body is my own. Retrieved from https://www.unfpa.org/sites/default/files/pub-pdf/State_of_World_Population_2021_EN.pdf
[84] United Nations Children's Fund. (2019). Knowledge, Attitudes, Practices and Behaviours Survey on Reproductive Health among Women and Men of Child Bearing Age in South Sudan. Retrieved from https://www.unicef.org/southsudan/reports/knowledge-attitudes-practices-and-behaviours-survey-reproductive-health-among-women

3.7 Recommendations

Addressing existing gaps is critical to ensuring that women in South Sudan have access to essential sexual and reproductive health services. Efforts to improve the quality and accessibility of these services must be sustained, and must involve a wide range of partners, including government, international organizations, civil society, and communities. The following actions should be taken:

1. The government of South Sudan should ensure that laws and policies fully reflect the sexual and reproductive rights of women and girls, and ensure their implementation in practice. The legal framework in South Sudan needs to be strengthened to ensure the protection of the sexual and reproductive rights of women. This includes implementing international and regional human rights instruments, developing and enforcing laws to protect women from violence and discrimination, and improving access to justice for survivors. The on-going permanent constitution making process is a great opportunity to ensure that South Sudan has a gendered constitution that addresses the intersectional needs of women.

2. Development partners, international organizations, and the private sector should increase their support for the provision of sexual and reproductive health services to women in South Sudan, including essential medicines, supplies, and equipment.

3. The government of South Sudan must strengthen the health system to improve the availability and quality of sexual and reproductive health services. This includes improving infrastructure, increasing the number of trained health workers, and improving the delivery of services.

4. Expand access to health services: In order to increase access to health services, the government and its partners can take practical measures such as improving infrastructure and resources in rural and conflict-affected areas, increasing the number of trained health workers, and providing comprehensive sexual and reproductive health services to women and girls. This would involve building and repairing health clinics, providing medical equipment and supplies, and ensuring that healthcare workers are adequately trained and supported. In addition, efforts could be made to increase awareness and understanding of sexual and reproductive health issues through community education and outreach programs. By prioritizing the provision of quality health services, including sexual and reproductive health services, the government and its partners can help to address the persistent gaps in healthcare access in South Sudan and improve the health outcomes of women and girls in the country.

5 Efforts should be made by the Government and its partners to address societal attitudes and beliefs that act as barriers to women's access to sexual and reproductive health information and services. This includes promoting gender equality and women's empowerment, as well as advocating for policies and programs that prioritize women's sexual and reproductive health and rights. By working together to address these societal barriers and promote gender equality, it is possible to improve women's access to sexual and reproductive health information and services and ultimately promote better health outcomes for women and girls.

6 The government, international organizations, and civil society government, should work together to enhance monitoring and accountability for respect of women's sexual and reproductive rights in South Sudan. Those responsible for abuses of these rights like government officials who fail to prioritize and allocate resources to SRHR programs, healthcare workers who discriminate against women seeking SRHR services, armed groups who commit sexual violence against women and community leaders who perpetuate harmful traditional practices such as female genital mutilation and early marriage should be held accountable through legal and policy measures. SRHR to be monitored include access to family planning services, maternal and child health services, sexual and reproductive health education, and prevention and response to sexual violence.

3.8 Conclusion

In conclusion, the sexual and reproductive health rights and needs of women in South Sudan are of great concern. Despite the existence of international and regional legal instruments that protect these rights, the country faces significant challenges in ensuring the protection and provision of these services to women. To close these gaps, it is crucial to increase funding for the health sector, strengthen the health system, address gender-based violence, promote women's empowerment, and strengthen the legal framework. With these efforts, the sexual and reproductive health rights and needs of women in South Sudan can be ensured and their overall well-being improved.

CASE STUDY OF:

CENTRAL AFRICAN REPUBLIC.

890

DEATHS PER

100,000

LIVE BIRTHS.

Central African Republic has the worst infant mortality rate in the world and one of the worst maternal mortality rates.

4.0 CENTRAL AFRICAN REPUBLIC

4.1 Background

The Central African Republic (CAR) has had a long history of violent conflict and political instability. Since the crisis erupted in 2013 several efforts have been made to bring the country back from the brink of armed conflict. In February 2019, the Sudan Peace Talks led to the signing of a Peace Accord by the government with the leaders of 14 armed groups. Unlike preceding deals this appeared to be making headway, with strong support from the international community and a disarmament, demobilization, reintegration and repatriation programme. However, disputed elections in December 2020 sparked fresh violence, and the forming of a new coalition of armed groups, known as the Coalition of Patriots for Change (CPC), comprising a number of signatories of the peace agreement[85].The drivers of fragility include a lack of social cohesion, the concentration of political power, social and regional disparities, the capture and mismanagement of natural resources by the elite and persistent insecurity fueled by a regional system of conflicts.

Years of conflict and instability have destroyed infrastructure and government institutions, leaving millions of Central Africans without access to clean water, health care and food. As of April 2022, more than 737,000 Central Africans were registered as refugees — a 16% increase compared to 2020. The UNHCR estimates an additional 632,000 are internally displaced[86], with 3.1 million people, nearly 65% of the population, requiring humanitarian assistance. CAR is consistently ranked at or near the bottom of the UNDP's annual Human Development Index, making it one of the least developed countries in the world[87].

CAR has the worst infant mortality rate in the world and one of the worst maternal mortality rates, with 890 deaths per 100,000 live births. Plagued by a measles epidemic since 2020, the country has also experienced major malaria epidemics, which remains the leading cause of severe illness. Life expectancy in CAR is among the lowest in the world, with the average Central African reaching just 53 years of age. While men account for most of the conflict's dead and wounded, women, girls, boys, and the disabled are greatly affected by difficulties in accessing basic social services such as education, sexual and reproductive healthcare, and nutrition. Women and girls are at a higher risk of abuse when they cannot access health facilities[88].

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[85] Conciliation Resources. Central Africa Republic: the conflict in focus.
https://www.c-r.org/programme/east-and-central-africa/CAR-conflict-in-focus?gclid=CjwKCAjw6liiBhAOEiwALNqncQ4wYK1Yben9FpXt5K1E5A-4VsCsIlLH0nHL-098dvA_o8B4G1BPTBoCRD0QAvD_BwE

[86] https://data.unhcr.org/en/situations/car#_ga=2.65597101.200544373.1650024833-1372254080.1634045872

[87] Concerned Worldwide. https://www.concernusa.org/story/central-african-republic-crisis-explained/

[88] Concerned Worldwide. https://www.concernusa.org/story/central-african-republic-crisis-explained/

4.2 The Status of Sexual and Reproductive Health and Rights of Women in CAR

The consequences of the conflict in Central African Republic have been particularly detrimental to women's sexual and reproductive health and rights. Total fertility rate in CAR is 4.8 births per women, adolescent birth rate is 129.1 per 1,000 women aged 15 to 19 years. Maternal mortality is very high at 829 per 100,000 live births with a neonatal mortality rate of 39.7 per 1,000 live births. Women's access to contraception/family planning is low with only 27.6% women demanding for modern method of contraception. Unmet needs of family planning is 37.6% for women aged 15 to 49 years. Women in the Central African Republic face high rates of maternal mortality and morbidity due to poor access to quality maternal health care and services[89].

The conflict had a devastating impact on the lives of women and girls as it has led to an increased incidence of sexual violence, lack of access to healthcare and contraception. Access to family planning services is limited in the Central African Republic, which contributes to high levels of unintended pregnancy and unsafe abortion[90].This has resulted in a decrease in women's overall health, including increased maternal mortality, a rise in unintended pregnancies and child marriage.

The conflict has displaced several people, resulting in decreased access to sexual and reproductive health services. This has made it difficult for women to access basic healthcare and contraception due to financial constraints. The conflict has also led to a decrease in the quality of healthcare available to women, as there is less access to essential health services such as antenatal care and HIV/AIDS prevention. Inadequate access to reproductive health services is also a product of the structural and socio-cultural context of the country, including the patriarchal system, gender-based violence, weak governance, and infrastructure.

4.3 The Status of Sexual and Reproductive Health and Rights of Women in CAR

The national and local legal frameworks in the Central African Republic provide some protection for the sexual and reproductive rights of women.
The 2016 National Constitution guarantees the right to health and equality before the law, including sexual and reproductive health and rights (Article 30). The Central African Republic has several laws and policies in place to address gender-based violence and protect the rights of women and girls. These include the 2016 Law on the Prevention and Punishment of Violence Against Women and Girls, which criminalizes all forms of violence against women and girls, including sexual violence.
The 2010 National Strategy for the Promotion of Gender Equality and the Empowerment of Women, also aims to promote gender equality and the empowerment of women in all sectors of society, including in the health sector.

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[89] UNFPA. (2020). The Central African Republic: A Humanitarian and Reproductive Health Crisis. Retrieved from https://www.unfpa.org/crisis/central-african-republic.
[90] UNFPA. (2020). The Central African Republic: A Humanitarian and Reproductive Health Crisis. Retrieved from https://www.unfpa.org/crisis/central-african-republic.

4.4 Factors Undermining Implementation of Legal Instruments on SRHR.

The government of the Central African Republic (CAR) faces several challenges in translating legal and policy commitments into action to protect the sexual and reproductive health and rights (SRHR) of women. One major challenge is the ongoing conflict, which has disrupted the delivery of essential health services and made it difficult to enforce laws and policies[91]. In addition, weak governance and limited access to justice make it challenging to implement legal protections[92].

Furthermore, the CAR government faces financial constraints that limit its ability to provide basic health services to its citizens, particularly in rural and conflict-affected areas[93]. This can lead to a lack of access to essential reproductive health services, including family planning and maternal healthcare. The government has also been criticized for failing to prioritize women's health and rights, particularly in the context of sexual and reproductive health[94].

For instance, despite the existence of laws and policies that criminalize gender-based violence, including sexual violence, and provide for the protection of women's rights, implementation of these protections remains a challenge in the CAR. The ongoing conflict and weak governance result in a lack of enforcement of these laws and protections, leaving women and girls vulnerable to violence and abuse[95].

4.5 National and International Actors providing SRH Services

The government of the Central African Republic has the responsibility of providing sexual and reproductive health services to women in the country. However, due to limited capacity and the ongoing conflict, the delivery of these services is often carried out by international and local non-governmental organizations (NGOs) in partnership with the government. Some of the government bodies and agencies involved in providing sexual and reproductive health services in the Central African Republic include the Ministry of Health which is responsible for providing health services to the population, including sexual and reproductive health services[96]. The National Reproductive Health Programme, within the Ministry of Health, is responsible for implementing policies and programs related to sexual and reproductive health, including maternal and child health, family planning, and the prevention of HIV and sexually transmitted infections (STIs)[97]

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[91] UNFPA. (2020). Central African Republic. https://www.unfpa.org/where-we-work/central-african-republic
[92] Global Majority E-Journal. (2019). Women, conflict, and post-conflict situations: The case of the Central African Republic. https://escholarship.org/uc/item/00m1613q
[93] World Health Organization (WHO). (2020). Central African Republic. https://www.who.int/countries/caf/en/
[94] UNFPA. (2020). Central African Republic. https://www.unfpa.org/where-we-work/central-african-republic
[95] Global Majority E-Journal. (2019). Women, conflict, and post-conflict situations: The case of the Central African Republic. https://escholarship.org/uc/item/00m1613q
[96] Ibid 7
[97] UNFPA. (2020). The Central African Republic: A Humanitarian and Reproductive Health Crisis. Retrieved from https://www.unfpa.org/crisis/central-african-republic.

International actors provide a range of health services, including sexual and reproductive health services, to women in conflict-affected areas. They include:

1. The United Nations Population Fund (UNFPA) working to improve sexual and reproductive health services such as maternal health care, family planning, prevention and response to gender-based violence[98]. Médecins Sans Frontières (MSF) provides medical and humanitarian aid in conflict-affected area including sexual and reproductive health services such as obstetric care, family planning, and treatment of sexually transmitted infections[99].

2. Population Services International (PSI) provides sexual and reproductive health services such as family planning and HIV/AIDS prevention and treatment[100]. The International Rescue Committee (IRC) provides sexual and reproductive health services such as family planning, maternal health care, and gender-based violence prevention and response[101].

3. Local NGOs and Community-based organizations working in partnership with the government and other stakeholders to ensure that women have access to quality sexual and reproductive health services in the Central African Republic include:

A. Association pour la Promotion de la Santé de la Femme et de l'Enfant en Centrafrique (APROSOFEC) a non-governmental organization that works to promote the health of women and children in the Central African Republic, including providing sexual and reproductive health services. Réseau Centrafricain des Associations et ONG de Lutte contre le Sida (RECAOLSA) a network of non-governmental organizations works to combat HIV/AIDS in the Central African Republic, by which includes providing sexual and reproductive health services to those affected by HIV/AIDS.

B. Association des Femmes Juristes de Centrafrique (AFJC) promotes and protects the rights of women in the Central African Republic, including advocating for women's access to sexual and reproductive health services. Fondation Voix du Coeur provides sexual and reproductive health education and services to women and girls in the Central African Republic.

[98] UNFPA. (2021). Central African Republic. Retrieved from https://www.unfpa.org/where-we-are/central-african-republic
[99] MSF. (2021). Central African Republic. Retrieved from https://www.msf.org/central-african-republic
[100] PSI. (2021). Central African Republic. Retrieved from https://www.psi.org/where-we-work/central-african-republic/
[101] IRC. (2021). Central African Republic. Retrieved from https://www.rescue.org/country/central-african-republic

4.6 Gaps in Access to Sexual and Reproductive Health Services

Despite efforts by the government, international actors and non-governmental organizations to provide sexual and reproductive health services in CAR, access remains limited.

Access to sexual and reproductive health services in the Central African Republic (CAR) is severely limited due to a range of structural and socio-cultural factors. One major challenge is the ongoing conflict in the country, which has disrupted the delivery of health services and left many women without access to essential care. The conflict has led to an increase in sexual violence against women and girls, as well as limited access to healthcare and contraceptives. This has resulted in increased rates of maternal mortality, unsafe abortions, and other health problems[102].

Weak governance and infrastructure, gender-based violence, poverty, limited education and awareness about sexual and reproductive health also contribute to the gaps in access to sexual and reproductive health services. The patriarchal system in CAR also contributes to the limited access to sexual and reproductive health services, as women's autonomy and decision-making power are often restricted in the context of their health[103].

Many women in rural areas lack access to health services due to limited infrastructure and resources, while those living in conflict-affected areas face increased risk of violence and limited access to healthcare. Furthermore, there is a lack of trained healthcare providers and resources, which limits the availability of essential health services such as antenatal care and HIV/AIDS prevention[104].

Limited funding and resources, as well as the ongoing conflict, make it difficult for local organizations to reach women in need of sexual and reproductive health care services.

[102] UNFPA. (2020). The Central African Republic: A Humanitarian and Reproductive Health Crisis. Retrieved from https://www.unfpa.org/crisis/central-african-republic
[103] International Planned Parenthood Federation (IPPF). (2020). Central African Republic: sexual and reproductive health and rights. Retrieved from https://www.ippf.org/where-we-work/central-african-republic
[104] UNFPA. (2020). The Central African Republic: A Humanitarian and Reproductive Health Crisis. Retrieved from https://www.unfpa.org/crisis/central-african-republic

4.7 Recommendations

The following actions should be taken to close the gaps in protecting the sexual and reproductive rights of women in the Central African Republic:

1. Strengthening legislation: The existing legislation in the Central African Republic aimed at protecting the sexual and reproductive rights of women is weak and in need of strengthening. For instance, the current laws do not explicitly prohibit child marriage, which remains a significant issue in the country. In addition, the penalties for sexual violence are not severe enough to deter perpetrators, and there is a lack of resources for law enforcement agencies to effectively prosecute cases of gender-based violence. Furthermore, there is a need to strengthen laws around access to reproductive health services to ensure that women are able to access the services they need without facing barriers.

2. Similarly, while the National Strategy for the Promotion of Gender Equality and the Empowerment of Women acknowledges the need for improving access to reproductive health services, there are no specific laws or policies that guarantee access to these services. This has resulted in a lack of access to essential reproductive health services such as contraception, antenatal care, and safe abortion. The lack of access to these services has contributed to high rates of maternal mortality and morbidity, as well as unintended pregnancies.

3. Providing access to information and services: the government and civil society organizations can collaborate to provide comprehensive sexual and reproductive health information and services to women, thereby increasing access to these crucial resources. Some of the steps that can be taken to achieve this include creating awareness campaigns on sexual and reproductive health, training healthcare professionals to provide quality services to women, and establishing clinics and facilities that are well-equipped to handle sexual and reproductive health issues. Additionally, outreach programs can be developed to ensure that women in remote or underserved areas have access to these services. Furthermore, the government can work towards creating policies that promote sexual and reproductive health and rights, such as ensuring that contraceptives and other family planning methods are readily available and affordable.

4. Addressing violence against women: Efforts must be made by the government for example through raising awareness about the negative effects of violence against women, strengthening laws and policies to hold perpetrators accountable, and providing access to comprehensive medical and psychosocial support for survivors.

5 Additionally, community-based initiatives can be established to empower women and girls, such as providing education and skills training to help them become more self-sufficient and less vulnerable to violence. It is also crucial to engage men and boys in efforts to end violence against women, including through education and advocacy programs that promote gender equality and healthy relationships. Finally, it is important to ensure that survivors of violence have access to safe and confidential reporting mechanisms, as well as legal and justice systems that are responsive to their needs.

6 Empowering women: Empowering women to make informed decisions about their sexual and reproductive health requires collaborative efforts from the government, civil society organizations, and the wider community. One critical step is to provide comprehensive sexuality education to girls and young women, including information about contraception, sexually transmitted infections, and healthy relationships. This can be done through programs led by the Ministry of Education and local organizations that engage with schools and communities. Another key action is to ensure that women have access to quality sexual and reproductive health services, including family planning and maternal health care. To achieve this, the government and non-governmental organizations can collaborate to establish and equip health centers and clinics that provide these services, especially in rural and underserved areas. Moreover, women's economic empowerment can play a vital role in ensuring their autonomy and ability to make decisions about their own health and well-being. This can be achieved by creating vocational training programs and entrepreneurship opportunities, which can be led by the Ministry of Women's Affairs and supported by civil society organizations. Additionally, there should be measures in place to ensure that women are represented in decision-making processes at all levels, including in government and civil society organizations, to ensure their voices are heard and their perspectives are considered.

7 Improving healthcare infrastructure: Specific actions that can be taken to improve healthcare infrastructure for women in CAR include building and equipping health centers and clinics that are accessible and offer comprehensive sexual and reproductive health services. This can be done through a collaborative effort between the government and international organizations, which can also provide training to healthcare providers on how to provide quality services. Furthermore, ensuring the availability and accessibility of essential medicines and supplies is key to improving healthcare infrastructure. The Ministry of Health, with the support of international organizations, can work towards ensuring that there is a reliable supply of essential medicines and supplies, especially those needed for maternal and child health. Additionally, measures can be taken to improve the capacity of healthcare providers, such as providing for continuous professional development and incentives to retain trained personnel in underserved areas.

8 Increasing resources: Specific actions that can be taken to allocate additional resources include increasing funding for government agencies and civil society organizations that work towards improving sexual and reproductive health outcomes for women. The Ministry of Health should work towards securing sufficient funding for comprehensive sexual and reproductive health services, including family planning and maternal health care. The Ministry of Women's Affairs can also advocate for increased funding to support initiatives that empower women and girls, such as education and skills training programs. Additionally, the international community should support these efforts by providing funding to government agencies and civil society organizations. This can include financial support for the establishment of health centers and clinics, training for healthcare providers, and the provision of essential medicines and supplies.

9 Involving men and boys: Engaging men and boys is crucial in promoting sexual and reproductive health and rights in a comprehensive and sustainable way. This requires a multi-faceted approach, including promoting gender equality, preventing violence against women and girls, and providing education and information on sexual and reproductive health. To achieve this, community-based initiatives can be established to engage men and boys in conversations on these issues, with the goal of challenging harmful gender norms and promoting positive behaviors. This can be done through activities such as peer-led education, community dialogues, and social media campaigns. Additionally, men and boys can be encouraged to become advocates for gender equality and the prevention of violence against women, which can lead to lasting social change. Schools can also play an important role in engaging boys and young men in discussions around sexual and reproductive health and rights, through the integration of comprehensive sexuality education into the curriculum.

4.8 Conclusion

In conclusion, the sexual and reproductive health and rights of women in the Central African Republic continues to be under threat, despite some national and international legal frameworks that provide protections for these rights. The ongoing conflict, limited access to health services, poor quality of services, and lack of information and education contribute to significant gaps in the protection and promotion of SRHR for women and girls in the country. This is worsened by stigma and discrimination, including gender-based violence, which limit women's access to and use of SRHR services.

CASE STUDY OF:

MALI

2,070

PEOPLE IN MALI HAVE DIED FROM VIOLENT CONFLICT SINCE MAY 2020.

It is well-documented that women in Mali face numerous barriers to accessing sexual and reproductive health services.

5.0 MALI

5.1 Background

The conflict in Mali, known as the Northern Mali Conflict, began in 2012 between the northern and southern parts of Mali[105]. In January 2012, several groups within Mali began an armed campaign against the Malian Government demanding for the independence of northern Mali, the area referred to as Azawad. Mali has taken the steps of formal peace agreements in attempts to creating stability and security, however the true validity of the peace processes lies in understanding, and subsequently solving the root causes of the violent conflict[106]. The multidimensional threats to Malian security can be observed as a result of cumulative continuous micro-conflicts since the 1960s after Malian independence[107]. The underlying causes of the Malian intra-state conflict are extensive, and include discriminatory political institutions, the exclusionary national ideologies, inter-group politics, and the elite politics.

Terrorists and armed groups occupying parts of northern Mali violated the rights of the local population, and especially those of women and girls. They flogged and publicly stoned women falsely accused of breaking the law. The rampant banditry and armed group attacks dramatically affected the delivery of health services, education, and aid to north and central Mali. Since May 2020, violent conflict has killed 2,070 people in Mali. Insecurity has forcibly displaced more than 300,000 people, of whom 56 per cent are women[108].

The sexual and reproductive health and rights of women in Mali have a long, complex history. For centuries, women have been controlled by and marginalized within traditional Malian society. It is well-documented that women in Mali face numerous barriers to accessing sexual and reproductive health services. Socio-cultural factors, such as religion and gender roles, play a major role in limiting women's access to sexual and reproductive health services. Specifically, religious beliefs and gender norms lead to a lack of knowledge and awareness of sexual and reproductive health services. Additionally, the existing services are often not financially accessible, further limiting women's access to health care[109].

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[105] Chauzal, G., & Thibault, T. (2015, March). The roots of Mali's conflict: Moving Beyond the 2012 Crisis. Retrieved from https://www.clingendael.org/pub/2015/the_roots_of_malis_conflict/

[106] McCoy, D. (2008). Rectifying horizontal inequalities: lessons from African conflict. African Journal on Conflict Resolution, 8(1), 105-134.

[107] Farah, E., Gandhi, R., & Robidoux, S. (2019, January 12). Mali 2019 Fragile States Policy Brief. Retrieved from https://carleton.ca/cifp/2019/mali-2019-fragile-states-policy-brief/

[108] Kheira, T and Anab O. G. 2021, Climate Change and Violent Conflict in Mali. https://www.accord.org.za/analysis/climate-change-and-violent-conflict-in-mali/

[109] Haidara, F., Maiga, A. S., Sow, A. O., & Traoré, D. (2017). Gender and Reproductive Health Care in Mali: A Qualitative Analysis of Women's Experiences. Journal of health care for the poor and underserved, 28(2), 790–810.

Moreover, the fear of judgement and stigma from health care providers and families prevents women from accessing sexual and reproductive health services. Lastly, that there is a lack of legal protection of women's sexual and reproductive health rights, which prevents women from accessing the resources they need[110].

Traditional gender roles have had a significant impact on the sexual and reproductive health and rights of women. Adherence to traditional gender roles has led to a lack of knowledge about sexual and reproductive health among women in Mali. This has also limited their access to resources and services related to sexual and reproductive health, such as contraception, family planning services, or knowledge of the risks associated with unsafe sexual activities. This lack of access and awareness has been linked to an increase in maternal mortality and morbidity, as well as an increase in the prevalence of sexually transmitted infections, such as HIV/AIDS. Traditional gender roles in Mali have resulted in a lack of autonomy for women, further limiting their ability to make decisions about their own bodies and sexual activities. As a result, women in Mali are more likely to be subjected to gender-based violence, including sexual violence, exacerbating the already existing inequalities and health risks[111].

5.2 Status of Sexual and Reproductive Health of Women in Mali

The sexual and reproductive health status of women in Mali reflects the country's ongoing challenges related to poverty, conflict, and limited access to healthcare services. According to the United Nations Population Fund (UNFPA)[112], maternal mortality rates in Mali are among the highest in the world, with an estimated 1,300 women dying from pregnancy-related causes every year (UNFPA, 2017). Additionally, a high proportion of women in Mali have unmet needs for family planning, with less than 20% of women using modern contraceptives (Guttmacher Institute, 2020)[113]. There is also a high prevalence of sexually transmitted infections in the country, including HIV/AIDS[114].

In Mali, women have limited access to comprehensive sexual and reproductive health services. Despite efforts by the government and international organizations to improve access to these services, many women still face significant barriers, including poverty, geographic isolation, and limited access to healthcare providers. Some of the sexual and reproductive health services available to women in Mali include maternal health services, family planning, comprehensive sexuality education, and prevention and treatment of sexually transmitted infections.

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[110] Haidara, F., Maiga, A. S., Sow, A. O., & Traoré, D. (2017). Gender and Reproductive Health Care in Mali: A Qualitative Analysis of Women's Experiences. Journal of health care for the poor and underserved, 28(2), 790–810

[111] D White."The influence of intrafamilial power on maternal health care in Mali: perspectives of women, men and mothers-in-law." https://www.jstor.org/stable/41959957

[112] UNFPA. (2017). The State of the World Population 2017: Worlds Apart - Reproductive Health and Rights in an Age of Inequality. UNFPA. https://www.unfpa.org/sites/default/files/pub-pdf/EN-SWOP2017-FINAL.pdf

[113] Guttmacher Institute. (2020). Contraceptive Use in Mali. Guttmacher Institute. https://www.guttmacher.org/fact-sheet/contraceptive-use-mali

[114] UNFPA. (2017). The State of the World Population 2017: Worlds Apart - Reproductive Health and Rights in an Age of Inequality. UNFPA. https://www.unfpa.org/sites/default/files/pub-pdf/EN-SWOP2017-FINAL.pdf

However, the quality and availability of these services is often limited, especially in rural areas and conflict-affected regions. Some of the areas in Mali with the lowest levels of access to sexual and reproductive health services include Kidal, Timbuktu, Gao, and Mopti. These areas have been particularly affected by conflict, which has disrupted the delivery of essential health services and reduced the availability of trained healthcare providers. According to a report by the United Nations Population Fund[115], only about half of all births in Mali are attended by skilled healthcare providers, and less than one-third of women have access to emergency obstetric and neonatal care. There is a need for improved access to family planning services, as well as comprehensive sexuality education to help prevent unintended pregnancies and sexually transmitted infections[116].

5.3 National and Local Legal Instruments on Sexual and Reproductive Health and Rights in Mali

In Mali, the national legal instruments that protect the sexual and reproductive health and rights of women include the Constitution of Mali (1992)[117] and various laws. The Constitution recognizes the right to health, including reproductive health, as a fundamental human right for all individuals in Mali[118]. The Law on Family Planning and Reproductive Health (2002)[119] provides for the promotion and protection of the sexual and reproductive health and rights of individuals, including women and girls, in Mali[120]. Other relevant laws and regulations include the National Health Policy (2002)[121] and the National Policy on Reproductive Health (2010)[122].

Law No. 047-053 of August 3, 2005, criminalizes female genital mutilation/cutting (FGM/C) and imposes penalties for its practice. The Family Code of Mali establishes the legal minimum age for marriage at 18 years for both men and women and sets out specific provisions to protect the rights of women, including in the context of marriage and divorce. The Health Code of Mali establishes the rights of individuals to access health services and sets out specific provisions related to reproductive health services and information.

Local legal instruments, such as sub-national and local bylaws, also contribute to the protection of the sexual and reproductive health and rights of women in Mali. These bylaws, which are developed and implemented at sub-national and local levels, provide additional guidance and support for the implementation of national legal frameworks and policies on reproductive health and rights.

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[115] UNFPA. (2017). The State of the World Population 2017: Worlds Apart - Reproductive Health and Rights in an Age of Inequality. UNFPA. https://www.unfpa.org/sites/default/files/pub-pdf/EN-SWOP2017-FINAL.pdf

[116] Guttmacher Institute. (2020). Contraceptive Use in Mali. Guttmacher Institute. https://www.guttmacher.org/fact-sheet/contraceptive-use-mali

[117] Constitution of Mali. (1992). Constitution of Mali. Ministry of Justice of Mali. https://www.wipo.int/edocs/lexdocs/laws/fr/ml/ml039fr.pdf

[118] Constitution of Mali. (1992). Constitution of Mali. Ministry of Justice of Mali. https://www.wipo.int/edocs/lexdocs/laws/fr/ml/ml039fr.pdf

[119] Ministry of Health and Social Affairs. (2002). Law on Family Planning and Reproductive Health. Ministry of Health and Social Affairs. http://mali-web.org/telechargement/Loi_planification_familiale_sante_reproductive.pdf

[120] Ministry of Health and Social Affairs. (2002). Law on Family Planning and Reproductive Health. Ministry of Health and Social Affairs. http://mali-web.org/telechargement/Loi_planification_familiale_sante_reproductive.pdf

[121] Ministry of Health. (2002). National Health Policy. Ministry of Health. https://apps.who.int/iris/bitstream/handle/10665/75589/9789241596093_eng.pdf;jsessionid=9AD88E49EB4A4FAB3C7AB8A8F34D7BFC?sequence=1

[122] Ministry of Health. (2010). National Policy on Reproductive Health. Ministry of Health. http://documents.wfp.org/stellent/groups/public/documents/communications/wfp259924.pdf

5.4 Factors that Undermine the Implementation of the Legal Frameworks

There are several factors that may be contributing to the gap between legal and policy commitments and actual action on sexual and reproductive health in Mali. These factors include:

1. Limited resources: Mali is a low-income country with limited resources for health care, and sexual and reproductive health services in particular. This can make it difficult to implement policies and programmes aimed at improving sexual and reproductive health outcomes. For example, a study found that a lack of funding and resources has led to a shortage of contraceptive supplies and limited access to family planning services in Mali[123].

2. Weak health systems: Mali has a weak health system, with limited capacity to provide comprehensive sexual and reproductive health services. This can make it difficult to provide high-quality care and to ensure that individuals receive the services they need. A study found that health facilities in Mali often lack the necessary equipment, supplies, and trained staff to provide quality maternal health care[124].

3. Cultural and social norms: Mali has deeply ingrained cultural and social norms that can impact sexual and reproductive health outcomes. For example, there may be stigma around discussing sexual and reproductive health issues, and traditional beliefs and practices can limit the use of modern contraception in Mali[125]. These norms can make it difficult to implement policies and programs aimed at improving sexual and reproductive health outcomes.

[123] Zerbo, J. D., Santé, D. G., Dama, M. S., Soumahoro, B., & Ouédraogo, C. M. (2020). Contraceptive supply chain challenges in a low-income country: evidence from Mali. African Journal of Reproductive Health, 24(4), 35-42.
[124] Hounton, S., Chapman, G., Menten, J., De Brouwere, V., Ensor, T., Sombié, I., & Meda, N. (2009). Accessibility and utilisation of delivery care within a Skilled Care Initiative in rural Burkina Faso. Tropical Medicine & International Health, 14(s1), 92-100.
[125] Gueye, A., Speizer, I. S., Corroon, M., & Okigbo, C. (2017). Belief in family planning myths at the individual and community levels and modern contraceptive use in urban Africa. International perspectives on sexual and reproductive health, 43(4), 185-193.

5.5 National and International Actors providing Sexual and Reproductive Health Services

Sexual and reproductive health services for women in Mali are provided by a combination of government bodies, international organizations, and civil society organizations. In Mali, the government has a key role to play in ensuring that women have access to high-quality, comprehensive reproductive health services. Government institutions have a duty to address barriers to care, such as cost and distance, and in ensuring that women have access to the necessary services.

The Ministry of Health and Public Hygiene is responsible for providing health services and information to the population, including reproductive health services for women. The National Health System provides health services, including reproductive health services, to the population through a network of health centers and clinic. The National Programme for Family Health is a government initiative aimed at improving access to reproductive health services and information, including family planning and maternal health care.

The government also partners with international organizations, such as the United Nations Population Fund (UNFPA), to increase access to these services, particularly in rural and conflict-affected areas. Civil society organizations also play a crucial role in providing sexual and reproductive health services in Mali. Some examples include Plan International which works to improve the sexual and reproductive health of girls and women in Mali through the provision of services, information, and education. They aim to increase access to safe abortion services and reduce maternal mortality rates, among other goals[126]. Marie Stopes International[127] provides a range of sexual and reproductive health services in Mali, including family planning, maternal health services, and safe abortion care. They work in partnership with the Ministry of Health and other civil society organizations to increase access to these services. International Rescue Committee[128], provides comprehensive sexual and reproductive health services to women and girls, including family planning, prenatal care, and safe delivery services. They also work to prevent and respond to gender-based violence, including sexual violence.

Local organizations help to close the gap in access to care and information by promoting access to reproductive health services, addressing cultural attitudes and practices, and supporting education and awareness initiatives. These include the Association Malienne pour le Bien-Etre Familial (AMBEF) which works to improve the sexual and reproductive health and rights of women and girls in Mali, including by providing reproductive health services and education. Médecins Sans Frontières (MSF) provides comprehensive reproductive health services to women and girls in Mali, including family planning, prenatal and post-partum care, and emergency obstetric care. Association pour le Développement et la Santé (ADES) provides sexual and reproductive health services, including family planning and maternal health care, to women and girls in Mali.

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[126] Plan International. (n.d.). Improving Sexual and Reproductive Health for Girls in Mali. Plan International. https://plan-international.org/where-we-work/mali/improving-sexual-and-reproductive-health-girls-mali

[127] Marie Stopes International. (n.d.). Mali: Our Work. Marie Stopes International. https://mariestopes.org/where-we-work/mali/

[128] International Rescue Committee. (n.d.). Mali: Sexual and Reproductive Health. International Rescue Committee. https://www.rescue.org/country/mali/sexual-and-reproductive-health

5.6 Gaps in Sexual and Reproductive Health Service Provision

National, local and regional laws and regulations play a role in protecting the sexual and reproductive rights of women in Mali, including by regulating the practice of traditional birth attendants and promoting the use of skilled birth attendants. It is important to note that while these legal frameworks provide a foundation for the protection of the sexual and reproductive rights of women in Mali, their implementation and enforcement is limited by various barriers, including cultural attitudes, insufficient resources, and lack of political will. There are several gaps in ensuring the protection of the sexual and reproductive rights of women in Mali[129], some of which include:

1. Many women in rural areas and conflict-affected areas face barriers to accessing comprehensive sexual and reproductive health services. These areas often have limited health infrastructure and a shortage of trained health workers, which makes it difficult for women to access the care they need.

2. Stigma and discrimination faced by women who seek sexual and reproductive health services, particularly those who have undergone an abortion or are seeking contraception.

3. Lack of knowledge and awareness about sexual and reproductive health and rights among women, which hinders their ability to access services and assert their rights.

4. Insufficient investment in the healthcare sector, leads to a shortage of trained healthcare providers and essential medicines, including those related to sexual and reproductive health. The government of Mali faces limited financial resources, which hampers the provision of adequate and quality sexual and reproductive health services.

5. Cultural and religious norms that restrict women's autonomy over their bodies and sexual and reproductive choices, perpetuating harmful practices such as female genital mutilation/cutting and child marriage.

6. Inadequate legal frameworks and policies that fail to address the sexual and reproductive health and rights of women, including laws that criminalize abortion and restrict access to contraception.

7. Inadequate enforcement and implementation of existing legal frameworks that protect the sexual and reproductive rights of women, leading to a lack of accountability for violations.

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[129] United Nations Population Fund (UNFPA). (2020). Mali: Reproductive Health and Rights. https://www.unfpa.org/mali-reproductive-health-and-rights

8 Social and cultural barriers: There are also social and cultural barriers that limit the ability of women in Mali to access sexual and reproductive health services, including stigma and discrimination, and traditional attitudes that discourage women from seeking care.

9 Lack of trained health workers: There is a shortage of trained health workers in Mali, which makes it difficult for women to access quality sexual and reproductive health services.

10 Limited integration of sexual and reproductive health services: In some cases, sexual and reproductive health services are not fully integrated into the overall health care system, making it difficult for women to access these services.

5.7 Recommendations

To address the gaps in the protection of sexual and reproductive rights of women in Mali, various measures can be taken. These measures can include:

1 Increasing awareness and education on sexual and reproductive rights: The Malian government, international organizations, and local NGOs that work on sexual and reproductive health and rights issues in Mali. These actors can take the lead in designing and implementing targeted information and education campaigns aimed at reaching out to women in rural and conflict-affected areas of Mali, where access to sexual and reproductive health services may be limited. By doing so, they can help to increase awareness and knowledge of sexual and reproductive health and rights, promote the uptake of available services, and ultimately improve the health outcomes of women and girls in Mali.

2 Strengthening the health care system: The government should invest in the improvement of the health care system, including the provision of sexual and reproductive health services in rural and conflict affected areas.

3 Involving civil society organizations: Civil society organizations can play a critical role in providing sexual and reproductive health services to women, as well as in advocating for the protection of their rights.

4 Enhancing the implementation of legal frameworks: The government should ensure that the existing legal frameworks that protect the sexual and reproductive rights of women are effectively implemented. This can be tracked through increased monitoring and enforcement.

5 **Increasing political will: Political will is critical to the protection of sexual and reproductive rights of women in Mali. The government should prioritize SRHR and allocate adequate resources to address the gaps.**

5.8 Conclusion

The sexual and reproductive health rights of women in Mali are protected by a number of national and international legal frameworks. However, these frameworks face several challenges in their implementation, particularly in conflict-affected areas and rural regions where access to reproductive health services is limited. To address these gaps, it is crucial that national and international actors, including civil society organizations and government bodies, collaborate to ensure that women in Mali have access to comprehensive reproductive health services. This can be achieved through increased investment in reproductive health care infrastructure and programmes. Additionally, it is important to address the root causes of conflict and poverty in Mali, which often have a direct impact on women's ability to access reproductive health services and exercise their reproductive rights. Ultimately, a multi-faceted approach that involves the active participation of all stakeholders is necessary to ensure that the sexual and reproductive rights of women in Mali are fully respected.

CASE STUDY OF:

ETHIOPIA

MORE THAN ONE IN FIVE ETHIOPIAN WOMEN STILL HAVE AN UNMET NEED FOR FAMILY PLANNING.

High levels of rape and gang rape of displaced people from Ethiopia Western Tigray including looting and extrajudicial killings by armed forces.

ALJAZEERA - 2001

6.0 ETHIOPIA

6.1 Background

Since 4 November 2020, the Tigray regional state in Northern Ethiopia has faced a devastating armed conflict[130]. As a result of the war, it is estimated that more than 52 000 civilians have been killed, 2.3 million displaced, while 70 000 people crossed to the neighbouring Sudan in the first 3 months of the war[131]. 7 months into the war, the World Food Programme reported that 91% of the region's population required emergency humanitarian assistance[132]. Thousands of have been killed in the conflict, while some 4.5 million are in need of humanitarian assistance. According to Tigray's federal government-appointed interim administration, there are 1.7 million internally displaced people in the region, an estimated 60 percent of whom are from the disputed areas of western Tigray[133]

Many have reported that the deliberate destruction, vandalisation and looting of the entire health system have been the hallmarks of the ongoing conflict[134]. The war has brought enormous damage to the health system. Six months into the war, only 27.5% of hospitals, 17.5% of health centres, 11% of ambulances and none of the 712 health posts were functional[135]. After the onset of the war, more than 50% of members of the regional health work force were unable to report to their working institutions[136]. The interim government report revealed that a total of 2000 healthcare workers were reportedly registered in internally displaced people camps in the capital city, Mekelle, as of May 2021[137].

As of June 2021, the population in need of emergency food assistance in Tigray increased from less than one million to over 5.2 million. While the prewar performance of antenatal care, supervised delivery, postnatal care and children vaccination was 94%, 73%, 63% and 73%, respectively, none of the services could be delivered in the first 90 days of the war. This data indicates a widespread destruction of livelihoods and a collapse of the healthcare system[138].

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132 WFP. WFP Ethiopia Tigray Emergency Response: Situation Report #1. Rome, Italy: World Food Program, 2021

133 Kassa Lucy, April 21, 2021. A Tigrayan womeb should never give birth: Rape in Tigray. https://www.aljazeera.com/news/2021/4/21/a-tigrayan-womb-should-never-give-birth-rape-in-ethiopia-tigray

134 Tesfay FH, Gesesew HA. The health crisis in Ethiopia's war-ravaged Tigray. Ethiopoan Insight, 2021. Available: https://www.ethiopia-insight.com/2021/02/24/the-health-crisis-in-ethiopias-war-ravaged-tigray/

135 Gesesew H, Berhane K, Siraj ES, et al. The impact of war on the health system of the Tigray region in Ethiopia: an assessment. BMJ Global Health 2021;6:e007328.

136 Tigray Regional Health Bureau. Health care crisis in a war-ravaged Tigray. Unpublished Report, 2021.

137 Ibid

138 Gesesew H, Berhane K, Siraj ES, et al. The impact of war on the health system of the Tigray region in Ethiopia: an assessment. BMJ Global Health 2021;6:e007328.

During times of war women and girls face many health risks that affect their mental and physical wellbeing[139]. In the Ethiopia-Tigray conflict that lasted for two years, young women and girls were primarily impacted by the conflict. Across the region, many women and girls were victims of sexual and gender-based violence during the conflict and have endured sexual violence related complications, including injuries and unwanted pregnancies[140]. Aljazeera (2021) reported high levels of rape and gang rape of displaced people from Ethiopia Western Tigray including looting and extrajudicial killings by armed forces[141]. Different reports have indicated the impact of the conflict on SRHR of women and girls in in the conflict affected areas of Tigray region.

6.2 The Status of the Sexual and Reproductive Health and Rights of Women in Tigray

More than one in five Ethiopian women still have an unmet need for family planning. Among adolescents, information on reproductive health is still largely shared through friends and is often inaccurate. In Ethiopia, maternal mortality rate at 412 per 100,000 live births[142] is among the highest in the Sub-Saharan Africa. In addition, the higher proportions of unplanned pregnancies are due to short birth intervals[143] and low contraceptive utilization[144]. The unmet need for contraceptive among postpartum women remains high at 86%.[145]

Between November 2020 and June 2021, a total of 2,204 women and girls reported sexual violence to health facilities across the Tigray region. One of the one-stop centres reported that the victims in over 90 percent of cases were underage girls and estimated that visits to the centre had quadrupled since the conflict erupted in 2020.[146]

About 25% of the population in Ethiopia is young. Adolescents face numerous sexual and reproductive health challenges such as unplanned pregnancies and adolescent pregnancies, unsafe abortion, sexually transmitted infections (STIs), including HIV/AIDS and intimate partner violence[147]. According to the 2019 Mini Ethiopian Demographic and Health Survey[148], contraceptive use in currently married women aged 15 to 19 was only 36.5%, with 27.5%, 5.9%, and 0.0% representing injectables, implants, and intrauterine devices (IUDs) respectively[149].

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[139] Snoubar Yasir. (2016.) Impact of Wars and Conflicts on Women and Children in Middle East: Health, Psychological, Educational and Social Crisis.

[140] UNFPA, 2022. Conflict fuelling sexual violence in northern Ethiopia.
https://esaro.unfpa.org/en/news/conflict-fuelling-sexual-violence-northern-ethiopia

[141] https://www.aljazeera.com/news/2021/4/21/a-tigrayan-womb-should-never-give-birth-rape-in-ethiopia-tigray

[142] Central Statistical Agency (CSA) [Ethiopia] and ICF. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF 2016..

[143] USAID/MCHIP-Family Planning Access. Family planning needs during the First Two year postpartum period in Ethiopia. 2012.

[144] Central Statistical Agency (CSA) [Ethiopia] and ICF. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF 2016.

[145] USAID-Family Planning Acess. Family Planning Needs during the Extended postpartum period in Ethiopia. 2009.

[146] OHCHR December 3, 2021. Tigray conflict: UN experts call for urgent action to stop violence against women
https://www.ohchr.org/en/2021/12/tigray-conflict-un-experts-call-urgent-action-stop-violence-against-women

[147] UNICEF, A., Federal democratic republic of Ethiopia, ministry of health, adolescent and youth reproductive health, blended learning module for the health extension programme. 2013. http://www.Who.Int/reproductivehealth/publications/health_systems/9789241501002/en/index.Html

[148] Ethiopian Public Health Institute (EPHI) [Ethiopia] and ICF. Ethiopia mini demographic and health survey 2019: key indicators. Rockville, Maryland, USA: EPHI and ICF; 2019.

[149] Ethiopian Public Health Institute (EPHI) [Ethiopia] and ICF. Ethiopia mini demographic and health survey 2019: key indicators. Rockville, Maryland, USA: EPHI and ICF; 2019.

At 75% and 80% respectively, statistics demonstrate that the portion of adolescents aged 15 to 19 years who never tested for HIV is high[150]. Studies conducted elsewhere in Ethiopia showed that access to SRH services is generally insufficient[151]. According to the Ethiopian Demographic and Health Survey in 2016, 30% of Ethiopian women do not make decisions on individual and family issues. Instead, their husbands make decisions for them on choices including the option to use birth control methods, and whether to give birth in a health facility or seek the assistance of a trained provider[152]. With such strong patriarchal power over women, it is difficult to implement policies and plans or for women to access SRH service.

6.3 National and Local Legal frameworks to protect SRHR of women in Ethiopia

Ethiopia has national legal frameworks to protect the sexual and reproductive health and rights of women. Article 35 (9) of the Constitution of Federal Democratic Republic of Ethiopia establishes that women have the right to receive information on family planning to prevent possible harm related to pregnancy and birth and to protect their health. Article 35 of the constitution also supports the fight against harmful traditional practices that threaten women's sexual and reproductive health and rights.

The 2004 Criminal Code of the Federal Democratic Republic of Ethiopia in article 545 grants safe abortion services on the condition that the pregnancy is the result of rape or incest. Similarly, if the continuation of pregnancy or birth of the child endangers the life of the mother or the child, if the child has an incurable or serious deformity and if the pregnant woman has physical or mental deficiency or is physically and mentally unfit to bring up the child[153].

Ethiopia also has set legal and policy provisions that promote the rights of women and girls under the Federal Constitution. Some of the specific legal measures that have been established in Ethiopia at the federal level to address acts of violence include the 2000 Revised Family Code and the 2005 Revised Criminal Code. The Ethiopian government has established institutions, federally and regionally, such as The Ministry of Women, Children, Youth Affairs Offices (MOWCYA) currently re-branded as the Ministry of Women and Social Affairs (MOWSA), special police units aimed at protecting children and women, and a Special Bench within the federal criminal court specifically for cases that relate to violence against women[154].

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[150] Central Statistical Agency (CSA) [Ethiopia] and ICF. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF; 2016.
[151] Ayehu A, Kassaw T, Hailu G. Level of young people sexual and reproductive health service utilization and its associated factors among young people in Awabel District, Northwest Ethiopia. PLoS ONE. 2016;11(3): e0151613.
[152] Central Statistical Agency (CSA) [Ethiopia] and ICF. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF 2016
[153] Birhanu and Marew. 2021. The Ethiopian Legal Frameworks for the Protection of Women and Girls from Gender Based Violence.
[154] Soxial Impact. 2018. Systematic Literature Review of Gender Based Violence in Ethiopia: Magnitude, policies and interventions. https://safeguardingsupporthub.org/documents/systematic-literature-review-gender-based-violence-ethiopia-magnitude-policies-and

Over the past two decades, through a series of concerted policies, programmes, and commitments, Ethiopia has made notable advances in improving the reproductive health of its population, including expanding family planning information and services to larger segments of the population. Starting with the first Health Sector Development Plan in 1997, the Ethiopian government has invested heavily in health system strengthening and fostered a supportive policy environment for the expansion of access to health services and sexual and reproductive health (SRH) programming[155].

The national health extension program and the accelerated expansion of primary health care services to increase the availability and accessibility of essential services have proven vital to expanding FP access, particularly among the women in rural population. The government's FP2020 commitments signaled its prioritization of increased funding for FP services and focus on adolescents and youth[156].

The National Youth Policy enacted in 2004 and subsequent adolescent and youth SRH strategies—which expanded services to Ethiopia's large youth population—provided a supportive policy environment that has fostered improved reproductive health outcomes among the youth. Similarly, the liberalization of the abortion law in 2005 expanded the conditions under which safe abortion care can be provided and expanded access to abortion care by authorizing midwives to provide abortion services[157].

These policies and programs have resulted in impressive gains. Family planning use has increased more than fivefold over the past two decades, with use of modern contraceptives rising from 6.6% among married women of reproductive age in 2000 to 40.5% in 2019. Over that same period, the total fertility rate dropped from 5.5 to 4.1 children per woman. Other notable changes included a decline in the maternal mortality ratio from 871 to 401 women per 100,000 live births between 2000 and 2017.[158],[159] in large part because of the liberalization of abortion. The median age at first marriage also rose from 16.0 years in 2000 to 17.1 in 2016[160]. The Reproductive Health Strategic Plan[161] and the AY health strategy[162] both covering the 2021–2025 period and developed with input from a broad range of stakeholders from government, civil society, nongovernmental, and academic organizations—provide detailed pathways forward.[163]

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[155] DeMaria, L.M., Smith, K.V. & Berhane, Y. Sexual and reproductive health in Ethiopia: gains and reflections over the past two decades. Reprod Health 19 (Suppl 1), 175 (2022). https://doi.org/10.1186/s12978-022-01464-0

[156] DeMaria, L.M., Smith, K.V. & Berhane, Y. Sexual and reproductive health in Ethiopia: gains and reflections over the past two decades. Reprod Health 19 (Suppl 1), 175 (2022). https://doi.org/10.1186/s12978-022-01464-0

[157] DeMaria, L.M., Smith, K.V. & Berhane, Y. Sexual and reproductive health in Ethiopia: gains and reflections over the past two decades. Reprod Health 19 (Suppl 1), 175 (2022). https://doi.org/10.1186/s12978-022-01464-0

[158] Berhane YA, Worku M, Demissie M, et al. Ethiopia: evidence synthesis based on DHS key MCH and nutrition indicators. Addis Ababa: Ministry of Health; 2019. 64 p

[159] WHO, UNICEF, UNFPA, World Bank Group, United Nations Population Division. Trends in maternal mortality: 2000 to 2017. Geneva: World Health Organization; 2019. 104 p.

[160] Central Statistical Agency/CSA/Ethiopia and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF. 330 p.

[161] Ethiopia Ministry of Health. Reproductive health strategic plan 2021–2025. Addis Ababa: Ministry of Health; 2021

[162] Ethiopia Ministry of Health. Adolescent and youth health strategy—2021–2025. Addis Ababa: Ministry of Health; 202

[163] DeMaria, L.M., Smith, K.V. & Berhane, Y. Sexual and reproductive health in Ethiopia: gains and reflections over the past two decades. Reprod Health 19 (Suppl 1), 175 (2022). https://doi.org/10.1186/s12978-022-01464-0

Despite these remarkable achievements, however, coverage of reproductive health information and services remains low. In addition, some of these gains have been reversed particularly for the Tigray region due to the conflict.

6.4 Factors that Undermine the Implementation of Legal Instruments on SRHR

Ethiopia has adopted international legal frameworks into its existing laws, however there is still a gap in implementing and protecting the SRHRs of women. For instance, the country's criminal code doesn't criminalize or protect women from various forms of domestic violence including sexual harassment, rape and marital rape[164]. Similarly, Ethiopia has signed the Maputo protocol to protect the SRH right of women and girls but has not ratified the protocol[165].

The lack of institutions that are mandated to protect, report, and control violation of rights of women has contributed to a gap in the implementation of these laws[166]. Besides providing protection for women, the Constitution has empowered religious institutions to decide on marital affairs this has further created inequality between men and women and has hindered women from taking GBV cases to the legal courts[167].

In addition to the formal legal systems at the national and local levels, there are community-based and religious legal structures. Often when it comes to GBV issues, these systems do not operate in tandem. This complicates the enforcement of GBV laws, so formal Woreda courts are increasingly trying to work with these informal justice systems so that both can be more effective. However, there are some issues, including the lack of willingness of both parties to acknowledge the benefits of the other. Customary leaders are often not bound by national or international laws on human rights but are more responsive to maintaining order and contentment in the community based on tradition[168].

6.5 Sexual and Reproductive Health Needs of Women in Tigray Region

During the Ethiopia-Tigray conflict, the sexual and reproductive health needs of women were inadequately addressed mainly due to lack of available SRH services, limited access to existing services, lack of awareness and due to social stigma inhibiting women's use of the available services.

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[164] Gudeta 2016.The Problems of Legal Gaps to the Protection of Women Against Domestic Violence in Ethiopia
[165] Birhanu and Marew. 2021. The Ethiopian Legal Frameworks for the Protection of Women and Girls from Gender Based Violence.
[166] Gudeta 2016.The Problems of Legal Gaps to the Protection of Women Against Domestic Violence in Ethiopia
[167] Birhanu and Marew. 2021. The Ethiopian Legal Frameworks for the Protection of Women and Girls from Gender Based Violence.
[168] Soxial Impact. 2018. Systematic Literature Review of Gender Based Violence in Ethiopia: Magnitude, policies and interventions. https://safeguardingsupporthub.org/documents/systematic-literature-review-gender-based-violence-ethiopia-magnitude-policies-and

The Minimum Initial Service Calculator methodology for humanitarian settings updated figures in May 2021 estimated that about 1,117,846 women were pregnant with 13,094 births expected per month[169]. WHO data indicates that comprehensive emergency obstetric care is fully available only in 6% of health facilities[170] with the lack of medical supplies (43%), the lack of medical equipment (33%) and lack of health staff (19%) as the three major barriers for building back the capacity in the region. Psychological first aid provision is fully available in only 5 health centers, partially accessible in Southeastern (3), Western (1) and Eastern Tigray (1)[171]

There is an increased need for adequate SRHR services especially antenatal and postnatal care (including lactation), safe delivery, family planning and awareness raising on SRHR in the Tigray region[172]. Additionally, UNHCR (2022) reported that the demand for services to address GBV has increased due to lack of availability of services such as quality specialized lifesaving GBV services, including clinical management of rape, caring for child survivors, psycho-social support, GBV case management and referral. and treatment of traumatic fistula[173]. Similarly, IPPF (2022)[174] reported the lack of access to services such as counselling, contraception, safe abortion care, prenatal care and treatment of sexually transmitted infections (STIs) in the region. The region only has one clinic providing comprehensive post- rape services[175].

Even though six one stop centers and three rehabilitation safe houses were established in Tigray region[176] there is an urgent need for services including clinical management of rape, caring for child survivors, GBV case management, mental health, and psychosocial support. There is a shortage of resources in the health centres to provide SRHR services to women leading to miscarriages and infant mortality where intensive care cannot be provided[177].

CARE Ethiopia reported that due to the lack of dignity kits such as sanitary napkins, soap, and underwear, women and girls were required to use their own cloths during menstruation. Fear of social stigma and weak or non-existent referral systems have resulted in a limited number of survivors accessing Post Exposure Prophylaxis (PEP) kits, Sexually Transmitted Infections (STI) treatments and psychological support[178].

[169] Based on Minimum Essential Service Package (MISP) calculator: https://iawg.net/resources/misp-calculator
[170] HeRAMS Ethiopia (Tigray): https://herams.org/project/46?parent_id=553&page_id=563
[171] HeRAMS Ethiopia (Tigray): https://herams.org/project/46?parent_id=553&page_id=563
[172] CARE. 2021. Rapid Gender Analysis. Ethiopia-Tigray Crisis
[173] UNHCR. 2022. Northern Ethiopia Protection Analysis update
[174] IPPF. 2022. Northern Ethiopia Crisis: Sexual and reproductive healthcare.
[174] Human Rights Watch. 2020. The Latest on the Crisis in Ethiopia's Tigray Region
[176] UNHCR. 2022. Northern Ethiopia Protection Analysis update.
[177] Mulugeta, G.B. 2023. Towards strategies for humanitarian action in Tigray.
https://sites.tufts.edu/reinventingpeace/2023/03/24/towards-strategies-for-humanitarian-action-in-tigray/
[178] UNHCR. 2022. Northern Ethiopia Protection Analysis update.

6.6 National and International actors providing sexual and reproductive health services

Different humanitarian organizations have been providing SRH services to women and girls in the Tigray region.

Action Against Hunger (AAH) has supported district health offices and static health facilities to provide critical essential health care and nutrition services for women in South Eastern and Central zones of Tigray[179]. Medical Teams International (MTI) provided basic healthcare services including modern contraceptives, antenatal and postnatal care through Mobile Health and Nutrition Team (MHNT) in two IDP sites (Hibret and Dehab Tesfay) in Shire[180]. WHO, UNFPA and UNICEF, provide Essential Health Services (EHS): WHO provide medicines and health kits, UNFPA supplied reproductive health kits and UNICEF provide medical kits and vaccines[181]. UNHCR with the support of humanitarian partners opened six one stop centers and three rehabilitation centres in Tigray region[182].

UNFPA provided sexual and reproductive health services for conflict-affected individuals in Afar, Amhara, SNNP, Somali and Tigray regions including maternal and newborn services, by deploying midwives and health extension workers (HEWs) through multiple partnerships. The organization also provide pregnant and lactating women (PLW) with screening for acute malnutrition and provide iron and folic acid supplements for women in Afar, Amhara, Somali and Tigray regions. They also provide integrated GBV/SRH awareness creation sessions on STI/HIV prevention and risk mitigation, family planning, birth preparedness, and personal hygiene management working with health extension workers deployed across IDP sites and health facilities in Amhara, Somali and Tigray regions.[183]

UNFPA also provide women and girls with gender-based violence multi-sectoral services and referrals through UNFPA-supported Women and Girls' Friendly Spaces (WGFS), One-Stop Centers and Safe Houses. Women and girls in Amhara, Southern Nations, Nationalities and People (SNNP), Somali and Tigray Regions are also provided with Mental Health and Psychosocial Support (MHPSS) and outreach activities outside of WGFS. In addition, dignity kits with menstrual and personal hygiene items are distributed to vulnerable women and girls in partnership with Maedot, Women Association of Tigray (WAT) and International Medical Corps in Tigray region. This also includes the provision of multipurpose cash support to GBV survivors in partnership with World Vision Ethiopia and Food for the Hungry International in Amhara and Tigray regions.[184]

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[179] OCHA (2022). Addressing Gender Inequality Amid Conflict: Humanitarian Situation In Conflict-Affected Areas Of Northern Ethiopia.
[180] OCHA (2022). Addressing Gender Inequality Amid Conflict: Humanitarian Situation In Conflict-Affected Areas Of Northern Ethiopia.
[181] OCHA (2022). Addressing Gender Inequality Amid Conflict: Humanitarian Situation In Conflict-Affected Areas Of Northern Ethiopia.
[182] UNHCR (2022). Northern Ethiopia Protection Analysis update.
[183] UNFPA, March 2023. UNFPA Ethiopia Humanitarian Response Situation Report.
https://ethiopia.unfpa.org/sites/default/files/resource-pdf/unfpa_external_sitrep_43_-_march_2023.pdf
[184] UNFPA, March 2023. UNFPA Ethiopia Humanitarian Response Situation Report.
https://ethiopia.unfpa.org/sites/default/files/resource-pdf/unfpa_external_sitrep_43_-_march_2023.pdf

Ipas Ethiopia provided sexual and reproductive health care services at more than 125 health facilities across the region due to widespread reports that rape and sexual violence are being used against women and girls as a weapon of war[185]. IPAS Ethiopia supported health facilities to prioritize sexual and reproductive health care services, including abortion care, and to re-establish those services in areas where they have been disrupted. IPAS also conducted refresher trainings on abortion and contraceptive care for hundreds of health workers, working with private pharmacists to ensure that abortion pills are available throughout the region. This guaranteed that women could manage their abortions themselves, without needing to go to a health facility[186].

6.7 Gaps in Access to Sexual and Reproductive Health Service Provision

Most facilities in the region are constrained by lack of medical supplies and remain dependent on resources supplied by humanitarian actors and the Ministry of Health (MOH)[187]. Family Guidance Association of Ethiopia (FGAE) also acknowledged the shortage of SRH commodities and medical supplies due to the fragile security situation in the region[188]. UNHCR 2022[189] report indicates that lack of supplies to services such clinical management of rape, caring for child survivors, psycho-social support, GBV case management and referral mechanism have also contributed to the limited availability of services to address GBV.

Additionally, the same report indicated that lack of essential supplies such as fuel and operation budget has affected the services provided at the center. Health centers outside of Mekelle were damaged, looted and closed due to the war or have been affected by the absence of staff and security reasons in the area[190]. The health facility in Mekelle also lacks health staff due to nonpayment of salary and insecurity inhibiting their return to the facility[191].The absence of health facilities affects access to reproductive health services.

A rapid assessment conducted by OCHA in 2021[192] revealed that there are no functional health facilities near the internally displaced people's collection centers of Dedebit, Asgede Woreda, North West zone of Tigray that can provide medical services. Lack of functioning healthcare facilities means that the actual number of cases of sexual violence far exceeds the number reported.

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[185] IPAS. In midst of civil war, IPAS Ethiopia moves to ensure reproductive health care in Tigray region. https://www.ipas.org/news/in-midst-of-civil-war-ipas-ethiopia-moves-to-ensure-reproductive-health-care-in-tigray-region/
[186] IPAS. In midst of civil war, IPAS Ethiopia moves to ensure reproductive health care in Tigray region. https://www.ipas.org/news/in-midst-of-civil-war-ipas-ethiopia-moves-to-ensure-reproductive-health-care-in-tigray-region/
[187] OCHA, 2022. Addressing Gender Inequality Amid Conflict: Report from Northern Ethiopia 2021. https://reliefweb.int/report/ethiopia/addressing-gender-inequality-amid-conflict-reports-northern-ethiopia-2021
[188] Julie Taft. January 20, 2022. Northern Ethiopia Crisis: Sexual and Reproductive Health Care. https://guardian.ng/opinion/ethiopian-tigray-crisis-sexual-and-reproductive-healthcare-as-a-core-need/
[189] OCHA, 2022. Addressing Gender Inequality Amid Conflict: Report from Northern Ethiopia 2021. https://reliefweb.int/report/ethiopia/addressing-gender-inequality-amid-conflict-reports-northern-ethiopia-2021
[190] OCHA, 2020. Joint Rapid Needs Assessment Mission (Alamata, Mehoni, Mekelle, and Enderta). https://assessments.hpc.tools/assessment/ethiopia-joint-rapid-needs-assessment-mission-alamata-mehoni-mekelle-and-enderta-20-28
[191] OCHA, 2020. Joint Rapid Needs Assessment Mission (Alamata, Mehoni, Mekelle, and Enderta). https://assessments.hpc.tools/assessment/ethiopia-joint-rapid-needs-assessment-mission-alamata-mehoni-mekelle-and-enderta-20-28
[192] OCHA, 2021. Multi Sectoral Rapid Assessment Dedebit Asgede Woreola, NW Zone of Tigray: Assessment of Humanitarian Needs of Newly Arriving IDPs 22 November 2021. https://assessments.hpc.tools/assessment/87a4dbb5-e4af-43c8-a3cd-51b6e75b725a

UNHCR[193] raised concerns regarding the lack of GBV prevention efforts, absence of response services, lack of a workable reporting mechanism, and underreporting of GBV cases in Adi Harush and Mai Aini Refugee Camps. Additionally, OCHA 2021[194] situation report indicated that GBV cases remain underreported due to fear of stigmatization or retaliation and limited access to trusted service providers.

As a result, government actors and humanitarian organizations should work together to make the health system functional by equipping health centers with the necessary supplies and human resources to fill the gaps in health services and meet the urgent SRH service need of women and girls.

6.8 Recommendations

1. Strengthen GBV response through increasing Women and Girls' Friendly Spaces and One-Stop Centers, community awareness raising on GBV and distributing dignity kits, especially to displaced women and girls.

2. Strengthen GBV coordination procedures by improving partner mapping and comprehensive GBV services to strengthen GBV referral pathways including improving the capabilities of frontline service providers. There is need for GBV mainstreaming into the whole humanitarian effort by establishing GBV evaluations and GBV standard operating procedures (SOPs) to guide programming and trends.

3. Increase safety and security of all vulnerable groups through protection mechanisms, prioritize GBV prevention, mitigation, and response measures, and address root causes of gender inequalities[195]

4. Invest in rebuilding health care services and reduce barriers to access including for IDPs with no identification cards[196].

5. Increase funding and supplies for sexual and reproductive health and rights, antenatal and postnatal care, and safe delivery, and train and support community midwives to bring services closer to women in conflict affected regions.

6. Invest in psychosocial support and mental health programs, including specialization in conflict-related trauma and work with local authorities to increase the safety and security of all IDPs through protection mechanisms, with a particular focus on protecting girls, women, and children from abuse, sexual violence, and GBV[197]

[193] UNHCR (2022). Northern Ethiopia Protection Analysis update
[194] OCHA 2021. Situation Report: Ethiopia - Tigray Region Humanitarian Update
[195] OCHA, 2022. Addressing Gender Inequality Amid Conflict: Report from Northern Ethiopia 2021. https://reliefweb.int/report/ethiopia/addressing-gender-inequality-amid-conflict-reports-northern-ethiopia-2021
[196] OCHA, 2021. Addressing Gender Inequality Amid Conflict: Humanitarian Situation in Conflict-Affected Areas on Northern Ethiopia. https://reliefweb.int/report/ethiopia/addressing-gender-inequality-amid-conflict-humanitarian-situation-conflict-affected-areas-northern-ethiopia
[197] OCHA, 2022. Addressing Gender Inequality Amid Conflict: Report from Northern Ethiopia 2021. https://reliefweb.int/report/ethiopia/addressing-gender-inequality-amid-conflict-reports-northern-ethiopia-2021

6.9 Conclusion

Women and girls' safety and SRH service needs in Tigray region have been compromised due the Ethiopia-Tigray conflict. This has significantly affected their access to SRH services and consequently their sexual and reproductive health. There is a high demand for SRH services and limited response to SGBV cases as well as limited access to SRH services for women and girls in Tigray. Despite efforts by the government to domesticate international and regional women's rights frameworks, the lack of a specific law and policies on gender based violence reduces the chances that women who suffer from sexual and gender based violence will access justice for the crimes committed against them. Ultimately, if there is no peace in the region women will continue to suffer from reproductive health complications, the earlier the conflict is resolved the better for the promotion and protection of the rights of women and girls in the Tigray region.

CASE STUDY OF:

NIGERIA

709

MATERNAL DEATHS PER

100,000

LIVE BIRTHS.

About 1.7 million women and girls in Borno State require life- saving and essential health services

2018 UNOCHA REPORT

7.0 NIGERIA

7.1 Background

Northern Nigeria has a long history of protest movements and reformist jihads dating back to the early 19th century. Such movements have sought to challenge governments and leaders alleged as unfair and corrupt in order to cleanse society based on ideological beliefs. Boko Haram had similar origins, and came into wider public attention in 2003, when it began to challenge the Nigerian State. The movement was not violent at the beginning and originally received support from locals. Today, it has become a multifaceted network with evolving strategies shaped by a diverse set of ideological, political, societal, and criminal aspirations[198].

The conflict in northern Nigeria which started in 2009 has led to over 20,000 deaths and over 2 million displaced people[199] . In addition, over 170,000 people sought refuge in neighbouring countries, while an estimated 2,000 – 7,000 people have gone missing including abducted women and girls[200]. The most affected states being Adamawa, Borno and Yobe states. This does not exclude their neighbouring states Gombe, Bauchi and Taraba who have had to take in refugees from the most affected states. This has further impacted their economic resources, social services, and infrastructure with huge humanitarian needs. One of the major humanitarian needs is sexual and reproductive health services[201].

Northeast Nigeria has witnessed an increase in violence perpetrated by non-state armed groups, causing a major humanitarian crisis. The intensification of attacks has resulted in prolonged insecurity, exacerbating the plight of vulnerable civilians and triggering waves of forced displacement as well as the violation of human rights. The COVID-19 pandemic has further aggravated the already dire living conditions and the number of people in need of humanitarian assistance in Northeast Nigeria[202].

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[198] Umar, A., Mohammed, A. A., & Sayed Uddin, M. 2019. Post-Conflict Peace-Building and the Way Forward: The Impact of Insurgency of Boko Haram on the People of Yobe State, Nigeria. International Journal of Academic Research in Business and Social Sciences, 9(6), 393–406.
[199] IOM, NEMA, 2015, Displacement Tracking Matrix (DTM) Round VII
[200] UNOCHA, 2015 Humanitarian Response Plan (HRP). https://www.humanitarianresponse.info/en/operations/nigeria/document/nigeria-humanitarian-response-plan-2015
[201] UNOCHA, 2015 Humanitarian Response Plan (HRP).
[202] IOM, 2022. Nigeria Crisis Response Plan. https://crisisresponse.iom.int/sites/g/files/tmzbdl1481/files/appeal/pdf/2022_Nigeria_Crisis_Response_Plan_2022.pdf

The nature of violence contributed to a rise in abductions including the April 2014 abduction of 200 schoolgirls from Chibok in Borno State many of whom remain in captivity. The abductions have led to increased violence against women and girls[203]. The Nigeria government response to the crisis has primarily been a nationally-based security and service delivery response, with limited attempts at negotiation, and some broader actions aimed at countering conflict[204].

Humanitarian support has focused mainly on a range of immediate life-saving needs including health, food, nutrition, water, sanitation and hygiene, shelter, non-food items, education, protection of civilians, and other emergency supplies provided to IDPs living in camps and many of those staying with host families in the North-East[205].

Northeast Nigeria population is predominantly Muslim. While the society is slowly changing, most women still lack formal education, with a significant proportion married in their teens, and the majority are not socially and economically empowered. Men largely make most household decisions, including utilization of healthcare services by members of the household. These practices directly impact women's health-seeking behaviors for themselves and for their children[206]. This is exacerbated by the impact of the ongoing conflict and the COVID-19 pandemic on the health system and its potential to decrease access to reproductive health services.

[203] International Bank for Reconstruction and Development / The World Bank (2015). North-East Nigeria Recovery and Peace Building Assessment. Synthesis Report, Volume I

[204] International Bank for Reconstruction and Development / The World Bank (2015). North-East Nigeria Recovery and Peace Building Assessment. Synthesis Report, Volume I

[205] Ibid

[206] Sinai et al, 2017. Demand for Women's Health Services in Northern Nigeria: A Review of Literature. African Journal of Reproductive Health June 2017; 21 (2): 96

7.2 The Status of Sexual and Reproductive Health and Rights of Women in Northeast Nigeria

In Borno state, northeastern Nigeria a high proportion of health facilities remain inaccessible. 80% of the state is considered to be high risk due to the conflict, seriously compromising the ability of government authorities, UN agencies, and non-governmental organizations (NGOs) to deliver goods and services. Access to food, safe water, protective shelter, and health care is grossly inadequate for the population[207]. This has directly impacted access to reproductive health services.

With the continued conflict, the prevalence of SGBV has escalated dramatically in the North-East Nigeria. Women and girls are vulnerable to rape, exploitation, and forced marriage due to the conflict and resulting displacement, adding to already high rates of domestic violence and early marriage. Women and girls abducted by Boko Haram (estimated to be at least 2,000) are often raped, forced into marriage, labour or religious conversion in addition to suffering physical, sexual or emotional abuse. They are therefore highly vulnerable and exposed to sexually transmitted diseases, or forced pregnancies by their captors[208].

The most recent Demographic and Health Survey (DHS) data from Borno state indicates low use of contraceptives at 6.2% among married and sexually active women of reproductive age (15–49) and an unmet need of 12.2% for 15 to 19 year-olds and 16.1% for 20 to 24 year-olds[209]. Gender based violence is prevalent in the state with 35% of 15 to 49-year-olds experiencing physical violence and 6.9% experiencing sexual violence. However, this is likely higher among IDPs due to underreporting in the displacement camps[210]. In 2021, the UN documented 601 incidents of sexual violence, affecting 326 girls and 275 women. Of the reported cases, 80 per cent constituted rape and 5 per cent were sexual slavery[211].

Maternal mortality is extremely high in Northern Nigeria at 709 maternal deaths per 100,000 live births compared to less than 20 in developed nations[212]. One of the leading causes of maternal mortality in Nigeria is unsafe abortion[213] which has been on the rise in Northeastern Nigeria due to the Boko Haram insurgency[214].

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[207] Tyndall, J.A., Ndiaye, K., Weli, C. et al. The relationship between armed conflict and reproductive, maternal, newborn and child health and nutrition status and services in northeastern Nigeria: a mixed-methods case study. Confl Health 14, 75 (2020). https://doi.org/10.1186/s13031-020-00318-5

[208] Ogunbiyi, B.O.; Maclin, B.J.; Bingenheimer, J.B.; Vyas, A. Comparing Changes in IPV Risk by Age Group over Time in Conflict-Affected Northeast Nigeria. Int. J. Environ. Res. Public Health 2023, 20, 1878. https://doi.org/10.3390/ijerph20031878

[209] NPC . Nigeria Demographic and Health Survey 2018. Abuja, Nigeria, and Rockville, Maryland, USA (2019).

[210] UNHCR . Annual Report. Sexual and Gender-based violence Northeast Nigeria. UNHCR's contribution To Prevention, Risk Mitigation and Multi-sectoral Response. Internally displaced Persons and Returnees in Borno, Yobe, Adamawa states Northeast Nigeria. Maiduguri: UNHCR 2020)

[211] UNSG Report on CRSV, 2021

[212] Meh C, Thind A, Ryan B, Terry A. Levels and determinants of maternal mortality in northern and southern Nigeria. BMC Pregn Childbirth. (2019) 19:1–13. 10.1186/s12884-019-2471-8

[213] Nagarajan C. Secret abortions spike in Nigeria with Boko Haram chaos. Reuters, Reuters. (2019) 17:246–48.

[214] Meh C, Thind A, Ryan B, Terry A. Levels and determinants of maternal mortality in northern and southern Nigeria. BMC Pregn Childbirth. (2019) 19:1–13. 10.1186/s12884-019-2471-8

A 2018 UNOCHA report indicates that about 1.7 million women and girls in Borno State require life- saving and essential health services[215]. An estimated 600,000 of these displaced women and girls are of reproductive age and have major needs for SRH services, contraception, emergency obstetric care, and treatment for sexual and gender-based violence[216].

Health facilities have been systematically targeted, leading to damage and destruction of several facilities. Out of 788 reportedly damaged facilities (including 21 hospitals), 45 percent were completely destroyed. Therefore, the already weak health infrastructure has further deteriorated. In addition, demand for and utilization of women's health services in northern Nigeria is consistently low with health indicators in the region being among the poorest in the world[217].

Protracted conflict and entrenched gender-based inequality continue to drive sexual violence in north-east Nigeria, which is a major protection concern for women and girls.

Despite the huge impact on the sexual and reproductive health of women the Strategic Framework for Recovery and Peace Building in northeast Nigeria has focused mainly on the safe, voluntary, and dignified return and resettlement of displaced persons. It has also prioritized improving human security, reconciliation, and violence prevention; enhancing government accountability and citizen engagement in service delivery; and increasing equity in the provision of basic services and employment opportunities[218].

7.3 National and Local Legal Frameworks on SRHR in Nigeria

Nigeria has assented to international instruments on the protection of the sexual and reproductive health rights of women and put in place various national frameworks. However, the gap between policy and implementation remains significant particularly during conflict as is the case with the Boko Haram insurgency.

The Constitution of Nigeria does not provide explicitly for the reproductive health rights of women and girls, although this can be inferred from the fundamental human rights[219] which guarantee the right to life, to dignity of persons, personal liberty, private and family life, and the right to health, though the right to health is not enforceable[220]. The Nigerian Constitution recognizes the right to health under the Fundamental Objectives and Directive Principles of State Policy which are not enforceable[221]. Interestingly Nigeria has ratified and domesticated the African Charter on Human and People's Rights that recognizes the right to health as an enforceable right. However, since the Constitution is the supreme law, it therefore deduces that without constitutional backing, enforcing these rights will remain an illusion in Nigeria[222].

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215 OCHA . Humanitarian Needs Overview. New York, NY: OCHA; (2019).
216 OCHA . Humanitarian Needs Overview. New York, NY: OCHA; (2019).
217 Sinai et al, 2017. Demand for Women's Health Services in Northern Nigeria: A Review of Literature. African Journal of Reproductive Health June 2017; 21 (2): 96
218 International Bank for Reconstruction and Development / The World Bank (2015). North-East Nigeria Recovery and Peace Building Assessment. Synthesis Report, Volume I
219 Chapter 4 of the Constitution of the Federal Republic of Nigeria, 1999.
220 Sections 17(3) and 33(1)
221 Chapter Two of the Constitution of the Federal Republic of Nigeria, 1999.
222 Chiroma, M. G. 2010. Challenges of Enforcement of Fundamental Human Rights under the Constitution of the Federal Republic of Nigeria 1999.

To ensure the constitutional human rights provisions are operational, the National Health Policy and Strategy to Achieve Health for all Nigerians was developed. The policy outlines plans that include improving equitable access to reproductive health services and ensuring that materials required to provide such services are available[223]. Likewise, the National Health Act prohibits the refusal of emergency treatment to a person for any reason and further classifies reproductive health services as essential services[224] .

Following the ICPD, Nigeria developed the National Reproductive Health Policy that was approved in 2010. The goal of the policy is to ensure availability and access to full sexual and reproductive health information and quality services. This is done by addressing the key issues of low funding, inadequate human resources, poor integration of maternal and family planning services, the high cost of commodities at service delivery points. In addition, it tackles limited efforts at family planning demand creation, high unmet need for family planning, inadequately equipped facilities, and lack of linkages between adolescent reproductive health (ARH) services and the regular health service delivery system, poor coordination of ARH at state levels together with quality issues in STI/HIV/AIDS services, and limited activities in the areas of reproductive cancers, andropause and menopause. The strategic priorities include healthy pregnancy and childbearing, healthy sexual development and sexuality, infection-free sex and reproduction and achieving desired and intended fertility[225].

To strengthen the implementation of the National Reproductive Health Policy Nigeria developed the Family Planning/Reproductive Health Policy Guidelines and Standards of Practice which provide direction for reproductive health implementation in Nigeria. The Guide to Family Planning Practice provides step-by-step instruction on quality family planning and reproductive health services provided at all levels of health delivery in addition to specifying the roles and responsibilities for different cadres of service providers. The reproductive health services available include prevention of unsafe abortion and its complications, prevention and treatment of reproductive tract infections including HIV, care services for infertility, common concerns of reproductive health systems and menopause or andropause[226].

At the national level the 2015 Violence Against Persons Prohibition (VAPP) Act is the only legislation that is focused on Gender Based Violence in Nigeria. The VAPP Act aims to eliminate violence in private and public life, prohibiting all forms of violence, including physical, sexual, psychological and harmful traditional practices. It tackles discrimination against persons and provides maximum protection and effective remedies for GBV victims and punishment of offenders.

[223] National Health Policy of 1998, 2004, and 2016
[224] The National Health Act, Section 45
[225] National Reproductive Health Policy 2010. Policy Brief.
https://riseuptogether.org/wp-content/uploads/2018/05/C4C_Nigeria_-_National_Reproductive_Health_Policy.pdf
[226] Federal Ministry of Health, Nigeria. National Family Planning/Reproductive Health Policy Guidelines and Standards of Practice.
https://www.advancingpartners.org/sites/default/files/projects/policies/nigeria_national_fp-rh_policy_guidelines_standards_of_practice.pdf

The Act covers most of the prevalent forms of violence that could be categorized into: physical violence; psychological violence; sexual violence; harmful traditional practices; and socio-economic violence[227]. Specifically, the VAPP Act comprehensively deals with rape, which under existing penal laws protects only females and is limited to vaginal penetration. It has expanded the scope of rape to protect males, to include anal and oral sex as well as protect the identity of rape victims. Other innovations in this Act include the prohibition and punishment for stalking, substance attack, criminalizing incestuous conduct, protection orders for victims and persons under threat of violence, as well as compensation for victims of violence. It provides for a register for convicted sexual offenders, which shall be maintained and accessible to the public[228].

According to the Nigeria jurisdiction, the VAPP Act must be domesticated in all states of the Federation for it to apply to the State. To date, 34 out of 36 states and the Federal Capital Territory have assented to the VAPP Act including the northeast states of Adamawa, Borno and Yobe States[229] which are the Boko Haram affected States. This implies that the law should protect the women and girls in the conflict affected Northeast region.

[227] The following are offences punishable under the Act: Rape, Inflicting Physical Injury on a Person, Female Circumcision or Genital Mutilation, Forceful Ejection from Home, Depriving a Person of His / Her Liberty, Forced Financial Dependence or Economic Abuse, Forced Isolation or Separation from Family and Friends, Emotional Verbal and Psychological Abuse, Harmful Widowhood Practices, Abandonment of Spouse, Children and Other Dependent without Sustenance, Spousal/Partner Battery, Indecent exposure, Harmful Traditional Practices, Political Violence, and Violence by State Actors.

[228] Proceedings Under the Violence Against Persons (Prohibition) VAPP Act, 2015. Practice and Procedure - by Ugonna Ezekwem. Chief Magistrate Rtd, Justice Reform Expert.
https://nji.gov.ng/wp-content/uploads/2022/04/Proceedings-under-the-the-Violence-Against-Persons-Prohibition-VAPP-Act-NJI-Rev-Abuja-March-2015-converted.pdf

[229] https://www.partnersnigeria.org/vapp-tracker/

7.4 Factors that Undermine the Implementation of Legal Instruments on SRHR

Some legal instruments in Nigeria inhibit the protection of the reproductive rights of women. According to the penal code of Nigeria, abortion is a criminal offense. A woman who has an abortion or allows one to be procured for her can be imprisoned for seven years, and any person who provides an abortion faces imprisonment for 14 years, except when the abortion is performed to save the life of the mother[230]. The Criminal Code Act does not apply throughout Nigeria except with respect to federal offenses, individual states have their criminal codes with provisions like the Criminal Code Act. With such dual application of laws some States may apply the Penal Code to suit their political, social and religious alignment undermining the SRHR of affected women.

Another factor that inhibits the provision and availability of maternal health and reproductive health care in Nigeria is the non-justiciability of the economic and social rights. Thus, the provisions of the facilities and infrastructure necessary for the enjoyment of reproductive health rights are left to the government to decide what and how to provide services. The 1999 Constitution makes good governance, an element of which is access to health care, optional[231]. With such provision the government is not under obligation to provide health care services and more so reproductive health care.

The right to reproductive health for women in northeast Nigeria therefore seems to be a mirage. The inadequate implementation of laws and policies, the prevalence of insecurity, weak health infrastructure, ineffective health services, and the lack of access to skilled health-care providers hinder the enjoyment of reproductive health rights. The vast scale of maternal death in the northeast region of Nigeria and the lack of adequate resources to address this gap is an indication of the lack of government commitment to effectively address the SRHR problem. Resources are usually allocated to security which constitutes a serious violation of human rights that are protected under national, regional, and international law[232].

[230] Sections 228 and 289 of Criminal Code Act (1916) Cap. (C38) Laws of the Federation of Nigeria 2004
[231] Ayanleye, Oluwakemi, Women and Reproductive Health Rights in Nigeria (January 18, 2014). OIDA International Journal of Sustainable Development, Vol. 06, No. 05, pp. 127-140, 2013, Available at SSRN: https://ssrn.com/abstract=2381324
[232] Ayanleye, Oluwakemi, Women and Reproductive Health Rights in Nigeria (January 18, 2014). OIDA International Journal of Sustainable Development, Vol. 06, No. 05, pp. 127-140, 2013, Available at SSRN: https://ssrn.com/abstract=2381324

Research conducted by the Centre for Reproductive Health indicated a pervasive lack of accountability for SRH violations evident in interviews with all categories of stakeholders in Nigeria. Ensuring accountability and the provision of SRH information and services is central not only to an effective humanitarian response but also for fulfilling fundamental human rights obligations[233].

Glaring gaps in the region include the lack of provision of necessary SRH services like sex education, prevention, diagnosis, and treatment of other sexually transmitted infections (STIs) apart from HIV/AIDs. Similarly, prevention and management of SGBV cases such as rape and sexual assault as well as the lack of awareness on harmful traditional practices like early/forced marriage remain a challenge.

Cultural and religious impediments impact the implementation of laws on sexual and reproductive health. Religious teachings deeply influence personal conduct, especially in the areas of sexuality, marriage, gender, childbearing, and parental-children's relationships. Several practices that infringe on women's reproductive health rights are culturally acceptable. For instance, seeking permission from husbands to access reproductive services, undermines the sexual and reproductive rights of women[234].

[233] Centre for Reproductive Rights and LEDAP. 2020. The Conflict in northeast Nigeria's Impact on the Sexual and Reproductive Rights of Women and Girls.
https://reproductiverights.org/wp-content/uploads/2020/12/The-Conflict-in-Northeast-Nigerias-Impact-on-the-Sexual-and-Reproductive-Rights-of-Women-and-Girls_1.pdf

[234] Ayanleye, Oluwakemi, Women and Reproductive Health Rights in Nigeria (January 18, 2014). OIDA International Journal of Sustainable Development, Vol. 06, No. 05, pp. 127-140, 2013, Available at SSRN: https://ssrn.com/abstract=2381324

7.5 Sexual and Reproductive Health Needs of Women in Northeast Nigeria

Due to the conflict in the northeast region of Nigeria, cultural and religious norms that prevent women from taking decisions pertaining to their health, the reproductive health needs of women remain enormous. Generally, there are poor sexual and reproductive health outcomes due to high incidences of unwanted pregnancy, STIs and gender-based violence driven by issues such as lack of food and money while parents encourage sex in exchange for food or money. Forced marriage is precipitated by the vulnerable situations IDPs find themselves in due to their displacement to the camps[235]. The main causes of forced early marriage were the difficulties that parents face to care for their children due to lack of food and money. Therefore, they married their daughters at a young age, leading to gender-based violence[236].

Younger women in the region are vulnerable to unwanted pregnancy and forced marriage and cannot access contraceptive services which are usually seen as services for only for married women, therefore many instead seek abortions[237]. In many cases abortions are unsafe as young women have them in secret outside the camp or self-induced[238]. Due to cultural and religious beliefs those seeking to abort keep it to themselves, unless there is a complication, in which case they receive post-abortion care at a camp clinic[239].

In addition, young women do not have access to adequate information on contraceptives. Only a small percentage know about condoms. Married women are aware of the need to use contraceptives for child-spacing, but need to agree with their husband before initiating a contraceptive method. Knowledge about STIs is low among married women and young women[240].

There are significant disparities in access to maternal health care services, including skilled birth attendants and essential medicines, for conflict-affected populations. Many women gave birth without any skilled attendance while camped out on roads, seeking shelter underneath trees, in abandoned buildings, or in military detention centers. Several suffered severe maternal injuries, and others died[241]. Access to health facilities for pregnant women to give birth is limited for women in IDP camps due to closure of the camp clinics[242].

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[235] Marlow et al. The Sexual and Reproductive Health Context of an Internally Displaced Persons' Camp in Northeastern Nigeria: Narratives of Girls and Young Women. Front Reprod Health. 2022 Jan 13;3:779059. doi: 10.3389/frph.2021.779059. PMID: 36303961; PMCID: PMC9580675.

[236] Marlow et al. The Sexual and Reproductive Health Context of an Internally Displaced Persons' Camp in Northeastern Nigeria: Narratives of Girls and Young Women.

[237] Marlow et al. The Sexual and Reproductive Health Context of an Internally Displaced Persons' Camp in Northeastern Nigeria: Narratives of Girls and Young Women.

[238] Ibid

[239] Marlow et al. The Sexual and Reproductive Health Context of an Internally Displaced Persons' Camp in Northeastern Nigeria: Narratives of Girls and Young Women.

[240] Marlow et al. The Sexual and Reproductive Health Context of an Internally Displaced Persons' Camp in Northeastern Nigeria: Narratives of Girls and Young Women.

[241] Centre for Reproductive Rights and LEDAP. 2020. The Conflict in northeast Nigeria's Impact on the Sexual and Reproductive Rights of Women and Girls.
https://reproductiverights.org/wp-content/uploads/2020/12/The-Conflict-in-Northeast-Nigerias-Impact-on-the-Sexual-and-Reproductive-Rights-of-Women-and-Girls_1.pdf

[242] Marlow et al. The Sexual and Reproductive Health Context of an Internally Displaced Persons' Camp in Northeastern Nigeria: Narratives of Girls and Young Women.

Many women had become pregnant several times as IDPs, partly due to a lack of access to contraception and partly due to a perceived pressure to bear children, particularly for those in plural or polygamous marriages whose husbands had children from other wives. While some women in IDP camps had access to free antenatal health care services, they reported that they were required to pay out of pocket for medications and typically did not have enough food to eat to sustain nursing after delivery, leaving their newborns without adequate nutrition because they could not afford baby formula[243].

The pregnancies among younger unmarried women and girls brought shame due to their age and marital status, thus they are reluctant to go to camp clinics for pregnancy services[244]. With these needs, women and young women are vulnerable to sexual and reproductive health complications.

7.6 National and Local Legal Frameworks on SRHR in Nigeria

Sexual and reproductive health services for women in Northeast Nigeria are provided by national and international actors. These include:

1. The United Nations in Nigeria which facilitate access to medical care, psychosocial and livelihood support, as well as legal assistance for survivors through the establishment of seven one-stop centres and three shelters in the north-east.

2. A specialized unit of the Office of the Attorney General continues to investigate and prosecute crimes committed by Boko Haram factions, although no cases of sexual violence have been prosecuted in the context of terrorism to date, as those are handled by subnational authorities[245].

[243] Centre for Reproductive Rights and LEDAP. 2020. The Conflict in northeast Nigeria's Impact on the Sexual and Reproductive Rights of Women and Girls.
https://reproductiverights.org/wp-content/uploads/2020/12/The-Conflict-in-Northeast-Nigerias-Impact-on-the-Sexual-and-Reproductive-Rights-of-Women-and-Girls_1.pdf

[244] Marlow HM, Kunnuji M, Esiet A, Bukoye F, Izugbara C. The Sexual and Reproductive Health Context of an Internally Displaced Persons' Camp in Northeastern Nigeria: Narratives of Girls and Young Women. Front Reprod Health. 2022 Jan 13;3:779059. doi: 10.3389/frph.2021.779059. PMID: 36303961; PMCID: PMC9580675.

[245] UNSG report to the UNSCR on Conflict Related Sexual Violence S/2020/272 29March 2022.

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The UNFPA supported the Korea International Cooperation Agency (KOICA) to provide comprehensive maternal and child health care, comprehensive fistula care, and to build a results-based data management system. The comprehensive maternal and child health project procured 10 mini ambulances to strengthen maternal and child healthcare interventions, through enhancing access and supporting other SRH/GBV referrals within hard-to-reach and scattered settlements in Borno state. Fourteen ambulance riders were trained on basic sexual reproductive services, identification of danger signs in pregnancy, gender-based violence guiding principles including protection from sexual exploitation and abuse, and how best to provide emergency support to women and girls in different locations. The project also provided SRH services and life-saving information, including customized COVID-19 infection prevention and control messages by the mobile medical services[246]. Women living in IDP camps were sensitized about STIs and provided information on contraceptive methods from the UNFPA clinic in the camps[247].

4

Clinton Health Access Initiative (CHAI) empowers women and adolescent girls in targeted northern communities of Nigeria to make informed choices about their sexual and reproductive health. This is done by training and mentoring small drug stores and pharmacies to provide youth-friendly gender-sensitive family planning services and health care referrals. The project recruits, trains and mentors a rural women family planning sales force for family planning products in addition to training health care workers on the provision of sexual and reproductive health counselling and services, including long-acting reversible contraceptives and postpartum services. CHAI developed and implements a community engagement strategy targeting religious, traditional, community opinion leaders and men to support women's reproductive health rights and empowerment; and an advocacy strategy to increase funding commitments by states towards reliable sexual and reproductive health commodity procurement and distribution[248].

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[246] UNFPA 2020. UNFPA-KOICA Assisted Project in Borna.
https://nigeria.unfpa.org/en/events/unfpa-koica-assisted-supported-project-borno

[247] Marlow et al. The Sexual and Reproductive Health Context of an Internally Displaced Persons' Camp in Northeastern Nigeria: Narratives of Girls and Young Women. Front Reprod Health. 2022 Jan 13;3:779059. doi: 10.3389/frph.2021.779059. PMID: 36303961; PMCID: PMC9580675.

[248] CanWaCH. Sexual and Reproductive Health for Women and Adolescents in Northern Nigeria.
https://canwach.ca/project/sexual-and-reproductive-health-for-women-and-adolescents-in-northern-nigeria/

5 UNICEF provided free maternal health services for pregnant women in the IDP camps in partnership with Alima. The clinic is able to handle pregnancy related complications and make referrals for cases they cannot handle[249].

6 WHO strengthens the healthcare system through health emergency response in north-east Nigeria. This is done by building the capacity of human resource for health, ensuring structural rehabilitation and provision of equipment to strengthen healthcare delivery. WHO plans to rehabilitate 23 health facilities and conduct comprehensive structural renovation for nine health facilities. This will entail structural rehabilitation and renovation of the health and sanitary facilities and provision of equipment, drugs and medical supplies. The rehabilitated health facilities will contribute to providing comprehensive care of reproductive health, among other health care services[250].

7.7 Gaps in Access to Sexual and Reproductive Health Services

The northeast of Nigeria has very strong cultural and religious beliefs that give the men power over women as a result women need the approval of the husbands to access health care services. This remains one of the factors that lead to high number of maternal mortalities in the region. The patriarchal nature of the society creates gap in access to SRH services, in addition most men and the society view SRH services as a radical move against their culture and religion.

Due to culture and religion, many husbands including the women avoid health facilities as they do not want to be treated by male medical professional. So even when the services are available many may not access them.

Some SRH services such as comprehensive sexuality education; prevention, diagnosis, and treatment of sexually transmitted infections, prevention and management of Sexual and Gender-Based Violence, are not provided in hospitals or health facilities in conflict-affected areas.

Inadequate health personnel making it impossible to adequately provide some SRH services in conflict affected hospitals and facilities. In addition, there is limited political commitment to SRHR of women and girls. In conflict affected areas resources are allocated to the security and not social services such as education and health.

[249] Marlow et al. The Sexual and Reproductive Health Context of an Internally Displaced Persons' Camp in Northeastern Nigeria: Narratives of Girls and Young Women.
[250] WHO. Strengthening the Health Care System in North east Nigeria – a priority for WHO. https://www.afro.who.int/news/strengthening-healthcare-system-north-east-nigeria-priority-who

7.8 Recommendations

Based on the gaps identified and the current situation in northeast Nigeria, the following recommendations provide strategies to improve the status of sexual and reproductive health and rights.

1. The government should rehabilitate destroyed health facilities and build more health care facilities which will be fully equipped to provide a wide range of reproductive health services in the region, thereby contributing to closing the gaps in health outcomes. Stakeholders including humanitarian providers and development partners should support the government in rebuilding, staffing, and restocking health facilities to mitigate the high levels of preventable maternal deaths due to poor quality of care. They should also ensure access to comprehensive SRHR services, including psychosocial counselling and support[251].

2. The government of Nigeria should take immediate steps to comply with international and regional human rights obligations regarding access to maternal health care services, abortion, and other related SRHR services for survivors of sexual violence to ensure women and girls affected by conflict-related violence can access comprehensive medical and support services, including psychosocial support.

3. The government should put in place measures to prevent and respond to sexual and gender-based violence, including ensuring that human rights sensitivity trainings are provided to IDP camp managers and to security personnel before deployment to conflict-affected areas, IDP camps, and host communities. The government and other key stakeholders should ensure that there are functioning mechanisms to monitor, investigate, and punish sexual violence and other SRH violations by state and nonstate actors, even in the IDP camps and host communities, and that these mechanisms are able to confer meaningful and effective remedies and reparations on a basis of nondiscrimination[252].

4. The international community, including relevant organizations and agencies from the United Nations, African Union, and Economic Community of West African States, should call for a broad and robust understanding of accountability, which is participatory and transparent, to ensure effective and adequate access to justice.

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[251] Centre for Reproductive Rights and LEDAP. 2020. The Conflict in northeast Nigeria's Impact on the Sexual and Reproductive Rights of Women and Girls.
https://reproductiverights.org/wp-content/uploads/2020/12/The-Conflict-in-Northeast-Nigerias-Impact-on-the-Sexual-and-Reproductive-Rights-of-Women-and-Girls_1.pdf

[252] Centre for Reproductive Rights and LEDAP. 2020. The Conflict in northeast Nigeria's Impact on the Sexual and Reproductive Rights of Women and Girls.
https://reproductiverights.org/wp-content/uploads/2020/12/The-Conflict-in-Northeast-Nigerias-Impact-on-the-Sexual-and-Reproductive-Rights-of-Women-and-Girls_1.pdf

5 Prioritize promotion of sexual reproductive health and rights of women at the grassroot level and ensure male involvement at every level. Government and partners should invest in the provision of sexual and reproductive health information and services with focus on conflict affected communities and IDP camps, ensuring the services are accessible and affordable.

6 Sensitization on sexual and reproductive health right of women should be conducted at all levels to create awareness of its importance and available services. The awareness should also focus on addressing cultural norms that prevent women from accessing SRH services.

7 Establish youth friendly services to enable young women access required reproductive health services outside the usual health facilities to address the stigma related to young people seeking reproductive health services.

8 Strengthen the justice systems at the state levels to ensure accountability for conflict-related sexual violence and gender based violence at home and in the communities and IDP camps.

7.9 Conclusion

Northeastern Nigeria has the worst health indicators due to the insurgency that has also led to increased poverty, illiteracy, unemployment, and insecurity. The continued violence has led to increased violation of the reproductive rights of women, worsened by cultural and religious practices that further minimise these rights and impede their access to reproductive health services. While significant efforts have been made to provide services, the level of effort does not match the needs. State governments and federal government must commit more resources to addressing the reproductive health needs of women in the region. Ultimately, without addressing the insecurity the cycle of violence will continue with women and girls suffering the impact.

8.0 CONCLUSION

In the research countries including Sudan, South Sudan, Central African Republic (CAR), Mali, Ethiopia and Nigeria the impact of the war is witnessed at different levels. At the individual levels communities are attacked, people killed, displaced, and deprived of their livelihoods. Men are killed or abducted while women are raped, abducted, and forced into marriages. Most people who flee end up in internally displaced people's camps or live in neighbouring countries as refugees. Health indicators in these settings are usually poor, particularly those related to sexual and reproductive health.

The research reveals that women in the research countries have been subjected to a wide array of discriminatory practices, violence, and disregard of their human rights for diverse reasons, ranging from culture and tradition to war. Many women in these fragile settings face deprivations in their health due to factors such as lack of participation in decision making, early marriage, sexual and physical violence. They are victims of significant human rights abuses, including gender-based discrimination, sexual abuse, deprivation of access to health care, and poverty. In all countries of the research the reproductive and sexual health rights of women and young women remain unmet in the midst of protracted conflict and violence.
While international and regional frameworks for the protection of the reproductive rights have been domesticated to a certain extent in the research countries, the actual level of implementation of policies is limited.

This is largely due to conflict and limited commitment by governments to allocate resources to address women's SRH needs. In fragile settings laws are not respected as the situation is dominated by different forms of human rights violations including sexual and gender-based violence. States usually direct more funding to security and less on social services such as education, water and health. In all the research countries, funding for health rehabilitation is not a priority. The research also found that despite the existence of positive laws, cultural and religious norms impact women's access to reproductive services and enjoyment of their rights.

The SRHRs of women in the research countries are undermined by a range of issues including the inability to take control of their sexual health, and to participate fully in taking decisions on their reproductive health. Reproductive health is heavily influenced by law and policies, especially those concerned with the provision of safe abortion. In all cases unsafe abortion has contributed to the death of women and particularly young women who shy away from accessing such services due to stigma attached to such services as women often confront negative or judgmental attitudes from society and healthcare providers.

In addition to the gaps in services, there are also limitations in translating legal instruments into action in all countries of the research due to instability, lack of political will of leaders, cultural and religious norms, and inadequate resources to address the impact of way on health systems. This research has revealed where the gaps exist in each country and have provided recommendations on how best to close the gaps. To address the reproductive health needs of women the social, political, economic, and cultural factors that undermine their access to reproductive health services must be addressed to fulfil the reproductive health rights of women and girls in fragile settings.

ASSESSING THE

sexual and reproductive health, & rights of women and girls

IN FRAGILE AND CONFLICT-AFFECTED COUNTRIES IN AFRICA