

Strengthening the protection of sexual and reproductive health and rights in the African region through human rights



**CHARLES NGWENA &
EBENEZER DUROJAYE (EDS)**

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Strengthening the protection of sexual and reproductive health and rights in the African region through human rights uses rights-based frameworks to address some of the serious sexual and reproductive health challenges that the African region is currently facing. More importantly, the book provides insightful human rights approaches on how these challenges can be overcome. The book is the first of its kind. It is an important addition to the resources available to researchers, academics, policymakers, civil society organisations, human rights defenders, learners and other persons interested in the subject of sexual and reproductive health and rights as they apply to the African region. Human rights issues addressed by the book include: access to safe abortion and emergency obstetric care; HIV/AIDS; adolescent sexual health and rights; early marriage; and gender-based sexual violence.

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ACKNOWLEDGMENTS

In October 2011, we convened an international colloquium at the University of the Free State in Bloemfontein, South Africa, where we were based at the time. The theme of the colloquium was *Strengthening Protection of Reproductive and Sexual Health in the Sub-Saharan Region through Human Rights*. It put a spotlight on identifying persistent gaps or challenges in the realisation of reproductive and sexual health as human rights in the African region, and advancing arguments for addressing the gaps and challenges. The present edited volume has been developed from the theme and proceedings of the colloquium. At the same time, this volume is much more than the product of the authors and editors. Rather, it is an outcome of the collective inputs of many people who, in various ways, have played a part in its creation. We take this opportunity to convey our deepest appreciation to all who had a hand in the making of the volume. We begin by taking a step backwards to recall the broader context in which the colloquium leading to this volume was conceived. In our view, this is a more fitting way of expressing our appreciation not just to those immediately associated with the publication of this volume, but also to people as well as institutions that played a significant role in creating the space and academic foundation for this volume.

The colloquium proceedings, from which chapters in this volume were developed, were a byproduct of an LLM programme in Reproductive and Sexual Rights offered in the Department of Constitutional Law and Philosophy of Law, Faculty of Law, University of the Free State. With the generous support of the Ford Foundation, this LLM programme, the first of its kind on the African continent, trained twenty-five graduates from the Eastern, Southern and Western regions of Africa over a course of four years, covering Cameroon, Eritrea, Ethiopia, Kenya, Lesotho, Malawi, Tanzania, Uganda and Zimbabwe. Among other objectives, the programme sought to promote and disseminate discourses at the intersection between reproductive and sexual health and African human rights systems. It sought to:

- raise public awareness about a type of human rights that are often contested and marginalised;
- build capacity among role players whose work impacts on reproductive and sexual health, including advocates, activists, policymakers, and civil society organisations at both regional and country levels; and
- ultimately influence domestic and regional policy and law.

The colloquium and this volume were conceived with a view to advancing these objectives.

Against this backdrop, we wish to thank Rebecca Cook for nurturing with one of us (Charles Ngwena) the idea of establishing an LLM programme in sexual and reproductive health and rights to serve the African region and subsequently supporting the programme through teaching. Rebecca offered her enormous intellectual wisdom and teaching time generously and with characteristic modesty. The LLM programme

could not have been established without the financial support of the Ford Foundation. We are grateful to the Ford Foundation for its generosity in steadfastly supporting the LLM programme through scholarships and for funding the colloquium and publication of this volume. Barbara Klugman and her successor Lourdes Rivera, as programme officers at the Ford Foundation, were the programme's immediate listening ears. They championed the programme's cause and lent unrelenting support. Equally, the LLM programme could not have been established without an academic home. We thank the Faculty of Law of the University of the Free State and its Department of Constitutional Law and Philosophy of Law for providing an academic home for the LLM programme and hosting the colloquium which led to this volume. We are grateful to successive Chairs of the Department of Constitutional Law and Philosophy of Law – Loot Pretorius, Shaun DeFreitas and Ilze Keevy – for welcoming and supporting the programme as an important addition to postgraduate learning and research in a novel and often contested discipline.

The organisation of the colloquium itself was a mammoth administrative task. The organisation fell mostly on the shoulders of Lizelle Petersen in the Department of Constitutional Law and Philosophy of Law. The colloquium brought together delegates from across the African continent and beyond. We are grateful to Lizelle for selflessly working round the clock to ensure that all the logistical pieces of the colloquium were in place.

Needless to say, we could not have been able to prepare this volume without the contributions of the participants who travelled far and wide to present papers that addressed the theme of the colloquium. Although not all the papers that were presented made it to this volume for reasons of space, we are grateful to all participants who sacrificed their academic time to write and present papers and enrich the colloquium discussions. In this regard, we say thank you to the following colleagues: Onyema Afulukwe-Oruchalu, Rebecca Amollo, Ayo Atsenuwa, Victoria Balogun, Tiffany Banda, Fana Hagos Berhane, Eunice Brookman-Amisshah, Mosope Fagbongbe, Lisa Forman, Olaide Gbadamosi, Michelo Hansungule, Aniekwu Nkolinka Ijeoma, Godfrey Kangaude, MaryFrances Lukera, Grace Malera, Flora Manyasa, Simangele Mavundla, Annie Mumbi, Patience Sone Munge, Babafemi Odunsi, Uju Okeke, Tolulope Oluwaranti, Timothy Omorodion, Doris Owoh, Susana SáCouto, Chrispine Sibande, Karen Stefiszyn, Jaime Todd-Gher and Christina Zampas. In the same breath, we express our gratitude to the following participants who served as lead discussants and commented on written papers, bringing much focus and insight to the discourse: Gina Bekker, Michelo Hansungule, Tinyade Kachika, NomaFrench Mbombo, Stella Nyanzi, Agnes Odhiambo and Elisa Slattery. We also express our appreciation to Mosope Fagbongbe, Ilze Keevy, Babafemi Odunsi, Bella Rametse and Christina Zampas who served as moderators for the colloquium sessions and to Toun Adebanjo who served as rapporteur.

The editing of the manuscripts comprising this book received inputs beyond those of the editors. In the initial editing of the manuscripts, we were assisted by Toun Adebanjo, a doctoral candidate in the Faculty of Law of the University of the Free State. Toun went beyond the call of duty in meticulously reading the first crop of the manuscripts, ascertaining the

overall readability of narratives and suggesting language changes. In the final stages of the book, Pretoria University Law Press (PULP) assisted with its language editing and housestyling of manuscripts. We are grateful to Lizette Hermann at PULP and PULP's language editors for bringing to bear technical editing skills we could not have otherwise mustered. The quality of the manuscripts benefitted immensely from the suggestions and recommendations made by independent reviewers who were appointed by PULP to anonymously review the manuscripts. We are grateful to PULP for agreeing to publish this volume.

It has been our enormous pleasure and privilege to work with such a highly committed set of authors on this volume. We apologise profusely to authors for the fact that the book took much longer to publish than we had planned. Initially we had anticipated that the book would be published at the end of 2012. Be that as it may, we extend our greatest appreciation to contributing authors and we thank you for your inordinate patience in waiting to see the fruits of your intellectual labour.

Charles Ngwena and Ebenezer Durojaye
Editors

FOREWORD

Twenty years ago, at the International Conference on Population and Development, the global community affirmed that realising sexual and reproductive health and rights of women and girls is essential for their well-being. This commitment was reaffirmed a year later at the Fourth World Conference on Women. Today, the sexual and reproductive health and rights of millions of Africans remain unmet. Indeed, the African region continues to bear the greatest burden of sexual and reproductive ill health, including high HIV/AIDS prevalence, high infant and maternal mortality rates, high incidence of unsafe abortion and high rates of sexually transmitted infections. More than 1 million HIV-related deaths and about 85 per cent of all maternal deaths that occur yearly are in the region. In addition, harmful cultural practices have continued to endanger the health and well-being of women and girls in the region.

African governments have begun to take steps to address the region's sexual and reproductive health challenges. For instance, in 2001 during the Abuja Declaration on HIV, Malaria, Tuberculosis and other related diseases, African governments agreed to commit at least 15 per cent of their annual budgets to addressing HIV/AIDS and other health challenges. A few years later, in 2006, the African Union adopted the Maputo Plan of Action of the Continental Policy Framework for the Operationalisation of Sexual and Reproductive Health and Rights. The Continental Policy Framework calls for the strengthening of the health systems in order to ensure universal access to basic health services, including sexual and reproductive health care services. It also calls on African governments to commit more resources to the health care sector and develop equitable healthcare systems that will eliminate barriers to sexual and reproductive health services for women and young people. More importantly, in 2003 the African Union adopted the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women (Maputo Protocol). The Maputo Protocol contains a number of landmark provisions, including the explicit recognition of women's sexual and reproductive health and rights, women's protection from HIV, access to contraceptive information and services and the right to abortion on limited grounds. More recently, the African Union has launched the Campaign for the Accelerated Reduction of Maternal Mortality in Africa (CARMMA) in a bid to address high maternal mortality in the region and ensure that African countries are on track in meeting Millennium Development Goal no 5.

On its part, the African Commission on Human and Peoples' Rights has continued to play a crucial role in advancing sexual and reproductive rights of women in the region. The Commission has adopted important resolutions and General Comments relating to sexual and reproductive health and rights of women in the region. For instance, in 2008 the Commission adopted two resolutions: one on access to medicines and another on maternal mortality as a human rights challenge in Africa. In 2012, during its 52nd Ordinary Session held in Yamoussoukro, Côte d'Ivoire, the Commission for the first time adopted a General Comment clarifying the nature of states' obligations in article 14(1)(d) and (e) of the

Maputo Protocol. This has been followed by General Comments on article 14(1)(a), (b), (c) and (g) and article 14(2)(a) and (c) of the Protocol which was adopted during the Commission's 55th Ordinary Session which was held in Luanda from 28 April to 12 May 2014. Also, the Commission has adopted a resolution on the human rights implications of forced sterilisation of women living with HIV in Africa. In addition, the activities of two of the special mechanisms of the Commission, the Special Rapporteur on the Rights of Women in Africa and the Committee on the Protection of the Rights of People Living with HIV (PLHIV) and those at Risk, Vulnerable to and Affected by HIV – are directly related to advancing the sexual and reproductive health and rights of women.

Despite efforts by African governments to address the sexual and reproductive health challenges in the region, some countries are not on track in meeting the health-related Millennium Development Goals, particularly goals 4 and 5. Lack of political will and poor implementation, inadequate allocation of resources to sexual and reproductive health issues, deep-rooted cultural practices and stereotypes have continued to hinder efforts at advancing sexual and reproductive health and rights of Africans. It is important to note that ensuring universal access to sexual and reproductive health is essential not only in achieving MDGs 4 and 5 but also goal 3 on promoting gender equality and goal 6 on combating HIV/AIDS and other diseases.

In the light of the foregoing, this book could not have come at a better time as it addresses some of the serious sexual and reproductive health challenges our continent is currently facing. More importantly, the book provides insightful and useful discussions on how these challenges can be overcome. It is the first of its kind in our region and will definitely be useful to researchers, academics, policy makers, civil society organisations, students and other persons interested in the subject of sexual and reproductive health and rights.

Soyata Maiga

Special Rapporteur on the Rights of Women in Africa

August 2014

STRENGTHENING THE PROTECTION OF SEXUAL AND REPRODUCTIVE HEALTH THROUGH HUMAN RIGHTS IN THE AFRICAN REGION: AN INTRODUCTION

Charles Ngwena and Ebenezer Durojaye

1 Introduction

The human rights relating to sexual and reproductive health typify unmet human rights needs in the African region. Despite drawing sustenance from international human rights jurisprudence, their realisation at a domestic level is often precarious. In developing countries, especially, the domestic political, legal, economic, social and policy environment has often appeared particularly unwilling to yield to the imperatives of respecting sexual and reproductive health and rights in all their manifestations. In the African region, there are good reasons to take the challenge of realising rights for protecting sexual and reproductive health seriously. There is ample evidence to suggest that such rights are being denied on a significant scale. The region's current challenges in effectively realising sexual and reproductive health for its people include: unmet needs in access to contraception; high levels of maternal mortality and morbidity, including mortality and morbidity from unsafe abortion and lack of access to obstetric care; the persistence of pandemic levels of HIV; early and/or coerced marriages; harmful cultural practices such as female genital mutilation; sexual violence and exploitation; and endemic discrimination on the basis of age, marital status, sexual orientation, disability and other vectors of discrimination. Though unmet sexual and reproductive health and rights are experienced across the gender divide, it is women who are at the receiving end of most deprivations.

It is essential to transcend the rhetoric of rights so as to ensure that sexual and reproductive rights are in practice secured for all. Commitments made by governments to respect, protect and fulfil sexual and reproductive health under human rights instruments as well as non-treaty global and regional consensus statements are meaningless without effective implementation at the domestic level. Where there is a failure to implement, there must be state accountability. As part of promoting accountability, it is essential to engage in concerted efforts to ensure that

governments that have not committed themselves to respecting, protecting and fulfilling rights related to sexual and reproductive health are persuaded and, ultimately, required to do so. This purpose can be achieved partly through optimal utilisation of available human rights systems, including the regional system.

It is a truism that in the African region, international human rights have been woefully slow in filtering to the domestic sphere. This applies to rights emanating from the region's human rights treaties as well.¹ Compared to its European counterpart under the European Convention of Human Rights (European Convention),² for example, the regional system of human rights protection under the African Charter on Human and Peoples' Rights (African Charter)³-based system is still far from achieving the same resonance at the domestic level in terms of both visibility and implementation. But the picture has not remained bleak or static. The African human rights landscape has been undergoing transformation in recent years, including in the area of sexual and reproductive health as human rights. In this regard, more than any other recent regional development, the adoption of the Protocol to the African Charter on the Rights of Women in Africa of 2003 (African Women's Protocol)⁴ and its entry into force in 2005 has signalled a new dawn in the advancement of human rights in Africa.⁵ In many areas, the African Women's Protocol charts a progressive and bold path in the articulation of women's sexual and reproductive health and rights. The Women's Protocol was borne out of a strongly-shared consensus that the African Charter was largely weak or mute in its acknowledgment and articulation of women's rights. It comes from a realisation that, despite the ratification of the African Charter by state parties, African women have continued to be at the receiving end of unfair discrimination and harmful practices, and that another layer of protection was needed.⁶

The African Women's Protocol is more than just a mere supplement to the African Charter. In key areas of women's human rights, it articulates rights and duties that are of primary and contemporary relevance to redressing gender inequality in the African region. More specifically, in the sexual and reproductive health sphere, the African Women's Protocol explicitly guarantees a wide range of rights, including rights to:

- 1 F Viljoen *International human rights law in Africa* (2012) 571-572.
- 2 European Convention for the Protection of Human Rights and Fundamental Freedoms, opened for signature 4 November 1950, 213 UNTS 221, ETS 5.
- 3 African Charter on Human and Peoples' Rights, adopted 27 June 1981, OAU Doc CAB/LEG/67/3 Rev 5, 1520 UNTS 217.
- 4 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, adopted 11 July 2003, OAU Doc AHG/Res. 240 (XXXI).
- 5 F Banda *Women, law and human rights: An African perspective* (2005) 66-82.
- 6 As above.

- control fertility, to decide whether to have children, the number of children and the spacing of children;⁷
- choose any method of contraception;⁸
- protection against sexually-transmitted diseases;⁹
- access to adequate, affordable and accessible health services;¹⁰
- abortion;¹¹
- life, integrity and security of the person;¹²
- protection from all forms of violence, including sexual violence;¹³
- protection against sexual harassment;¹⁴
- protection against harmful cultural and traditional practices, including female genital mutilation;¹⁵ and
- equality within marriage.¹⁶

The African Women's Protocol, which has been ratified by at least two-thirds of African states,¹⁷ advances the substantive understanding of sexual and reproductive health as human rights. The obligations it imposes on states provide civil society, including human rights advocates, with a ready-made regional template for accelerating the realisation of sexual and reproductive health and rights at the domestic level. The African Women's Protocol is an important addition to the panoply of other international instruments that already exist to promote sexual and reproductive health. In this connection, the Women's Protocol reaffirms the commitments undertaken by African states arising from regional instruments such as the African Charter itself, United Nations (UN) instruments such as the International Covenant on Civil and Political Rights (ICCPR),¹⁸ the International Covenant on Economic, Social and Cultural Rights (ICESCR),¹⁹ the Convention on the Elimination of All Forms of

7 Arts 14(1)(a) & (b) African Women's Protocol.

8 Art 14(1)(c).

9 Arts 14(1)(d) & (e).

10 Art 14(2)(a).

11 Art 14(2)(c).

12 Art 4.

13 As above.

14 As above.

15 Art 5.

16 Art 6.

17 Angola, Benin, Burkina Faso, Cameroon, Cape Verde, Comoros, Congo, Côte d'Ivoire, Democratic Republic of Congo, Djibouti, Equatorial Guinea, Gabon, The Gambia, Ghana, Guinea-Bissau, Guinea, Kenya, Lesotho, Liberia, Libya, Malawi, Mali, Mauritania, Mozambique, Namibia, Nigeria, Rwanda, Senegal, Seychelles, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe: African Commission on Human and Peoples' Rights Status of ratification/accession to OAU/AU human rights treaties http://www.achpr.org/english/_info/index_ratification_en.html (accessed 8 August 2014).

18 International Covenant on Civil and Political Rights 999 UNTS 171, adopted 16 December 1976, entered into force 23 March 1976.

19 International Covenant on Economic, Social and Cultural Rights, GA Res 2200A (XXI), adopted 16 December 1966, entered into force 3 January 1976.

Discrimination Against Women (CEDAW),²⁰ and the Convention on the Rights of the Child (CRC),²¹ as well as programmatic commitments arising from global consensus on taking positive and targeted steps to realise women's sexual and reproductive health, such as commitments made under the International Conference on Population and Development,²² the Fourth World Conference on Women,²³ and the Millennium Development Goals (MDGs).²⁴

It would be a mistake, though, to look at the African Charter-based regional system as the only institutional framework with an important bearing on the realisation of human rights in the region. The very notion of human rights *systems* (as opposed to *a system*) necessarily encompasses all institutions, actors, juridical and political norms, and processes that intersect and synergise in the protection of human rights. The promotion and sustenance of a human rights culture crucially depends on the commitment of complementary institutions, actors and processes. In this regard, domestic courts, national human rights commissions, ombudspersons, public protectors and national as well as transnational civil society, including non-governmental organisations (NGOs), advocacy groups, religious organisations, political and social movements and the media, all have a vital role to play in complementing the objects of the African Charter. Thus, any attempt to explore the potential of realising reproductive and sexual rights, perforce, entails taking into cognisance that human rights systems are interdependent systems that go beyond the purview of a single human rights instrument.

2 About this volume

The chapters in this book are the outcome of a colloquium that was convened in October 2011 at the University of the Free State in Bloemfontein, South Africa. The colloquium sought to explore the potential of augmenting sexual and reproductive health in ways that make optimal use of human rights systems and tools in the African region. The chapters in this book are divided into three parts: Part 1 focuses on the reproductive autonomy, access to safe abortion and emergency obstetric care; Part 2 has an HIV/AIDS focus; and Part 3 focuses on the intersections between sexual and reproductive health and rights,

20 Convention on the Elimination of All Forms of Discrimination Against Women, GA Res 34/180 adopted 18 December 1979, entered into force 3 September 1981.

21 Convention on the Rights of the Child, GA Res 44/25 adopted 20 November 1989, entered into force 2 September 1990.

22 United Nations Population and Development, Programme of Action Adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994 (1994) (ICPD).

23 United Nations, Platform for Action and Beijing Declaration, Fourth World Conference on Women, Beijing, China, 4-15 September 1995 (1995) (Beijing Declaration).

24 United Nations Millennium Development Goals (2000).

adolescence, early marriage, sexual violence and poverty. But while the arrangement of the chapters into three parts facilitates the juxtaposition as well as discursiveness analysis of topics that have a closer relationship with one another, it is important to highlight that all the parts are not intended to convey a sense of sacrosanct silos. All the parts and topics in this volume are intertwined and do not yield to sharp demarcations.

3 Part 1: Reproductive autonomy, access to safe abortion and emergency obstetric care

Meaningful control over whether to become a mother is absolutely fundamental to the realisation of women's reproductive health, agency and socio-economic well-being. This is underscored at the African regional level by the bundle of rights in article 14 of the African Women's Protocol, which guarantees women the rights to:

- control fertility;
- decide whether to have children, the number and the spacing of children;
- choose any method of contraception; and, ultimately,
- abortion.

A human right to reproductive health means little if women with unwanted pregnancies are implicitly compelled to either become mothers or to have recourse to unsafe abortion due to the criminalisation of abortion or the inaccessibility of safe abortion services. Equally, choosing motherhood becomes a perilous experience when women go through pregnancy and childbirth without support from the state in terms of adequate provision of accessible and appropriate health care services, including provision of emergency obstetric care. As part of guaranteeing safe motherhood, article 14 enjoins state parties to establish and strengthen prenatal and postnatal care for women.²⁵

The persistence of unsafe abortion in the African region in the new millennium can be understood as a failure by African states to honour the commitments they made under the International Conference on Population and Development (ICPD)²⁶ and the Beijing Declaration.²⁷ The sedimentation of unsafe abortion is indicative of failure to domesticate as well as regionalise the major sexual and reproductive health-related accomplishments of the ICPD and the Beijing Declaration. Essentially, these accomplishments lay in building synergy between public health and human rights in ways that put women at the centre, and recognising reproductive health as a human right in ways that do not merely seek to

²⁵ Art 14(2)(b) African Women's Protocol.

²⁶ ICPD (n 22 above).

²⁷ Beijing Declaration (n 23 above).

respect reproductive self-determination, but also to ascribe to governments the urgent task of empowering women to regulate their own fertility and to make meaningful choices about whether to become mothers free from coercion, discrimination and violence.²⁸

An important accomplishment of ICPD in the conceptualisation of reproductive health as a human right was in transcending classical liberalism and the notion of rights as giving rise only to obligations of restraint on the state which can often amount to a mere abstraction.²⁹ Instead, the human right to reproductive health was conceived as an empowerment tool for giving women ‘capabilities’ in a gendered society in which women’s health needs have been historically excluded or marginalised.³⁰ ICPD tethered reproductive rights to state obligations to provide requisite services and, ultimately, to demonstrate positive reproductive health outcomes. The African Women’s Protocol has regionalised this innovative conceptual shift. Ultimately, the Protocol requires state parties to take all appropriate measures to provide affordable and accessible services, including information, education and communication programmes to women, especially those in rural areas,³¹ to adopt all necessary measures, in particular budgetary measures for the full and effective implementation of the rights that are guaranteed,³² and to report periodically on implementation.³³

This section has four chapters. It interrogates African human right systems in two main areas: (i) the provision of access to safe abortion for women with unwanted pregnancies; and (ii) accountability of the state for a failure to provide adequate and appropriate obstetric care for safe motherhood. As all four chapters highlight, both unsafe abortion and failure to provide adequate obstetric care to render motherhood safe are major contributors towards maternal mortality in the African region. It is not just the loss of women’s lives that is the outcome of failure by African states to provide access to safe abortion services and to render healthcare systems that assure safe motherhood. With each maternal death, many more women are rendered seriously ill and are often permanently disabled. There are also economic implications at the individual as well as wider community levels.

The first three chapters, namely, Eunice Brookman-Amissah and Tinyade Kachika’s chapter on ‘Reducing abortion-related maternal

28 RJ Cook *et al* *Reproductive health and human rights* (2003) 11-12; MJ Roseman & L Reichenbach ‘Global reproductive health and human rights: Reflecting on ICPD’ in L Reichenbach & MJ Roseman (eds) *Reproductive health and human rights* (2009) 8-10.

29 Cook *et al* (n 28 above) 9.

30 On human rights as ‘capabilities’, see eg MC Nussbaum *Women and human development: The capabilities approach* (2000) 96-101; A Sen ‘Elements of a theory of human rights’ (2005) 32 *Philosophy and Public Affairs* 328-338.

31 Art 14(2)(a) African Women’s Protocol.

32 Art 26(2).

33 Art 26(1).

mortality in Africa: Progress in implementing Objective 5 of the Maputo Plan of Action on Sexual and Reproductive Health Rights', Simangele Mavundla and Charles Ngwena's chapter on 'Access to legal abortion for rape as a reproductive health right: A commentary on the abortion regimes of Swaziland' and Christina Zampas and Jaime Todd-Gher's chapter on 'Abortion and the European Convention on Human Rights: A lens for abortion advocacy in Africa', revolve around access to safe abortion as a human right. The chapters are set against the backdrop of African abortion laws as major contributors towards the region's high burden of unsafe abortions. The fourth chapter by Onyema Afulukwe-Eruchalu, titled 'Accountability for non-fulfilment of human rights obligations: A key strategy for reducing maternal mortality and disability in sub-Saharan Africa', is set against palpable failures by the region to implement human rights obligations to render motherhood safe.

One of the African region's unenviable colonial legacies lies not just in the criminalisation of abortion, but also in the sustenance of criminalisation long after the demise of colonial rule. African abortion laws have their origins in laws which were transplanted from Europe at the time of the region's colonisation in the nineteenth century.³⁴ Abortion laws were imposed on the colonial state as replicas of highly-restrictive laws in the colonising countries. They were deliberately intended to regulate abortion using a crime and punishment approach. The criminalisation of abortion in colonial jurisprudence, as expressed in penal codes as well as in unwritten law, was underpinned by European masculinist theologies that had scarce regard for women's agency or their reproductive health. The Catholic and Protestant theologies, which were the provenance of European abortion laws transplanted to colonies in Africa, sought to protect the sanctity of foetal life and to reflect abortion as a mortal sin, but at the expense of women's reproductive autonomy, health and even life.³⁵

Historically, abortion laws have been the quintessence of laws that seek to enforce dominant cultural norms. The criminalisation of abortion has served to disqualify women's life accounts, experiences and, ultimately, their agency through a discriminatory and infantilising paternalism that is grounded in patriarchy. Colonial abortion jurisprudence assumed that maternity was a principal vocation for women. The jurisprudence assumed women were taken as procreative instruments at the service of natalist patriarchies, rather than respected as human beings with moral agency. This is apparent especially from the fact that, at their inception, abortion laws only countenanced abortion to save the life of the pregnant woman. Literally, this meant only permitting abortion

34 C Ngwena 'Access to abortion: Legal developments in Africa from a reproductive and sexuality rights perspective' (2004) 19 *South African Public Law* 328 335-338.

35 RJ Cook & BM Dickens 'Human rights dynamics of abortion law reform' (2003) 25 *Human Rights Quarterly* 9.

when it was physically impossible for the woman to survive the pregnancy or childbirth.³⁶ In this way, abortion laws have served to appease theologies that are profusely sex- and gender-scripting as to be repositories of patriarchal power in socio-political economies in which women are not valued like men are and, certainly, are intended to be subordinate to men.³⁷ The criminalisation of abortion accentuates the stigma around abortion. It typifies the role of law not only as a medium of the exercise of power, but also as means of enforcing the stigma which, in turn, serves as an additional deterrent to the provision of abortion even where it is permitted under domestic laws.³⁸

Over and above oppressing women and denying them equality, criminalising and stigmatising abortion has served as a veritable pathway for unsafe abortion, especially for poor women. Highly-restrictive laws compel women to seek clandestine abortions that are frequently unsafe. The association between laws that are highly restrictive of abortion and unsafe abortion-related mortality and morbidity of women who have no means and knowledge to access safe abortion services is well-established.³⁹ All three chapters in this section acknowledge that the African region, especially sub-Saharan, bears a disproportionate burden of unsafe abortion-related mortality and morbidity that is linked to highly-restrictive laws or a lack of accessible abortion services. Certainly, the African region has been slow to reform abortion laws in ways that are effective in protecting the health and lives of women in contradistinction to the former colonising countries, where the public health rationale for decriminalising abortion and rendering abortion services accessible has long spurred effective reforms. At the same time, there has been progress aimed at reforming the region's abortion regimes.

Over and above the reform of abortion regimes at the domestic level, there has also been reform at the regional level. The high point of reform has been the adoption of the African Women's Protocol in 2003 and the express recognition of abortion as a human right, for the first time ever in a human rights treaty.⁴⁰ At a regional policy level, the Maputo Plan of Action of the Continental Policy Framework for the Operationalisation of Sexual and Reproductive Health and Rights has been the most significant policy initiative to come from the African Union (AU).⁴¹ The Maputo Plan of Action constitutes the regionalisation of ICPD's Programme of Action and Africa's plan of action for realising the Millennium

36 R Siegel 'Reasoning from the body: A historical perspective on abortion regulation and questions of equal protection' (1992) 44 *Stanford Law Review* 364-365.

37 RJ Cook & S Cusack *Gender stereotyping: Transnational legal perspectives* (2010) 86-89.

38 S Burris 'Disease stigma in US public health law' (2002) 30 *Journal of Law, Medicine and Ethics* 185.

39 Guttmacher Institute *Abortion worldwide: A decade of uneven progress* (2009) 25-29.

40 CG Ngwenya 'Inscribing abortion as a human right: Significance of the Protocol on the Rights of Women in Africa' (2010) 32 *Human Rights Quarterly* 783.

41 African Union *African Women's Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health 2007-2010* (2006).

Development Goals as they pertain to sexual and reproductive health. Reducing the region's high burden of unsafe abortion is among the key strategic goals of the Maputo Plan of Action. It commits African states to provide abortion services to the maximum extent permitted by domestic laws.

At the same time as instituting significant reforms of abortion regimes, as all three chapters in this section highlight, the preponderance of states in the region has yet to translate reforms into tangible legal entitlements to safe abortion and, most crucially, access to abortion services. In their chapter, Brookman-Amissah and Kachika review progress in six selected African states – Ethiopia, Ghana, Malawi, Nigeria, South Africa and Zambia – on the implementation of the Maputo Plan of Action, focusing on the duty of member states to adopt and implement laws, policies and programmes to reduce the incidence of unsafe abortion-related mortality. Their study reveals that efforts to implement the Maputo Plan of Action have been inconsistent. Though progress has been made in reducing unsafe abortion-related mortality, it is not evenly and sufficiently spread out to fulfil the Maputo Plan of Action. The persistence of highly-restrictive laws in some countries or the poor implementation of laws that are otherwise enabling, together with the unavailability of resources to provide safe abortion services, explains the continuing prevalence of significant levels of unsafe abortion in the majority of the countries that were studied. The authors urge not just African governments to honour their commitments under human rights treaties as well as global and regional soft laws, but also the African Commission on Human and Peoples' Rights (African Commission) as well as civil society to play their part in making a women's human right to safe abortion a tangible reality in the African region.

Mavundla and Ngweni's chapter examines the implementation of rape, which is one of the more common indications for abortion in the legal regimes of African states. United Nations (UN) treaty-monitoring bodies have reiterated that denying survivors of sexual violence access to safe abortion constitutes a violation of the woman's human right, including constituting cruel, inhumane and degrading treatment.⁴² Using Ethiopia and Swaziland as comparative case studies, the chapter seeks to elicit whether domestic legal systems have instituted mechanisms for guaranteed access to abortion on the ground of rape so that women could be spared the additional trauma of being compelled to become mothers. In Ethiopia's case, the authors find that the domestic legal system has gone beyond merely providing rape as a ground for abortion under the reforms ushered in by the Ethiopian Criminal Code of 2005. The rape ground, as with the other grounds for abortion under the reformed law of abortion in

42 *LC v Peru*, Communication 22/2009, CEDAW/C/50/D/22/2009, Committee on the Elimination of Discrimination against Women (2011) para 8.18; *LMR v Argentina*, Communication 1608/2007, CCPR/C/101/D/168/2007, Human Rights Committee (2011) para 9.2.

Ethiopia, is accompanied by guidelines that are intended to facilitate implementation, including dispensing with onerous certification requirements on survivors of rape. Concomitantly, while applauding Ethiopia for introducing significant reforms, the authors note that implementation is still far from complete. Women, especially poor women who depend on public health facilities, are still experiencing significant service barriers. They highlight that Swaziland stands in stark contrast to Ethiopia. Though reforms of the country's abortion law through the route of section 15 of the Constitution of Swaziland of 2005 liberalised the grounds for abortion under the country's unwritten abortion law, there has been no effort at all by organs of state or the health care professions to implement the reforms. Thus far, Swaziland's abortion law reforms only promise paper entitlements.

In their chapter, Zampas and Todd-Gher highlight the importance of taking cognisance of the persuasive and potentially-transformative value of abortion jurisprudence that is emerging from UN treaty-monitoring bodies and the European regional human rights system in particular. The authors see the emerging jurisprudence as a new juridical resource for giving life to abortion rights in the African region, especially the fundamental right to abortion that is guaranteed by article 14 of the African Women's Protocol. The authors acknowledge the important historical and substantive differences between the African human rights system and its counterpart under the European Convention on Human Rights (European Convention). At the same time, they argue that emerging European regional human rights jurisprudence can serve the African region well as a resource for developing transformative litigation-related strategic advocacy in the African region. This is partly because African regional abortion jurisprudence has remained legally untested in practice and largely under-implemented at the domestic level even in ratifying states.

In their comparative study, Zampas and Todd-Gher highlight the novelty and potential usefulness of decisions of UN treaty bodies taken under Optional Protocols⁴³ and judgments of the European Court of Human Rights,⁴⁴ which have found human rights violations against member states for failure to implement domestic abortion laws in ways that ensure that women have effective access to lawful abortions. An important implication of the emerging jurisprudence is that advocacy and litigation to vindicate the right to safe abortion need not be confined to

43 *KL v Peru*, Communication 1153/2003, adopted 24 October 2005, UN GAOR, Human Rights Committee, 85th session, UN Doc CCPR/C/85/D/1153/2003 (2005); *LC v Peru*, Communication 22/2009, CEDAW/C/50/D/22/2009, Committee on the Elimination of All Discrimination Against Women (2011); *LMR v Argentina*, Communication 1608/2007, CCPR/C/101/D/168/2007, Human Rights Committee (2011).

44 *Tysiac v Poland* Application 5410/03, ECHR 2007-IV (2007); *A, B & C v Ireland*, Application 25579/05 (2010), [2010] ECHR 2032; *RR v Poland* Application 27617/04 (2011); *P & S v Poland* Eur Ct HR, Application 57375/08 (2012).

arguing for substantive reform of abortion laws, which is harder to achieve as consensus to liberalise abortion is difficult to muster. Arguments for reform can also be strategically pegged around the accountability of the state for failure to institute legal and administrative measures that facilitate effective access to abortion under laws which the state itself has already adopted.

Afulukwe-Eruchalu's chapter highlights that, in spite of significant progress at the global level to reduce maternal deaths and maternal mortality rates (MMR), sub-Saharan Africa continues to have the highest numbers of maternal deaths and that this is partly a result of the failure by states to provide adequate access to emergency obstetric care and other reproductive health services to render pregnancy and childbirth safe and to treat any complications timely. Using a human rights framework that identifies the discrete rights, including the rights to life, health, non-discrimination and equality, and information which are adversely impacted by the state's failure to respect, protect and fulfil women's rights to safe motherhood, the chapter argues that holding the state accountable for preventable maternal deaths is an emerging and important litigation strategy which can be used by civil society and national human rights institutions in the African region.

In arguing for the judicialisation of maternal mortality in the African human rights systems, Afulukwe-Eruchalu draws jurisprudential support from decisions of human rights treaty-monitoring bodies as well as courts outside of the African region where the state has been held accountable for preventable maternal deaths. In this regard, the decision of the Committee on the Elimination of All Discrimination Against Women (CEDAW Committee) in *Alyne da Silva Pimentel v Brazil* is particularly significant for the development of human rights standards.⁴⁵ In the *Alyne* case, the CEDAW Committee found Brazil in breach of its obligations under CEDAW for the preventable 'maternal death' of a 28 year-old woman for a lack of provision of appropriate health care to treat obstetric complications related to pregnancy. The decision constitutes the first time that a UN treaty-monitoring body has conceptualised and applied accountability for preventable death in justiciable terms. Part of its jurisprudential significance lies in its inclusive approach to equality through demonstrating an awareness of the operation of multiple and overlapping vectors of discrimination and not merely just one enumerated vector.⁴⁶ The Committee found that Alyne, a Brazilian of African descent who came from a poor socio-economic background, had been discriminated against, not only on grounds of gender, but also on the bases of race and socio-economic status. Compliance with the *Alyne* decision

45 *Alyne da Silva Pimentel v Brazil* UN CEDAW Committee (10 August 2011), UN Doc CEDAW/C/49/D/17/2008; RJ Cook 'Human rights and maternal health: Exploring the effectiveness of the *Alyne* decision' (2013) 41 *Global Health and the Law* 103-123.

46 C Sheppard *Inclusive equality* (2010) 32-33.

requires states to organise and dispense health care services in ways that are not only responsive to intersectionalities.⁴⁷ It is not just gender that the state has to take into account in order to respect, protect and fulfil equality, but also other associational characteristics such as race, ethnicity, geographical location and socio-economic background, which burden some women more than others, serving as headwinds when they attempt to access health services.

But whether African courts and tribunals will embrace the emerging jurisprudence on preventable maternal mortality, at the domestic level especially, depends on a number of factors, including the enabling nature of domestic bills of rights and willingness on the part of the judiciary to take socio-economic rights seriously and impugn executive policies where they impact adversely on fundamental rights. The decision of the Ugandan Constitutional Court in *Centre for Health Human Rights and Development (CEHURD) & 3 Others v Attorney-General*,⁴⁸ as Afulukwe-Eruchalu notes, is a disappointment. The Ugandan Constitutional Court shied away from an inquiry into accountability of the Ugandan state for the maternal deaths of two women from a lack of access to emergency obstetric care. The guarantee of the right to life in the Ugandan Constitution,⁴⁹ the express recognition of the state obligation to ensure ‘access to health services’ and the provision of ‘basic medical services’ as constitutional national directives⁵⁰ and the ratification of treaties, including the African Charter, which guarantees the right to health,⁵¹ were not enough to persuade the Ugandan Constitutional Court that it could inquire into the claim. Instead, it chose to categorise the claim as raising a ‘political’ question which was for the executive rather than the judiciary to determine. Even allowing for the polycentric nature of claims that ultimately implicate socio-economic rights,⁵² and the constitutional importance of respecting the doctrine of separation of powers, the Ugandan decision comes across as an instance of undue judicial deference towards the executive in a way that undermines the promotion of women’s reproductive health.

4 Part 2: HIV/AIDS focus

This section contains three chapters that in different dimensions address HIV/AIDS in the African region. These are Karen Stefiszyn’s chapter on ‘Adolescent girls, HIV and state obligations under the African Women’s Rights Protocol’; Rebecca Amollo’s chapter on ‘Advancing a feminist capabilities approach to HIV and AIDS in sub-Saharan Africa;’ and Lisa

47 Cook (n 45 above) 108-109.

48 Constitutional Petition 16 of 2011.

49 Art 22 Constitution of the Republic of Uganda, 1995.

50 Ugandan Constitution (n 49 above) objectives XIV(ii) & XX respectively.

51 Art 16 African Charter.

52 L Fuller ‘The forms and limits of adjudication’ (1978) 92 *Harvard Law Review* 395 353-409.

Forman's chapter on 'The right to health and AIDS medicines in sub-Saharan Africa: Assessing the outcomes of a human rights-based approach to medicines'.

More than three decades into the HIV pandemic, its devastating effects, particularly in sub-Saharan Africa, have not abated sufficiently. Although enormous progress has been made, there are continuing challenges in many sectors. A recent report by UNAIDS shows that Africa's share of the global HIV burden remains the largest, accounting for 23,5 million of the 34 million people living with HIV.⁵³ The report further shows that, of the estimated 1,7 million HIV-related deaths in 2011 worldwide, the majority occurred in Africa.

On the positive side, there has been a significant decrease in the number of HIV infections. Furthermore, significant progress has been made in broadening access to HIV/AIDS medicines and anti-retroviral drugs in particular. According to a recent report, about 8 million people in low- and middle-income countries were on anti-retroviral therapy at the end of 2011, about four times more than the figure a decade ago.⁵⁴ Access to anti-retroviral treatment has led to a decrease in HIV-related deaths. These developments have renewed hope that the HIV pandemic can be contained, if not overcome. More than ever, developing countries, particularly African countries, are committing a substantial amount of their resources towards combating the HIV pandemic. It is estimated that total domestic HIV resources in low- and middle-income countries rose from US \$3,9 billion in 2005 to almost US \$8,6 billion in 2011.⁵⁵ For the first time since the AIDS epidemic, average domestic funding to address HIV in Africa reached 51 per cent.⁵⁶ At the same time, a huge gap in funding remains, not least because budgetary allocations to the health sector in many African countries still fall short of the 15 per cent agreed under the Abuja Declaration.⁵⁷

Infection rates among young people, especially young women, have remained high. It is estimated that young women aged 15-24 are nearly four times more likely to be infected than their male counterparts.⁵⁸ HIV-related information and services for young people remain acutely low. Women continue to bear the burden of the epidemic in Africa. HIV/AIDS remains a major cause of death among women and contributes significantly to the proportion of pregnancy-related deaths in the African

53 UNAIDS *Report on the global AIDS epidemic* (2012) 4.

54 UNAIDS *Together we can end AIDS* (2012) 4.

55 As above.

56 As above.

57 African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, Abuja, Nigeria, 24-27 April 2001, OAU/SPS/ABUJA3.

58 UNAIDS *Report on the global AIDS epidemic* (2010).

region.⁵⁹ While women account for about 50 per cent of the total number of people infected with HIV worldwide, the figure for the African region is about 60 per cent.⁶⁰ Several factors account for the disproportionate adverse impact of HIV/AIDS on women, including the low socio-economic status of women, patriarchal traditions that fuel gender inequality, and harmful cultural practices. Sexual violence and a lack of respect for the sexual and reproductive health of women contribute to HIV transmission.⁶¹ HIV status exposes women to stigma and discrimination, including acts of violence.⁶² Women living with HIV experience deprivations of other rights, such as access to land and property, including housing and a means of livelihood.

The African Women's Protocol is an additional juridical tool for protecting women's rights in the HIV/AIDS context, not least through specifically imposing on the state a duty to protect women from HIV transmission.⁶³ In her chapter, Karen Stefiszyn examines the provisions of the Women's Protocol in relation to protecting women, particularly young women, from HIV. She argues that the Protocol serves as an important tool to guide state action towards mitigating the devastating effects of HIV on young women in the region. She highlights that the provisions of articles 14(1)(d) and (e) of the Protocol, dealing with HIV/AIDS are couched in unclear language in terms of the obligations imposed on states. As a remedial response, Stefiszyn proposes that the African Commission develop an interpretative guidance in the form of a General Comment explaining states' obligations regarding articles 14(1)(d) and (e). She then outlines some of the possible contents of the interpretative guidance. With regard to article 14(1)(d), for example, she proposes that states should be under an obligation to provide youth-friendly information and services on sexual and reproductive health, and access to contraception, including male and female condoms and post-exposure prophylaxis. In respect of article 14(1)(e), Stefiszyn proposes that states should ensure the availability of voluntary counselling and testing services, respect for privacy and confidentiality, and create an enabling environment where the human rights of all individuals, including people living with or at risk of HIV, are promoted and protected.

The African Commission has heeded the call for a General Comment. During its 52nd ordinary session, for the first time in its history, the Commission adopted General Comments on articles 14(1)(d) and (e).⁶⁴

59 WHO *et al Trends in maternal mortality: 1990 to 2008* (2010) 13; *PLoS Medicine* Editors (2010) 'Maternal health: Time to deliver' (2010) 7 *PLoS Medicine* 300.

60 UNAIDS (n 53 above).

61 AIDS Law Project *et al Gender violence and HIV* (2012) 4.

62 As above.

63 L Gerntholtz *et al 'The African Women's Protocol: Bringing attention to reproductive rights and the MDGs'* (2011) 8 *PLoS Medicine* 429; see also the chapters by Amollo and Stefiszyn in this volume.

64 This Resolution was adopted at the 52nd ordinary session of the African Commission on Human and Peoples' Rights held in Côte d'Ivoire, 3-23 October 2012.

The General Comments are divided into four broad parts, including introduction, normative content, states' obligations and specific obligations. The Commission reaffirms that women in Africa have the right to the highest attainable standard of health, which includes sexual and reproductive health and rights. It recognises that the high risk to HIV exposure prevents women from realising these rights. According to the General Comments, the right to be informed of one's health status includes the rights of women to access adequate, reliable, non-discriminatory and comprehensive information about their health. Furthermore, the right to self-protection and the right to be protected are intrinsically linked to other women's rights, including the right to equality and non-discrimination, life, dignity, health, self-determination, privacy and the right to be free from all forms of violence.

The immediate impact of HIV on individuals and families cannot be mitigated without access to HIV medicines. While the number of people receiving treatment has increased significantly, universal access to HIV/AIDS-related treatment has yet to be achieved. Moreover, disparities still exist across the region with regard to the number of people receiving treatment, particularly in relation to the prevention of mother-to-child-transmission of HIV. While some countries, such as Namibia, Botswana and South Africa, have made tremendous progress and attained universal treatment with regard to the prevention of mother-to-child-transmission of HIV, others, such as countries in West and Central Africa, are still lagging behind.⁶⁵ In their efforts to secure universal access to anti-retroviral medicines to preserve health and protect lives, African governments must, however, reckon with the barriers that flow from patent protection of medicines as well as international agreements on patent protection.⁶⁶ The Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement has remained a barrier to life-saving medicines for people in poor regions.⁶⁷ Although, as affirmed by the Doha Declaration, TRIPS recognises some exceptions that can be invoked to ensure access to medicines,⁶⁸ developed countries and pharmaceutical companies have continued to oppose the use of these exceptions to facilitate access to life-saving medications in poor regions.⁶⁹

Part of how developed countries undermine the TRIPS exceptions is through exerting pressure on least-developed and developing countries to

65 UNAIDS (n 53 above).

66 This issue is addressed in ch 8 of this book by Lisa Forman.

67 The TRIPS Agreement was part of the final Act establishing the WTO, commonly referred to as the Marrakech Agreement, attached as Annex 1C to the WTO Agreement. The TRIPS Agreement grants a patent holder 20 years' protection over a patent. Activists from developing countries consider this provision to be a stumbling block to access to cheaper life-saving medicines in the context of HIV/AIDS.

68 See eg arts 6 on parallel imports and 33 on compulsory licensing; see also paras 4 and 6 of the Doha Declaration.

69 See E Durojaye 'Compulsory licensing and access to medicines in the post-Doha era: What hope for Africa?' (2008) 55 *Netherlands International Law Review* 33.

adopt a stricter intellectual property rights regime than is envisaged by the TRIPS Agreement, even in respect of life-saving medicines.⁷⁰ This manifests in different forms, including pressuring developed countries into accepting the adoption of anti-counterfeit laws that are wider than is necessary to protect legitimate patent rights. Where the term ‘counterfeit’ is defined broadly so as to include generic drugs, it has the effect of limiting legitimate access to more affordable alternative drugs.⁷¹ It results in undermining the rights to health and life that are guaranteed in international and regional human rights instruments as well as in domestic constitutions. In a recent decision, a Kenyan High Court found that certain provisions of the country’s Anti-Counterfeit Act were inconsistent with the constitutional guarantees on rights to life, health and non-discrimination because it limited access to generic drugs for people living with HIV.⁷² The Kenyan decision is welcome. It underlines the need for continued human rights vigilance and the persistent dangers that uncircumscribed claims to patent rights can pose to access to life-saving medications in poorer regions.

In her chapter, Lisa Forman examines the progress made so far on access to medicines in Africa. She explores the link between global trade-related intellectual property rights and international human rights. Drawing on the experiences of Thailand, Brazil and India, she emphasises the importance of adopting a rights-based approach to addressing the challenge of access to medicines in Africa. According to Forman, the lack of access to essential medicines will impact on a range of rights, particularly the right to the highest attainable standards of health. Also, the chapter suggests that a rights-based social action has been central to the legal and policy changes on access to medicines globally and concludes that this may offer important strategies for addressing other health inequities within the sub-Saharan African region.

Mitigating the impact of HIV entails going beyond preventing HIV transmission and providing access to anti-retroviral medicines in order to respond holistically to the wider socio-economic impact of the pandemic on individuals and families. In her chapter, Rebecca Amollo examines the impact of HIV on women’s socio-economic needs. She argues that it is imperative to address HIV and AIDS by tackling gendered inequalities in

70 For a detailed discussion on this, see J Chen *et al* ‘TRIPS-Plus and access to medicines in China’ (2013) 34 *Journal of Public Health Policy* 1-13.

71 Eg, sec 2 of the Kenyan Anti-Counterfeit Act 2008, which defines counterfeit broadly to mean (a) the manufacture, production, packaging, re-packaging, labelling or making, whether in Kenya or elsewhere, of any goods whereby those protected goods are imitated in such manner and to such a degree that those other goods are identical or substantially similar copies of the protected goods; ... (d) in relation to medicine, the deliberate and fraudulent mislabelling of medicine with respect to identity or source, whether or not such products have correct ingredients, wrong ingredients, have sufficient active ingredients or have fake packaging.

72 *PAO & Others v Attorney-General & Another* High Court of Kenya, Nairobi Petition 409 of 2009, (Judgment 2012).

relation to women's rights to access health services. In addition, she draws the link between protecting women from HIV and ensuring the enjoyment of the underlying determinants of the right to health, such as housing, good nutrition and sanitation. According to Amollo, poverty and poor socio-economic conditions force men and women to adopt risky lifestyles that may predispose them to HIV infection. As a remedial human rights response, she proposes the feminist capabilities approach as developed by Martha Nussbaum, Amartya Sen and other scholars.⁷³ For Amollo, the capabilities approach is a tool for giving women the material means with which to reckon not only with the socio-economic impact of HIV/AIDS, but also its gendered dimensions.

A worrisome development in many parts of Africa is the attempt by countries to criminalise HIV transmission. In about 60 countries, including African countries, governments have either enacted or are in the process of enacting laws that will criminalise HIV transmission or people who engage in same-sex relationships.⁷⁴ In many countries, laws exist that tend to dehumanise many of those to be at highest risk of HIV, such as sex workers, men who have sex with men, people who use drugs, prisoners and migrants.⁷⁵ It is estimated that 600 people living with HIV have been convicted in about 24 countries under these punitive laws.⁷⁶ These laws do not lead to safer sex practices; rather they discourage people from knowing their status or seeking treatment for fear of being punished for exposing their partners to HIV infection. Although these issues are relevant and important, they are beyond the scope of this book.

While the HIV pandemic remains a public health and socio-economic challenge to the African region, it is also important to note that there are renewed efforts by the international community to see the end of the HIV pandemic. To this end, the UN Joint Network on HIV and AIDS (UNAIDS) has adopted a new vision of 'zero new infection, zero discrimination and zero HIV-related deaths'. As a follow-up to the UN General Assembly's Declaration of Commitment of 2001,⁷⁷ members of the UN in 2011 adopted clear and important targets that will lead to the reduction of HIV infections and AIDS-related deaths, and uptake of HIV treatment by 2015.⁷⁸ These targets set during the Political Declaration on

73 Nussbaum (n 30 above); A Sen 'Human rights and capabilities' (2005) 6 *Journal of Human Development* 152-166.

74 UN Commission on HIV and Law *Risks, rights and health* (2012) 8.

75 UNAIDS (n 54 above) 5.

76 UNAIDS (n 58 above).

77 United Nations General Assembly Resolution on Declaration of Commitment on HIV/AIDS June 2001 A/RES/S-26/2.

78 UN General Assembly Resolution on Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS July 2011 A/RES/65/277. Some of the targets include ensuring accountable leadership in the efforts to combat HIV/AIDS; intensifying efforts to prevent new HIV infection; commitment to universal HIV treatment in order to eliminate HIV/AIDS-related deaths; advancing human rights in order to address HIV-related stigma and discrimination; and committing more resources to the fight against HIV.

HIV and AIDS are realisable if they are matched with the right commitment and political will and allocation of resources by governments across the world.

At the African regional level, there are also renewed efforts to combat the pandemic, including the re-launch of AIDS Watch Africa by African leaders to monitor commitments towards ending the HIV pandemic. This is a step in the right direction.⁷⁹ It is hoped that this will propel African leaders to commit more resources to the HIV pandemic and, more importantly, to take ownership of programmes and measures to address the pandemic. This development could not have come at a better time, given that the great proportion of resources for HIV treatment in Africa comes from donor organisations outside the region.⁸⁰ It is hoped that African governments, in line with their commitment made during the Abuja Declaration, will allocate more of their resources to address the HIV pandemic.⁸¹

5 Part 3: Sexual and reproductive health and rights: Intersections with adolescence, early marriage, violence and poverty

Though ICPD largely subsumed sexual health under reproductive health,⁸² it nonetheless recognised its importance and concomitantly contributed towards the foundations of a holistic and expansive concept of sexual health as a human right.⁸³ ICPD acknowledged the importance of protecting sexual health, not merely for the purposes of counselling and care related to reproduction and sexually-transmitted infections (STIs). Even more significantly, it acknowledged the importance of sexual health for the purpose of enhancing life and personal relations.⁸⁴ At an African regional level, article 14(1) of the African Women's Protocol takes the recognition further by bringing sexual health into the compass of a mainstream human right rather than a merely derivative right. Article 14(1) juxtaposes sexual health with reproductive health as the twin human rights interests that form the main corpus of its protective compass. Article 14(1) enjoins state parties to ensure that the 'right to health of women, including sexual and reproductive health, is respected and promoted'.

79 UNAIDS (n 54 above).

80 UNAIDS (n 58 above).

81 African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, Abuja, Nigeria, 24-27 April 2001 OAU/SPS/ABUJA/3.

82 A Miller 'Sexual but not reproductive: Exploring the junction and disjunction of sexual and reproductive rights (2002) 4 *Health and Human Rights* 69.

83 Cook *et al* (n 28 above) 12.

84 ICPD (n 22 above) para 7.2.

Elaborating on the content of sexual health is important for human rights protection and delineating state obligations, not least because of the contested nature of sexual health. In this connection, in 2002, as part of giving content to a rights-based universal approach to sexual health, an expert consultation meeting under the auspices of the World Health Organisation (WHO) defined sexual health as:

A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.⁸⁵

From this concept, sexual rights were defined in the following way:

Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to: (1) the highest attainable standard of health, including access to sexual and reproductive health care services; (2) seek, receive and impart information related to sexuality; (3) sexuality education; (4) respect for bodily integrity; (5) choose their partner; (6) decide to be sexually active or not; (7) consensual sexual relations; (8) consensual marriage; (9) decide whether or not, and when, to have children; and (10) pursue a satisfying and pleasurable sexual life. The responsible exercise of human rights requires that all persons respect the rights of others.

This definition suggests that, from a rights-based approach, though intertwined with several other human rights, sexual rights for realising sexual health are capable of being a distinct interest with normative implications for human rights. This is particularly valuable for the development of strategic advocacy as well as strategic policy making by the state.⁸⁶ Sexual health and rights can provide the inspiration as well as tools for human rights advocacy in the same way as reproductive health and rights have in the aftermath of ICPD.⁸⁷ In much the same way as health is a human right that is universal, its derivative – sexual health – is also a universal human right. Furthermore, once conceived holistically, sexual health creates strategic space for formulating cogent arguments about recognising sexual health as capable of giving rise to an indivisible corpus of civil and political as well as socio-economic human rights with tangible and binding vertical and horizontal obligations that should be honoured in public policies, laws, programmes and private human relations beyond the

85 World Health Organisation *Report of a Technical Consultation on Sexual Health* 28-31 January 2002.

86 A Miller *Sexuality and human rights* (2009) 7.

87 S Gruskin 'The conceptual and practical implications of reproductive and sexual rights: How far have we come?' (2000) 4 *Health and Human Rights* 1.

narrow paradigm of protecting or restoring health in the sense of preventing or treating disease and infirmity.

Moreover, even if contested by national authorities and religious and cultural constituencies, as part of conceding to the indivisibility of human rights,⁸⁸ an expansive and human rights-sensitive concept of sexual health has the capacity to open the door, not only for a duty to recognise the legitimacy of diverse sexualities, but also a duty to affirmatively support the realisation of diverse sexualities through the creation of an enabling environment.⁸⁹ In short, the now well-established triad of human rights obligations – to ‘respect’, ‘protect’ and ‘fulfil’⁹⁰ – applies equally to corresponding state obligations arising from a human right to sexual health.

The four chapters in this section speak in various ways to sexual and reproductive health and rights and also to their intersections. The first chapter is a joint chapter by Godfrey Kangaude and Tiffany Banda titled ‘Sexual health and rights of adolescents: A dialogue with sub-Saharan Africa’. The authors address unmet sexual and reproductive health needs of adolescents in the African region, including unwanted pregnancy, STIs and sexual exploitation. They highlight that, for the most part, prevailing domestic social and cultural norms as well as laws, health policies and systems serve to exclude and marginalise adolescents to the detriment of their sexual and reproductive health. Using human rights frameworks and relying on substantive rights drawn from UN as well as African regional systems and instruments, including the Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child (African Children’s Charter), the authors call on governments to honour their treaty obligations. They highlight the importance of providing sexual and reproductive health services that are responsive to the particular needs of adolescents, such as contraceptives, safe abortion and psychosocial care. They also highlight the importance of looking beyond the provision of mere services so that services are delivered in contexts that also respect other attendant rights, including rights to education, information, confidentiality and privacy.

88 The United Nations Vienna Declaration and Programme of Action of 1993 that was adopted at the World Conference on Human Rights, Vienna, 11-25 June 1993 is associated with the global reaffirmation of the indivisibility and interdependence of human rights; C Puta-Chekwe & N Flood ‘From division to integration: Economic, social and cultural rights’ in I Merali & V Oosterveld (eds) *Giving meaning to economic, social and cultural rights* (2001) 39-51.

89 RP Petchesky ‘Sexual rights: Inventing a concept, mapping an international practice’ in R Parker *et al* (eds) *Framing the sexual subject: The politics of gender, sexuality, and power* (2000) 81-103.

90 Some of the earliest thinking about the obligations to ‘respect, protect and fulfil’ and their normative content are associated with a report of Asbjørn Eide, then Special Rapporteur on the Right to Adequate Food - *Report on the Rights to Adequate Food as a Human Right*, submitted by Asbjørn Eide, Special Rapporteur, ECOSOC E/CN.4/sub2/1987/23, 7 July 1987.

The second chapter is by Ayodele Atsenuwa and is titled 'Promoting sexual and reproductive rights through legislative interventions: A case study of child rights legislation and early marriage in Nigeria'. Atsenuwa's point of departure is that early marriage, especially of the girl child, has a well-established adverse effect on sexual and reproductive health and rights. Early marriage is closely associated with women's inability to control their sexuality and reproduction, violations of sexual autonomy and bodily integrity, and increased maternal mortality and morbidity due to early motherhood. With particular reference to Nigeria, the author examines the role and efficacy of legislation to domesticate international human rights norms and standards for protecting women and girls from early marriage. More particularly, Atsenuwa examines a federal piece of legislation, the Child Rights Act of 2003, and its state counterpart in the Jigawa State, the Jigawa State Child Rights Law of 2007. She highlights the strengths as well as weaknesses of these legislative instruments. For example, she argues that, while the federal child rights law has introduced a positive policy climate for transforming the sexual and reproductive health status of girl-children, at the same time, its insistence of 18 years as the chronological benchmark is at odds with the notion of evolving capacities of children and the cultural context in which they manifest the capacities. The challenge, as Atsenuwa sees it, is how to balance protective mechanisms with emancipatory rights. The author reaches a similar conclusion in her analysis of the Jigawa State Child Rights Law, seeing some positive aspects but also negative aspects in setting a rigid minimum age for marriage. As a way forward, Atsenuwa proposes a less rigid approach that accommodates the recognition of evolving capacities.

The third chapter, by Susana SáCouto, is titled 'Gaps in the gender-based violence jurisprudence of international and hybrid criminal courts: Can human rights law help?' SáCouto's point of departure is that, while a global problem, sexual and gender-based violence during conflict and periods of domestic repression has been a problem of enormous proportions in a number of African states, including Rwanda, Uganda, the Democratic Republic of the Congo, Sierra Leone and Sudan. Furthermore : observes, as a starting point, that sexual and gender-based violence were historically rarely prosecuted. She examines critically the progress that has since been made in bringing these crimes under the radar of international criminal tribunals.

SáCouto argues that, while significant progress has been achieved in the investigation and prosecution of sexual and gender-based violence, there are still remaining gaps and challenges. In this regard, the kernel of her argument is that (i) there is still ambiguity in the jurisprudence pertaining to whether prosecuting rape in the context of mass atrocity crimes requires the 'non-consent of the victim'; (ii) the theories of criminal responsibility that have been relied upon to find perpetrators accountable, especially top political or military leaders, have a number of shortcomings and inconsistencies; and (iii) that there has been inadequate investigation

and prosecution of crimes of sexual and gender-based violence. As a remedy, SáCouto principally suggests using human rights, especially integrating the principle of non-discrimination, more distinctly into the process of investigation and prosecution. She argues that this will secure better outcomes for the investigative, prosecutorial and adjudicative processes in terms of developing a better understanding of the context in which sexual violence takes place; improving on evaluating how the elements of sexual violence crimes should be interpreted and what theories of criminal responsibility to use; and a more discerning selection of cases for investigation and prosecution.

SáCouto's chapter focuses on well-publicised incidences of sexual violence which occurred during times of conflict that was very intense and fairly prolonged so as to attract widespread global scrutiny, reportage and sustained calls for accountability. On the other hand, state- and/or political party-orchestrated sexual violence during relatively short and less intense periods of domestic repression, such as during a general election, has tended to receive little outside attention and reportage. Consequently, the absence of a sustained spotlight contributes towards a culture of impunity for the use of sexual violence by some ruling parties and their agents in the African region to systematically intimidate or subdue political opponents or suspected opponents, especially women. Zimbabwe is a case in point. The 2008 election was particularly violent to the extent that the Movement for Democratic Change, the main contender against ZANU-PF (the ruling party), was forced to withdraw from contesting the presidential elections during the 'run-off', thus assuring the ruling party a clear 'win', but by default.⁹¹

The 2008 Zimbabwean election saw systematic violence being perpetrated by supporters of the ruling party against, among other targeted persons and groups, women.⁹² The violence was perpetrated under the umbrella or even at the direction of the country's security forces.⁹³ Women were singled out for rape and other acts of sexual violence, abuse and humiliation. The women were unable to rely on the protective arms of the state. Zimbabwe is currently a country where the chiefs of police and security forces are ultra-politicised. The interests of the top echelons of the executive machinery of ZANU-PF are scarcely distinguishable from those of the police and security forces which have a monopoly over the state's coercive machinery. The security forces themselves are routinely implicated as perpetrators.⁹⁴ In such an environment, it would be naïve in

91 K Chitsike 'The role of women in Zimbabwe's transition' in T Murithi & A Mawadza (eds) *Zimbabwe in transition: A view from within* (2011) 159-160; B Raftopoulos & S Eppel 'Desperately seeking sanity: What prospects for a new beginning in Zimbabwe?' (2008) 2 *Journal of Eastern African Studies* 369.

92 Chitsike (n 91 above) 161-162.

93 B Raftopoulos 'The crisis in Zimbabwe, 1998-2008' in B Raftopoulos *Becoming Zimbabwe: A history from the pre-colonial period to 2008* (2009) 201-229.

94 Chitsike (n 91 above) 161.

the extreme to rely on the country's enforcement and protective agents or even domestic courts as effective and impartial accountability mechanisms for systematic gender-based violence which is politically motivated in ways that implicate the ruling party. Impunity for systematic gender-based violence is further institutionalised by the culture of post-election presidential pardons for election-related violence.⁹⁵ Part of responding to the African region's contemporary challenges in the sphere of gender-based violence requires developing strategies for bringing into the fold of the accountability net of international tribunals systematic violence during relatively shorter and less intense periods of domestic repression.

The last chapter in this section by Fana Hagos Berhane is titled 'Women, sexual rights and poverty: Framing the linkage under the African human rights system'. Berhane explores the interconnections between the realisation of human rights and poverty. She points out that, because women are over-represented in the indices of poverty, it renders them more vulnerable to a lack of capabilities for realising their human rights, including in respect of sexual health and rights. Her chapter, which also places the emphasis on sexual rights pertaining to sexuality, including sexual orientation, underscores the importance of gender empowerment as a tool for women's realisation of sexual rights. The author observes, for example, that the causes of sexual violence are often related to deeply-embedded structural inequalities in patriarchal societies. She highlights the vicious circle between poverty that predisposes women to gender-based sexual violence that impoverishes women's economic well-being through being rendered homeless, physically and psychosocially ill, having one's education and employment interrupted and even being ostracised by family and communities. Berhane's ultimate argument is that fulfilling women's sexual rights and fulfilling their economic well-being are not alternatives, but twin objectives as they are inextricably intertwined.

6 Postscript

During its 55th ordinary session, for the second time in its history, the African Commission adopted General Comments on articles 14(1)(a), (b), (c) and (g) and articles 14(2)(a) and (c) of the African Women's Protocol.⁹⁶ The latest General Comments provide interpretive guidance on the family planning, contraception and abortion provisions of the African Women's Protocol. If disseminated effectively, they should contribute towards awareness-raising and promoting understanding of, and education about, state obligations and individual rights and, ultimately, state accountability in a field often attended by controversy and denial of rights. In an area of

⁹⁵ Chitsike (n 91 above) 162.

⁹⁶ African Commission on Human and Peoples' Rights Final Communiqué of the 55th ordinary session of the African Commission on Human and Peoples' Rights that was held in Luanda, Angola, 28 April -12 May 2014, para 33(a).

new or emerging jurisprudence, such as the recognition of abortion as a discrete human right under the African Women's Protocol, it is unwarranted to assume that policy makers, legislators and judicial officers have an instinctive understanding of the normative content and juridical implications of rights guaranteed by the Protocol. General comments can be invaluable in educating stakeholders at the domestic level about new jurisprudence that might otherwise remain unknown or inaccessible to them.

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**PART I: Reproductive autonomy,
access to safe abortion and emergency
obstetric care**

CHAPTER 2

REDUCING ABORTION-RELATED MATERNAL MORTALITY IN AFRICA: PROGRESS IN IMPLEMENTING OBJECTIVE 5 OF THE MAPUTO PLAN OF ACTION ON SEXUAL AND REPRODUCTIVE HEALTH RIGHTS

Eunice Brookman-Amissah and Tinyade Kachika

Summary

Although the African continent has been inconsistent in its efforts to implement the 2006 Maputo Plan of Action on Sexual and Reproductive Health and Rights, it is indisputable that the Plan of Action has prompted meaningful action and challenged inaction towards addressing unsafe abortion. This chapter builds on the findings of a desk research that was conducted in 2010 to assess progress made towards addressing unsafe abortion in Africa, a key challenge under the Plan of Action. The Plan of Action commits African Union member states to enact policies and laws to reduce the incidence of unsafe abortion. The research analysed studies, policies and interventions related to unsafe abortion that have occurred in six countries with respectively liberal, moderate and restrictive abortion laws. The evidence suggests that an enabling environment for safe abortion is not fully realised. There is a lack of fulfilment of the Plan of Action and other relevant human rights agreements that is apparent by the continuing prevalence of restrictive laws, the slow development and/or implementation of policies to make moderate and liberal laws practical, and the lack of availability of enough resources to support reproductive health. However, one progress is certain. Unlike restrictive laws, liberal laws have had a positive impact on maternal mortality rates. To be on track, governments need to fulfil the commitments on access to safe abortion in the Plan of Action. International treaty monitoring bodies' language and jurisprudence, as well as abortion jurisprudence in other regional human rights systems, are pertinent in strengthening the protection of the right to safe abortion on the African continent.

1 Introduction

Unsafe abortion remains the most neglected aspect of reproductive ill health in Africa.¹ The World Health Organisation (WHO) estimates that one in seven maternal deaths on the continent results from unsafe abortion.² With an estimated 92 per cent of African women of childbearing age living in countries with restrictive abortion laws,³ many African countries clearly sideline abortion law reforms in their strategies to address high maternal mortality due to unsafe abortions. By 2009, 12 (27,9 per cent) of African countries had no legislative or policy frameworks on abortion, while seven countries (16,3 per cent) had only kick-started such a process.⁴

Addressing unsafe abortion in Africa through progressive statutory and policy measures is a key component in creating an enabling environment for safe abortion.⁵ This component was central to a desk review conducted in 2010 to track progress made towards addressing unsafe abortion in Africa under the Maputo Plan of Action for the Operationalisation of the Sexual and Reproductive Health and Rights Continental Policy Framework (Maputo Plan of Action).⁶ Specifically, Objective 5 of the Maputo Plan of Action requires African states to reduce the incidence of unsafe abortion by taking clear actions under three strategic areas: policy and advocacy; capacity building; and service delivery.⁷

Although the Maputo Plan of Action is 'soft law' due to its non-binding nature, it is the vehicle through which the African continent could concretise the realisation of reproductive health provisions in binding treaties, such as the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol). The Maputo Plan of Action was adopted by Health Ministers in

- 1 E Brookman-Amissah & J Moyo 'Abortion law reform in sub-Saharan Africa: No turning back' (2004) 12 (24 Supplement) *Reproductive Health Matters* 227.
- 2 World Health Organisation *Safe abortion: Technical and policy guidance for health systems* (2003) 12.
- 3 Guttmacher Institute 'Abortion and unintended pregnancy in Africa' (October 2009).
- 4 African Union Commission 'African Women's Plan of Action progress review' (May 2010) 13 http://www.google.mw/search?sourceid=navclient&ie=UTF-8&rlz=1T4ADRA_enMW430MW431&q=maputo+plan+of+action+review+report (accessed 28 September, 2011).
- 5 The statutory and policy measures, together with three others - the mobilisation and allocation of resources to support safe abortion, the presence of support for women's empowerment and gender equality, and the presence of critical will supporting access to safe abortion - were analysed in a review study as forming the package that constitutes an enabling environment for safe abortion.
- 6 A process that was supported by United Nations Economic Commission for Africa and Ipas.
- 7 African Union *Universal access to comprehensive sexual and reproductive health services in Africa: African Women's Plan of Action for the operationalisation of the continental policy framework for sexual and reproductive health and rights 2007-2010* AU Doc Sp/Min/Camb/5(I) (adopted in September 2006).

September 2006 and approved by the African Union (AU) Heads of State and Government.⁸ It seeks to propel the continent to achieve universal access to comprehensive sexual and reproductive health services by 2015.⁹ Safe abortion care is considered part of such services.¹⁰

The desk review used experiences of six countries with varying levels of abortion legal frameworks to illustrate the range of success in creating an enabling environment for access to safe abortion in Africa. Ethiopia and South Africa have liberal abortion laws, Ghana and Zambia have moderate laws, and Malawi and Nigeria have highly-restrictive laws. Admittedly, a thin line exists between the liberal laws in Ethiopia and South Africa, and the moderate laws in Ghana and Zambia. For example, it might be argued that the letter of Zambian and Ghanaian laws on abortion is liberal to the extent that risk to the health of the pregnant woman alone suffices as a ground for abortion. Furthermore, the recognition of socio-economic grounds as abortion grounds under Zambian law could be said to be very liberal.

However, this chapter recognises that, when read in their totality, the statutes regulating abortion in Ghana and Zambia still limit access to safe abortion for many women. As described in section 2.2, these limitations relate to health providers and certification procedures. The existence of implementation guidelines in both countries has not altered this position. On the other hand, South Africa's law on abortion is ahead because it permits abortion on demand, subject to limitations in some gestational periods. Likewise, when the broad abortion law in Ethiopia is read together with relevant implementation guidelines, the result is a fairly liberal law that guarantees access to minors and allows a range of health providers to terminate pregnancies.

The study findings in the six countries illuminate that, despite varied progress, no country has fully met Objective 5 of the Maputo Plan of Action. Thus, the full realisation of women's sexual and reproductive rights will not be attained in Africa unless states create an enabling environment for safe abortion that combines the presence of liberal laws with progressive policy frameworks that are made practical on the ground. The achievement of an enabling environment for safe abortion in Africa is challenged by weak compliance with the duty to respect, promote and fulfil the right to safe abortion, as stipulated in the African Women's Protocol, and as supported by international treaty-monitoring bodies.

8 Initially it was developed as a short-term plan for the period up to 2010. In 2010, it was extended up to 2015 by the Executive Council of the AU.

9 African Women's Plan of Action (n 7 above).

10 African Women's Plan of Action, para 5; International Women's Health Coalition 'Access to safe abortion is a human right' (January 2008).

Even the African human rights monitoring and enforcement systems are yet to expansively define the course of abortion jurisprudence on the continent. Nevertheless, the African Commission on Human and Peoples' Rights (African Commission) and its partners are taking solid steps to ensure the realisation of the Maputo Plan of Action. The Plan of Action is significant because it is premised on the Millennium Development Goals (MDGs). It is meant to accelerate the achievement of maternal health targets under MDG 5 by 2015, hence the re-alignment by the AU for the two to end in 2015.¹¹ These global targets aim at reducing maternal mortality rates by two-thirds and ensuring universal access to reproductive health by 2015.¹² The Maputo Plan of Action therefore complies with WHO's recommendation that unsafe abortion must be addressed as part of MDGs, including by taking urgent action to ensure that, to the extent allowed by law, safe abortion services are available.¹³ The International Conference on Population and Development (ICPD) in 1994 also called for similar action, just as has been done by the recently-released WHO packages of interventions for safe abortion care.¹⁴

This part of the chapter asserts that both the strong and weak progress in locating safe abortion care within core packages of reproductive services justify the need to closely assess how Objective 5 of the Maputo Plan of Action is being fulfilled through statutory and policy measures in Ethiopia, Ghana, Malawi, Nigeria, South Africa and Zambia. Such scrutiny would demonstrate the level of seriousness by African countries to move from rhetorical policy commitments to real action. Therefore, the rest of this chapter analyses the following: the state of legal and policy frameworks relating to abortion in the six study countries, including their impact on maternal mortality and service provision; the linkages between the call under the Maputo Plan of Action to address unsafe abortion; developments in the international human rights system; and how the African human rights system could demonstrate leadership in asserting the right to safe abortion by strengthening the development of its own jurisprudence.

2 Capacity of laws and policies to create an enabling environment for safe abortion in Africa

Constitutional frameworks in Ethiopia, Ghana, Malawi, Nigeria, South Africa and Zambia directly or indirectly comply with the recommendation

11 African Union Commission (n 4 above) 3.

12 UN Commission for Africa, African Union & African Development Bank *Assessing progress in Africa towards the Millennium Development Goals* (2009).

13 See WHO Executive Board 113th Session 'Reproductive health draft strategy to accelerate progress towards the attainment of international development goals and targets' 18 December 2003.

14 World Health Organisation *Packages of interventions for family planning, safe abortion care, maternal, newborn and child health* (2010) para 51 Doc EB113/15 Add.1.

under the Maputo Plan of Action that African countries should enact legal frameworks to reduce the incidence of unsafe abortion.¹⁵ However, these countries have made different strides in enacting laws that mirror their constitutional provisions, with Malawi and Nigeria still maintaining highly-restrictive statutory abortion laws. For the other countries, there have been positive developments in efforts to provide abortion services to the fullest extent of the law through the adoption of protocols and guidelines – also urged by the Maputo Plan of Action.¹⁶ However, full implementation of these tools is yet to be achieved, particularly in Ghana and Zambia.

2.1 The role of national constitutions in supporting safe abortion as a human right

Constitutional developments that have occurred in Ethiopia, Ghana, Malawi, Nigeria, South Africa and Zambia over the past 20 years have asserted national constitutions as guardians of fundamental human rights, with sexual and reproductive health rights being expressly or impliedly entrenched. Stipulating these rights in national constitutions is an important factor in building an enabling environment for the provision of safe abortion services. When women's human rights are included in a national constitution, they become part of a country's baseline for rights protection and government's obligations.¹⁷

Countries that have specific provisions on sexual and reproductive health rights in their constitutions have emerged with stronger statutory laws that safeguard a woman's right to safe abortion. South Africa's 1996 Constitution is the most explicit, and guarantees everyone the right to make decisions concerning reproduction, and to security in and control over their body.¹⁸ The 1994 Constitution of the Federal Democratic Republic of Ethiopia may not have mentioned the term *reproductive health rights*, but it commits the state to prevent harm arising from pregnancy and childbirth, and to safeguard women's rights to access family planning education, information and capacity.¹⁹ In Zambia, although the 1991 Constitution does not couch safe abortion as a right, it allows for the termination of pregnancy, so long as this is done within the laid-down conditions of the law.²⁰ The inclusion of this provision in a constitution throws weight behind the rights of women to access abortion services where legally indicated.

15 African Women's Plan of Action (n 7 above) Objective 5.1.2a.

16 As above.

17 SD Ross *Women's human rights: The international and comparative law casebook* (2009).

18 Secs 12(2)(a) & (b) Constitution of the Republic of South Africa, Act 108 of 1996.

19 Art 32 Constitution of the Federal Republic of Ethiopia, 1994.

20 Art 12(2) Constitution of Zambia Act, 1991.

The absence of express constitutional provisions on reproductive rights in Ghana, Malawi and Nigeria does not grant these countries a licence not to address unsafe abortion. Such countries still have constitutional rights that, when broadly interpreted, have the effect of binding states to the duty to protect, respect and fulfil the right to safe abortion. These include the rights to life, equality, dignity and freedom of conscience.²¹ Particularly, Ghana is a model of a country that has a moderate abortion law, despite the absence of a specific right to reproductive health in its 1992 Constitution.

The existence of progressive constitutional provisions relevant to safe abortion is only a starting point. A substantive approach to gender equality necessitates legislative frameworks to ensure that constitutional commitments are reflected in national legislation.²² In some contexts, this requires reviewing existing laws.

2.2 Developments in statutory laws affecting abortion

Laws can support or hinder the availability of public safe abortion services, including the willingness of providers to offer services. The historical location of abortion laws in criminal laws perpetuates the treatment of abortion as a crime, rather than a human rights issue.²³ Out of the six study countries, only Zambia and South Africa have stand-alone statutes governing abortion. In the rest, abortion is regulated under criminal codes. Fortunately, article 14 of the African Women's Protocol²⁴ has the potential to transform the underlying premises of African abortion laws from a crime and punishment paradigm to a reproductive health paradigm.²⁵

The liberal laws in Ethiopia and South Africa, moderate laws in Ghana and Zambia, and highly-restrictive laws in Malawi and Nigeria have occurred in a reverse chronological time span. The liberal laws were passed more recently – 2006 in Ethiopia and 1996 in South Africa. The moderate laws were passed some decades back – 1985 in Ghana and 1972 in Zambia. The centuries-old highly-restrictive laws in Malawi and Nigeria

21 Arts 13(1), 17, 15 & 21(1)(b) Constitution of the Republic of Ghana, 1992; secs 16, 20, 19 & 33 Constitution of the Republic of Malawi, 1994; arts 33, 42, 34 & 38 Constitution of the Federal Republic of Nigeria, 1999.

22 UNIFEM *Progress of the world's women 2008/2009: Who answers to women?* September 2008 76 <http://www.unhcr.org/refworld/docAs/above/4a09773a2.html> (accessed 20 September 2011).

23 'Report of a workshop on reducing maternal mortality and addressing unsafe abortion: A human rights imperative for African women' Workshop for the African Commission on Human and Peoples' Rights, Nairobi, Kenya, 1 December 2010.

24 Discussed under 3.3.1.

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

were borrowed from the British Offences Against the Person Act of 1861 upon colonisation.²⁶

The Choice on Termination of Pregnancy (CTOP) Act in South Africa allows abortion on demand up to 12 weeks and, subject to certain conditions, up to 20 weeks or beyond.²⁷ South Africa amended its law in 2004 to expand the scope of service providers to include registered nurses²⁸ and, subject to some conditions, to allow health facilities with a 24-hour maternity service to provide first trimester termination of pregnancy services.²⁹ The CTOP Amendment Act was initially challenged in the Constitutional Court owing to a failure to consult the public prior to passing the Act,³⁰ but was reinstated in 2008 after government had complied with the duty to consult.³¹

The CTOP Act has since survived two legal challenges. In *Christian Lawyers Association v Minister of Health*,³² the plaintiff sought the striking down of the entire Act on the ground that it violated the constitutionally-guaranteed right to life of the foetus. However, the Court determined that the word 'everyone' could not include the unborn child. In *Christian Lawyers Association v National Minister of Health*,³³ the plaintiff applied for an order declaring unconstitutional the provisions that permitted a minor with the capacity to consent to terminate a pregnancy without parental consent or control. The court ruled that abortion rights (without parental involvement) could apply to adolescents with the capacity to give informed consent.

Ethiopia broadened its Penal Code indications for legal abortion in 2005 to cover incidences of rape, incest, serious and incurable foetal deformity, risk to life or health of the pregnant woman, risk to health of the child, and physical and mental incapacity, including by reason of minority status.³⁴ Zambia's 1972 Termination of Pregnancy Act permits the termination of pregnancy on health and socio-economic grounds.³⁵ In Ghana, abortion was declared legal by the Criminal Code (Amendment) Law of 1985.³⁶ Abortion is legally permitted if pregnancy results from

26 C Ngwena 'An appraisal of abortion laws in Southern Africa from a reproductive health rights perspective' (2004) 32 *Journal of Law, Medicine & Ethics* 713; E Jackson *et al* 'A strategic assessment of unsafe abortion in Malawi' (2011) 11 *Reproductive Health Matters* 133-143.

27 Choice on Termination of Pregnancy Act 1996, sec 2.

28 Choice on Termination of Pregnancy Amendment Act 2004, sec 6(1)(a).

29 Choice on Termination of Pregnancy Amendment Act 2004, secs 3(1)(a) & (b).

30 *Doctors for Life International v Speaker of the National Assembly & Others* 2006 (12) BCLR 1399 (CC).

31 Choice on Termination of Pregnancy Amendment Act 2008.

32 1998 SACLR LEXIS 58.

33 2004 SACLR LEXIS 20.

34 The Criminal Code of the Federal Democratic Republic of Ethiopia, 2004, art 551.

35 See sec 3(1); see also Ngwena (n 25 above); Guttmacher Institute *Unsafe abortion in Zambia* (2009).

36 Provisional National Defence Council (PNDC) Law 102: The Criminal Code (Amendment) Law, 1985.

rape, defilement or incest; when there is risk to a woman's mental or physical health; or due to serious foetal deformity.³⁷ Narrow interpretation of the moderate laws has been observed in Ghana and Zambia. The fact that only gynaecologists are allowed to perform the procedure is also a barrier.³⁸

Abortion is only permitted to preserve a pregnant woman's life under Malawi's Penal Code and the two criminal laws of Nigeria: the Criminal Code Act (applicable to southern states) and the Penal Code (northern states) Federal Provisions Act. Otherwise, the procedure is a felony.³⁹ Nigeria's statutory position is in conflict with *R v Edgal* (a 1938 decision of the then West African Court of Appeal),⁴⁰ in which the English court's ruling in *R v Bourne*⁴¹ was assumed to be applicable to West Africa. It is therefore alarming that *R v Bourne* has not been read into the relevant statutes of Nigeria just as England read it into the Offences Against the Persons Act of 1861 before the country reformed its abortion law in 1967.

For Ethiopia, Ghana, South Africa and Zambia, the study found a direct correlation between the extent of implementation of liberal and moderate abortion laws and the presence of an enabling policy framework.

2.3 Milestones and gaps in policy frameworks related to abortion

The availability or absence of national standards, guidelines and protocols that support safe abortion is an indicator of a country's level of compliance with the call under the Maputo Plan of Action that 'abortion services should be provided to the fullest extent of the law'.⁴²

2.3.1 Existence of policy frameworks

Without implementing mechanisms in the form of standards, protocols and guidelines, potentially good laws fail to impact positively on women's

37 PNDC Law sec 58(2).

38 'Ghana: Ignorance on abortion law means death' *IRIN News* 12 October 2007 [http://www.irinnews.org/Report.aspx?ReportAs above=74774](http://www.irinnews.org/Report.aspx?ReportAs%20above=74774) (accessed 27 August 2012); *IRIN Africa* 'Ghana: Safe abortion services virtually non-existent despite 1985 law' *IRIN News* (accessed 27 August 2012) http://article.wn.com/view/2010/07/23/GHANA_Ignorance_on_abortion_law_means_death/; Guttmacher Institute (n 35 above); Ngwena (n 25 above).

39 Penal Code Cap 7:01 of the Laws of Malawi secs 149 & 150; Criminal Code Act Chapter 77 Laws of the Federation of Nigeria 1990 secs 228 & 229 (applicable to Southern States); Penal Code (Northern States) Federal Provisions. Act Cap. 345 Laws of the Federation of Nigeria 1990 sec 232.

40 1938 4 WACA 133.

41 1938 3 All ER 612. It indicated that a woman's 'life' was contingent on both her physical and mental health, so that abortion was not 'unlawful' if carried out to preserve either of these.

42 Maputo Plan of Action (n 7 above) Objective 5.3.1a.

maternal health. Ghana, Ethiopia and Zambia have recently taken policy measures to develop technical guidelines to aid the implementation of their abortion laws – Zambia in 2009⁴³ and Ghana and Ethiopia in 2006.⁴⁴ This conforms to WHO recommendations that countries should develop medical practice standards that establish the essential parameters for safe, good quality abortion care for their health facilities.⁴⁵

Ethiopia, Ghana and South Africa all provided for medical abortion in their guidelines even before Misoprostol and Mifepristone drugs were registered for abortion care in these countries.⁴⁶ This is a progressive approach that allows for immediate implementation once the drugs are approved by domestic authorities.⁴⁷ The qualities of guidelines in Ethiopia, Ghana and Zambia include articulating guiding principles, providing interpretation of the law, filling legal gaps, providing knowledge on other laws relevant to abortion, clarifying approved methods of termination of pregnancy and delivery, and clarifying who the service providers are.

Guidelines therefore allow for the provision of safe abortion services to the fullest extent of the law, such that their presence, even in environments with restrictive laws, can promote women's health. Despite these milestones, gaps within the policy frameworks still exist.

2.3.2 Gaps in policy frameworks and service provision challenges

The total absence of guidelines on comprehensive abortion care in Malawi and Nigeria is problematic, just as is the lack of a final push to make existing guidelines in other countries a reality. The failure in Malawi and Nigeria to adopt guidelines to enable the interpretation of the countries' restrictive laws to their fullest extent results in the conservative application of the laws by service providers.⁴⁸ This situation obtains in Malawi, although the reproductive health policy requires service providers to provide or refer for safe abortion to the fullest extent of domestic laws

43 Government of the Republic of Zambia 'Standards and guidelines for reducing unsafe abortion morbidity and mortality in Zambia' (2009).

44 Family Health Services *Technical procedural guidelines for safe abortion in Ethiopia* (2006); Ghana Health Service & Ministry of Health *Standards and protocols for the prevention and management of unsafe abortion* (2006).

45 K Otsea *Lives worth saving: Abortion care in sub-Saharan Africa since ICPD: A progress report* (2004).

46 D Cooper *et al* 'Ten years of democracy in South Africa: Documenting transformation in reproductive health policy and status' (2004) 12 *Reproductive Health Matters* 70-85; Ipas *Misoprostol and medical abortion in Africa* (2009); J Harries 'Termination of pregnancy legislation in South Africa: Implications for health service providers' (2009) 27 *Continuing Medical Education* 462.

47 Ipas (n 46 above).

48 FE Okonofua *et al* 'Perceptions of policy makers in Nigeria toward unsafe abortion and maternal mortality' (2009) 35 *International Perspectives on Sexual and Reproductive Health* 194; Jackson *et al* (n 26 above).

women who qualify for abortion.⁴⁹ Hopefully, the situation in Malawi could be reversed if action is taken to implement the findings of a ‘cost study’, which revealed that the government could realise substantial savings by shifting from the provision of costly post-abortion care to comprehensive abortion care.⁵⁰

The extent of availability of resources also influences the degree to which a country is able to provide safe abortion services to the fullest extent of the law. The lack of a sufficiently-trained work force is one obstacle to the implementation of progressive laws. Because of this, in Ethiopia, more urban women get safe abortions from trained personnel than their rural counterparts.⁵¹ In South Africa, more than a decade after the passing of the CTOP Act, the need for more health providers to receive training in the termination of pregnancy persists.⁵² Safe abortion services are also limited by the low use of medical abortion in public facilities. In Ethiopia, only one per cent of all health facilities were using Misoprostol between 2007 and 2008.⁵³ In Zambia, all providers interviewed in a 2008 study said they rarely used Misoprostol.⁵⁴

The lack of adequate public facilities to provide safe abortion care services also translates into the poor implementation of guidelines. In Ethiopia, out of the 80 per cent of public health centres more accessible to rural women, only 34 per cent provide legal abortion services,⁵⁵ and in South Africa, a 2006 study showed that over 69 per cent of the designated facilities in KwaZulu-Natal were not offering termination of pregnancies.⁵⁶

2.4 Implications of the legal and policy situation on maternal mortality rates

While liberal laws have had a positive impact on maternal mortality, restrictive and poorly-implemented moderate laws have had the opposite effect. Despite some challenges, liberal laws in Ethiopia and South Africa

49 Government of Malawi ‘National sexual and reproductive health and rights policy 2009’ para 3.2.2.9.

50 Ipas ‘Report of a workshop on documenting the health systems costs of treating complications of unsafe abortion in Malawi’ Dissemination workshop for stakeholders, Lilongwe, Malawi, 3-4 May 2011.

51 S Singh *et al* ‘The estimated incidence of induced abortion in Ethiopia 2008’ (2010) 36 *International Perspectives on Sexual and Reproductive Health* 19.

52 National Committee on Confidential Enquiries into Maternal Deaths ‘Saving mothers 2005-2007: Fourth report on confidential enquiries into maternal deaths in South Africa, Expanded executive summary’ (2010).

53 Singh *et al* (n 51 above).

54 Ministry of Health & Ipas ‘Strategic assessment of policies, programmes and research issues related to prevention of unsafe abortion in Zambia’ (2008).

55 Singh *et al* (n 51 above).

56 J Roberts *Barriers to women’s rights in implementation of the Choice of Termination of Pregnancy Act (CTOP) in KwaZulu-Natal* (2007).

have made safe abortion more accessible, thereby reducing incidences of unsafe abortion. The liberalisation of the abortion law in South Africa has led to a 90 per cent reduction in maternal mortality and morbidity related to abortion.⁵⁷ Abortion-related deaths only constituted 3,4 per cent of the country's maternal deaths between 2005 and 2007.⁵⁸

In Ethiopia, the study did not conclusively determine a reduction in abortion-related maternal deaths, although there are claims that maternal mortality due to unsafe abortion has dropped significantly from a level of 32 per cent at the time of the enactment of the law.⁵⁹ Recent preliminary estimates in Malawi are that 17 per cent of maternal mortality is attributable to unsafe abortions.⁶⁰ In Ghana and Nigeria, estimates stand at 11 per cent.⁶¹ Zambia estimates that unsafe abortion contributes up to 30 per cent of maternal deaths in the country.⁶² Obtaining more accurate figures from Ghana, Nigeria and Zambia is dependent on the conducting of magnitude studies.

When governments endorse regional or global plans of action, they express an intention to honour the recommended actions.⁶³ The impetus to take the correct action to reduce the incidence of unsafe abortion in accordance with the Maputo Plan of Action emanates from similar obligations under international and regional human rights frameworks.

3 Correlation between gaps in achieving the Maputo Plan of Action and human rights jurisprudence

With the exception of the African Women's Protocol, the right to safe abortion under the international human rights system has mainly evolved from interpretations provided by treaty-monitoring bodies. And with the unequivocal legal status that the right to safe abortion has assumed in Africa under the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol),

57 M Stevens 'What was done in South Africa and what can be learnt from it: A case study prepared for the Women and Gender Equity Knowledge Network of the WHO Commission on social determinants of health' (2007) <http://www.hst.org.za/publications/barriers-womens-rights-implementation-choice-termination-pregnancy-act-ctopa-kwazulu-na> (accessed 29 August 2011).

58 National Committee on Confidential Enquiries into Maternal Deaths (n 52 above).

59 Y Gebrehiwot & T Liabsuetrakul 'Trends of abortion complications in a transition of abortion law revisions in Ethiopia' (2010) 31 *Journal of Public Health* 81.

60 Government of Malawi *Preliminary results of a magnitude study on unsafe abortion in Malawi* (2010).

61 Guttmacher Institute *Facts on unwanted pregnancy and induced abortion in Nigeria* (2006); G Sedgh 'Abortion in Ghana' (2010) 2 *In Brief* 1.

62 Government of the Republic of Zambia (n 43 above).

63 *Ipas Human rights, unwanted pregnancy and abortion-related care reference information and illustrative cases* (2002).

numerous lessons on how to make the rights work for women can be learnt by the African Commission and African Court from comparative jurisprudence, including the jurisprudence of the European Court of Human Rights.

3.1 Safe abortion as a human right: The history

Reproductive rights were first acknowledged in a human rights framework when the 1968 Teheran Human Rights Conference recognised the right to make childbearing decisions.⁶⁴ Family planning was first mentioned in an international human rights treaty under the 1979 Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW).⁶⁵ The broader philosophy of reproductive health as a human right was popularised by the 1994 ICPD and its Programme of Action (PoA).⁶⁶ It noted that in circumstances where it is not against the law, abortion should be safe.⁶⁷ Soon afterwards, the 1995 Beijing Conference and its Platform for Action highlighted the impact of unsafe abortion on women's health.⁶⁸

The recommendations under the ICPD PoA were further strengthened by the ICPD review conference of 1999 (ICPD+5) which supported the provision of safe, legal abortion within a country's legal framework.⁶⁹ In December 1994, the UN Commission on Population and Development was given a mandate to follow up on the implementation of the ICPD PoA.⁷⁰ Resolutions passed at the Commission's annual sessions in the past

64 United Nations 'Final Act of the international conference on human rights' Tehran 22 April to 13 May 1968 A/CONF.32/41 ch XVIII http://untreaty.un.org/cod/avl/pdf/ha/fatchr/Final_Act_of_TehranConf.pdf (accessed 15 February 2012).

65 CEDAW art 12(1) <http://www2.ohchr.org/english/law/cedaw.htm> (accessed 15 February 2012); UN Economic Commission for Africa, UN Population Fund & African Union Commission 'Africa regional review report: ICPD and the MDGs working as one, fifteen year review of the implementation of the ICPD PoA in Africa 1994-2009' (2009) 115.

66 International Conference on Population and Development (ICPD '94) Summary of the Programme for Action ch VII <http://www.un.org/ecosocdev/geninfo/populatin/icpd.htm#chapter7> (accessed 1 May 2012); Ngwena (n 26 above).

67 UN Economic Commission for Africa, UN Population Fund & African Union Commission (n 66 above) 113.

68 United Nations, Platform for Action and Beijing Declaration, Fourth World Conference on Women, Beijing, China, 4-15 September 1995 (1995) (Beijing Platform for Action) para 106(k) <http://www.un.org/womenwatch/daw/beijing/platform/health.htm> (accessed 26 August 2012); Centre for Reproductive Rights 'Beijing + 15 no equality without full enjoyment of women's sexual and reproductive rights' (undated) <http://righttomaternalhealth.org/sites/iimmhr.civactions.net/files/beijing+15per cent20factsheet.pdf> (accessed 27 August 2012).

69 As above.

70 Department of Economic and Social Affairs Population Division 'About the Commission' <http://www.un.org/esa/popu> (accessed 27 August 2012).

three years have contained explicit concerns about unsafe abortion.⁷¹

Over the years, treaty-monitoring bodies, which are charged with monitoring government compliance with major human rights treaties, have raised many of the concerns addressed in the Beijing Platform for Action. Most treaty-monitoring bodies now routinely recommend that governments take action to ensure sexual and reproductive rights, including safe abortion, for women. In 2003, the African continent boldly articulated the right to reproductive health and safe, legal abortion under its regional human rights system. This is discussed under section 3.3 of this chapter.

3.2 Accountability to promote the right to safe abortion in international human rights mechanisms

Treaty-monitoring bodies have confirmed the right to safe abortion through General Recommendations or Comments, and through their Concluding Observations to state party reports.⁷² Some have also issued decisions related to abortion. These are discussed in relation to regional jurisprudence in section 3.3.2.

3.2.1 General Recommendations and Comments on unsafe abortion

Having ratified CEDAW and the International Covenant on Civil and Political Rights (ICCPR), Ethiopia, Ghana, Malawi, Nigeria, South Africa and Zambia all are expected to take seriously the General Recommendations or Comments of relevant treaty-monitoring bodies on abortion.⁷³ General Recommendation 24 of the CEDAW Committee stipulates that efforts to reduce maternal mortality include the removal of punitive legal provisions imposed on women who undergo abortion.⁷⁴ The General Recommendation asserts that it is discriminatory to refuse to legally provide for the performance of certain reproductive health services for women.⁷⁵ Further, in its General Comment 28, the UN Human Rights

71 UN Commission on Population and Development 'The contribution of the Programme of Action of the International Conference on Population and Development to the internationally-agreed development goals' Resolution 2009/1 Doc E/CN.9/2009/10; Commission on Population and Development 'Health, morbidity, mortality and development' Resolution 2010/1 Doc E/2010/25; Commission on Population and Development Forty Fourth Session 'Fertility, reproductive health and development' Draft Resolution Facilitator's Text 15 April 2011.

72 As above; Center for Reproductive Rights (n 69 above).

73 Ethiopia: CEDAW (10 September 1981), ICCPR (11 June 1993); Ghana: CEDAW (2 January 1986), ICCPR (7 September 2000); Malawi: CEDAW (12 March 1987), ICCPR (2 December 1993); Nigeria: CEDAW (13 June 1985), ICCPR (2 July 1993); South Africa: CEDAW (15 December 1995), ICCPR (10 December 1998); Zambia: CEDAW (21 June 1985), ICCPR (10 April 1984).

74 CEDAW Committee General Recommendation 24: Art 12 of the Convention (Women and Health) A/54/38/Rev1, ch I (1999) para 31(c).

75 CEDAW Committee (n ... above) para 11.

Committee (which monitors the implementation of the ICCPR) requires that state parties in their periodic reports should specify measures that they have undertaken to ensure that women do not have to undertake life-threatening clandestine abortions.⁷⁶

3.2.2 Concluding Observations on unsafe abortion

The lack of full access to safe abortion services has also become more defined as a human rights issue in the Concluding Observations that treaty-monitoring bodies issue after considering state party reports. In recent Concluding Observations by the CEDAW and Human Rights Committees on reports submitted by Ghana, Malawi, Nigeria and Zambia, the leading concern has been the contribution of unsafe abortion to high maternal mortality rates. Thus, in 2010, the CEDAW Committee urged Malawi to review its laws and remove the punitive provisions imposed on women who undergo an abortion⁷⁷ and, commenting on Nigeria's report in 2008, the CEDAW Committee urged the government to assess the impact of its abortion law on maternal deaths – the second highest in the world – and give consideration to its reform.⁷⁸

The CEDAW Committee's observations on Ghana's report in 2006 pressed the government to take measures to increase knowledge and access to safe abortion in accordance with domestic legislation.⁷⁹ In 2007, the Human Rights Committee observed that the legal requirement in Zambia that three physicians must consent to an abortion is a significant barrier for women wishing to undergo legal and safe abortion. The Committee urged Zambia to amend its laws accordingly.⁸⁰ In 2011, the CEDAW committee expressed concern about Zambia's high rate of maternal mortality and morbidity resulting from unsafe abortions, despite abortion laws that do not prohibit women from seeking safe abortions. It recommended the

76 United Nations Human Rights Committee General Comment 28: Equality of rights between men and women (article 3) UN Doc CCPR/C/21/Rev1/Add.10 (2000) para 10.

77 UN CEDAW Committee 45th session 18 January-5 February 2010 'Concluding Observations of the Committee on the Elimination of Discrimination Against Women, Malawi' Doc CEDAW/C/MWI/CO/6.

78 UN CEDAW Committee 41st session 30 June-18 July 2008 'Concluding Observations of the Committee on the Elimination of Discrimination against Women, Nigeria' Doc CEDAW/C/NGA/CO/6.

79 UN CEDAW Committee 36th session 7-25 August 2006 'Concluding Observations of the Committee on the Elimination of Discrimination against Women, Ghana' Doc CEDAW/C/GHA/CO/5.

80 Human Rights Committee 90th session 9-27 July 2007 Consideration of Reports Submitted by States Parties under Article 40 of the Covenant 'Concluding Observations of the Human Rights Committee, Zambia' Doc UN CCPR CCPR/C/ZMB/CO/3.

vigorous raising of awareness amongst both women and clinicians about the legislation on abortion.⁸¹

Adherence to General Recommendations, Comments and Concluding Observations is associated with the obligations of state parties to respect, protect and fulfil human rights. The committees that monitor the International Covenant on Economic, Social and Cultural Rights (ICESCR) and CEDAW have said that, once states have ratified conventions, they are legally obliged to meet these duties.⁸² The triple obligations also weave through regional treaties that facilitate the protection of women's human rights in Africa.

3.3 The right to safe abortion in the African human rights system

African countries could be more energised to fully implement the Maputo Plan of Action if the regional human rights system demonstrates interest in safeguarding women's rights to safe abortion. The existence of a strong continental legal framework to protect this right requires support from regional mechanisms that have been instituted to promote human rights.

3.3.1 Existence of legal protection for the right to safe abortion

The African Women's Protocol represents the first time that a legally-binding human rights instrument has explicitly embraced a woman's right to abortion under specified circumstances (sexual assault, rape, incest, physical and mental health of the pregnant woman, or life of the foetus).⁸³ The Women's Protocol was adopted in July 2003 to supplement the African Charter on Human and Peoples' Rights (African Charter).⁸⁴ As of 14 August 2012, 33 countries had ratified the Protocol, which entered into force in November 2005.⁸⁵ Ghana, Malawi, Nigeria, South Africa and Zambia have all ratified the African Women's Protocol.⁸⁶ Although Ethiopia has not yet ratified the Protocol,⁸⁷ nonetheless, it has taken concrete steps to protect the right to safe abortion.

81 UN CEDAW Committee 49th session 11-29 July 2011 'Concluding Observations of the Committee on the Elimination of Discrimination against Women, Zambia' Doc CEDAW/C/ZMB/5-6.

82 RJ Cook *et al* *Advancing safe pregnant womanhood through human rights* (2001).

83 African Women's Protocol art 14(2)(c).

84 K Stefiszyn 'The African Union: Challenges and opportunities for women' (2005) 5 *African Human Rights Law Journal* 376-382; JC Mubangizi 'Some reflections on recent and current trends in the promotion and protection of human rights in Africa: The pains and the gains' (2006) 6 *African Human Rights Law Journal* 146-157.

85 Information available at http://www.au.int/en/sites/default/files/Rightspercent20offer%20Women_0.pdf (accessed 18 August 2012).

86 Ghana ratified the Protocol on 2 January 2007; Malawi on 20 May 2005; Nigeria on 16 December 2004; South Africa on 17 December 2004; and Zambia on 2 May 2006.

87 Ethiopia only signed the Protocol on 1 June 2004.

3.3.2 *Enforcement of the right to safe abortion and lessons from other regional treaty jurisprudence*

In 2008, African leaders agreed to establish an African Court of Justice and Human Rights to serve as the main judicial organ of the African Union (AU).⁸⁸ This Court is a merger of the African Court on Human and Peoples' Rights that was created in 1998, and the African Court of Justice, created in 2003.⁸⁹ The African Court on Human and Peoples' Rights currently operates from Arusha in Tanzania, and will remain in force for a specified transitional period after entry into force of the Protocol establishing the merged court.⁹⁰ As of February 2012, the Protocol had only been ratified by three out of the 15 states that are required for it to enter into force.⁹¹

Meanwhile, compliance with and implementation of the African Women's Protocol will be promoted and monitored by the African Commission, the body established to monitor compliance with the African Charter and its Protocols, until the establishment of the merged African Court.⁹² Even after the establishment of the merged court, the African Commission will likely continue to play a prominent role. This is because, unlike the European Court of Human Rights, non-governmental organisations (NGOs) and individuals do not have an automatic right to bring cases before the African Court. The state against which they are complaining has to sign a special declaration accepting this route of lodging complaints.⁹³ Like UN treaty-monitoring bodies, the African Commission can hear individual complaints, but its decisions are not binding.⁹⁴

For the first time in the African human rights system, the African Commission addressed unsafe abortion in the Concluding Observations and Recommendations on the Fourth Periodic Report of the Federal Republic of Nigeria in November 2011.⁹⁵ This is a major breakthrough

88 Protocol on the Statute of the African Court of Justice and Human Rights <http://www.africa-union.org/root/au/documents/treaties/text/Protocolpercent20onpercent20thepercent20Mergedpercent20Courtpercent20-percent20EN.pdf> (accessed 29 September 2011).

89 Ch I of the Protocol on the Statute of the African Court of Justice and Human Rights, arts 1 & 2.

90 Ch II of the Protocol on the Statute of the African Court of Justice and Human Rights, art 7.

91 African Union http://www.au.int/en/sites/default/files/9999Protocol_on_Statute_of_the_African_Court_of_Justice_and_HR.pdf (accessed 27 April 2012).

92 Centre for Reproductive Rights (n 73 above).

93 Protocol on the Statute of the African Court of Justice and Human Rights (n 90 above) art 30(f) as read with art 8.

94 The African Commission on Human and Peoples' Rights Information Sheet 4: State Reporting Procedure http://www.achpr.org/english/_info/state_procedure_en.html (accessed 26 August 2011); Ipas (n 86 above) 61.

95 African Union Concluding Observations and Recommendations on the fourth periodic report of the Federal Republic of Nigeria' 50th ordinary session of the African Commission, 24 October to 5 November 2011.

that could motivate more state parties to take measures to address the issue. Though the Nigerian team made no mention of abortion in their country report and subsequent answers to questions, they were requested to include information on abortion in their next report. Notably, the Special Rapporteur on the Rights of Women in Africa (SRRWA) played a key role in framing questions on abortion. The Commission created the position of SRRWA in 1998 as a special mechanism for the reinforcement and promotion of the rights of women in Africa.⁹⁶

Evidence indicates that, previously, a lack of abortion jurisprudence at the African Commission level was not because the issue was regarded as unimportant. Rather, the Commission lacked insight into the depth to which abortion impacted on the health and rights of women on the continent.⁹⁷ A workshop organised by Ipas, an international NGO, in December 2010 for the African Commission, sparked the Commission's interest to have its capacity strengthened in order to monitor countries' implementation of human rights commitments related to reproductive rights and abortion in Africa.⁹⁸ It is, therefore, encouraging that a year later, the results of this intervention became visible, as witnessed through the Concluding Observations on Nigeria's report.

The African Commission stands challenged to continue looking consistently and closely into abortion-related rights. Encouragement to adopt a bold position on the abortion question is provided by equally bold steps, such as those that have been taken by the Inter-American Commission on Human Rights. In 2006, the Inter-American Commission issued a pivotal statement declaring that Nicaragua's ban on abortion was contrary to international law, and threatened women's human rights.⁹⁹ In 2005, the UN Human Rights Committee, in the case of *KL v Peru*, held that the rights of a 17 year-old Peruvian woman had been violated when medical authorities denied her a therapeutic abortion although her foetus carried a fatal abnormality and endangered her life.¹⁰⁰

Just as the CEDAW Committee has adopted the ICPD Programme of Action as a basis for its observations and recommendations regarding

96 http://www.achpr.org/english/_info/index_women_en.html (accessed 1 September 2011).

97 Ipas (n 23 above); Ipas 'Regional programme to increase women's access to reproductive health services in sub-Saharan Africa 1 October 2007-30 September 2012 Fourth progress report for the period 1 July 2010-30 June 2011'.

98 As above.

99 Global Fund for Women <http://www.globalfundforwomen.org/impact/media-center/blog/2006/287> (accessed 26 August 2012); Centre for Reproductive Rights 'Inter-American Commission issues landmark statement declaring Nicaragua's abortion ban jeopardizes women's human rights' <http://reproductiverights.org/en/press-room/inter-american-commission-issues-landmark-statement-declaring-nicaragua-percent80percent99s-abortion-ban-je> (accessed 26 August 2012).

100 Communication 1153/2003, *KL v Peru*, UNHR Committee (24 October 2005), UN Doc CCPR/C/85/D/1153/2003 (2005); Ross (n 17 above); Centre for Reproductive Rights (above).

states' observance of human rights related to sexual and reproductive health,¹⁰¹ the African Commission could also consider similarly embracing the Maputo Plan of Action. Although the African Commission's decisions and resolutions are non-binding, experience at international level has shown that publicly declaring violations of human rights at international fora may successfully pressure governments to take action.¹⁰²

3.3.3 *Lessons for the African Court of Justice and Human Rights*

If the African Court is to be relevant to women once operational, it has to signal its commitment to upholding women's reproductive rights through progressive judgments. Fortunately, it can draw both positive and negative lessons from elsewhere, like the 2010 decision of the European Court of Human Rights in *A, B and C v Ireland*.¹⁰³ In this case, a challenge was brought by three women who had to travel outside of Ireland for an abortion because the law in Ireland only allowed abortion to save a woman's life. The Court found that Ireland violated the right to private life of applicant C, who had a rare form of cancer that could potentially relapse because of her pregnancy.

However, despite the Court acknowledging that Ireland's abortion law had a negative impact on applicants A and B, it still deferred to Ireland to determine legal indications for abortion.¹⁰⁴ Thus the *A, B and C* decision is positive because the Court held that domestic abortion laws must be transparent in order to enable women seeking abortion to exercise their rights effectively.¹⁰⁵ However, it is negative because it suggests that women's health can be sufficiently protected by a law that restricts access to safe abortion domestically, while providing information on where women can get abortions abroad.¹⁰⁶ The caution for the African Court is therefore that, while in Ireland denying women abortion under domestic law compels 'abortion tourism', in the African region, it commonly compels unsafe abortion.¹⁰⁷

101 *Ipas* (n 63 above) 3.

102 *Ipas* (n 86 above) 62.

103 *A, B & C v Ireland* (2010) ECHR 2032.

104 Centre for Reproductive Rights 'Press release issued on 16 December 2010' <http://reproductiverights.org/en/press-room/european-court-of-human-rights-rules-that-ireland-abortion-ban-violates-human-rights-but-> (accessed 7 September 2011).

105 As above.

106 As above.

107 C Ngwena 'Developing abortion jurisprudence under the African Charter on Human and Peoples' Rights: Lessons from Europe on the misrecognition of women' Seminar delivered at Columbia University, Morningside Campus <http://www.columbia.edu/event/developing-abortion-jurisprudence-under-african-charter-human-and-peoples-rights-lessons-europ.html> (accessed 23 August 2011).

The decision of the European Court of Human Rights in *Tysiac v Poland*¹⁰⁸ holds important lessons for the African human rights system on the implementation of the abortion provisions of the African Women's Protocol at the domestic level.¹⁰⁹ In this case, a pregnant Polish woman was advised to terminate the pregnancy because its continuation and delivery would worsen her eyesight problems. She was denied abortion, leading to her being certified as 'significantly disabled' after delivery. When her suit for being wrongly denied abortion was domestically unsuccessful, she sued in the European Court. The Court held that the state had failed to put in place effective and fair procedural and institutional mechanisms for determining whether a condition for obtaining abortion had been met.¹¹⁰ The Court's ruling therefore requires domestic abortion laws and related interpretive guidelines to be very clear in order to confer tangible, rather than illusory, rights on women.¹¹¹

Similarly, in the recent case of *RR v Poland*,¹¹² the European Court of Human Rights found a violation of the prohibition of inhuman or degrading treatment under the European Convention on Human Rights.¹¹³ This marked the first time that the European Court established such violation in a reproductive freedom case.¹¹⁴ In this case, a woman was repeatedly and deliberately refused genetic tests during her pregnancy until it was too late for an abortion. She subsequently gave birth to a child with Turner's syndrome. This decision is an encouragement for the African Court to apply the African Women's Protocol provisions intelligently even beyond the letter of article 14(2), if need be.

While the continent awaits its own jurisprudence, efforts that are being undertaken by the African Commission, which has a mandate to implement the Maputo Plan of Action, are worth noting.

3.3.4 Efforts by the African Union to implement the Maputo Plan of Action

Under the Maputo Plan of Action, the African Union is mandated to play an advocacy role, resource mobilisation, monitoring and evaluation, dissemination of best practices and harmonisation of policies and strategies.¹¹⁵ Apart from disseminating the Maputo Plan of Action to African states for them to put it into operation at national level, the AU has

108 *Tysiac v Poland* (2007) IV ECHR.

109 Ngwena (n 25 above) 805.

110 Ngwena (n 25 above) 802-807.

111 As above.

112 *RR v Poland* (2011) ECHR 828.

113 European Convention on Human Rights art 3.

114 Strasbourg Observers '*RR. v Poland: Of reproductive health, abortion and degrading treatment*' <http://strasbourgobservers.com/2011/05/31/r-r-v-poland-of-reproductive-health-abortion-and-degrading-treatment/> (accessed 15 January 2012).

115 Maputo Plan for Action (n 7 above) para 26.

collaborated with partners in instituting mechanisms to ensure the implementation of the Maputo Plan of Action. For instance, a Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) was launched in May 2009 to speed up the process of implementing the Maputo Plan of Action.¹¹⁶ In September 2009, the WHO Regional Committee for Africa launched Women's Health Day in the African region.¹¹⁷ A Commission on Women's Health has also been established to co-ordinate and follow up on recommended advocacy and action.¹¹⁸

In line with the AU Gender Policy, the African Women's Decade, was extended to 2010 to 2020.¹¹⁹ One of its objectives is to continue raising awareness and mobilising support and political will for implementing commitments on gender equality – including priorities related to health and maternal mortality.¹²⁰ A review of the implementation of the Maputo Plan of Action was undertaken and discussed in April 2010, which led to a decision by the Executive Council of the AU to align the indicators of the Maputo Plan of Action to those of MDGs 4 and 5.¹²¹

Sub-regional bodies are also supporting the continental efforts. For instance, a resolution towards strengthening evidence-based reproductive health services was passed by the East Central and Southern Africa Health Community.¹²² The Economic Community of West African States (ECOWAS) has reiterated the significance of passing abortion laws that reflect the social contexts of member states which are burdened with the high incidence of maternal mortality due to unsafe abortion.¹²³

4 Conclusion

Despite being soft law, the commitments towards addressing unsafe abortion under the Maputo Plan of Action are a conscience on African governments. The commitments are a consistent reminder that progressive domestic legal and policy frameworks are a significant part of the strategies towards improving maternal health by making safe abortion accessible. The implementation of the Maputo Plan of Action is therefore a

116 African Union Commission 'Report of the African Union Commission Chairperson on health-related activities (2009-2011)' 5th session of African Union conference of Ministers of Health (17-21 April 2011) Doc CAMH5-I; African Union 'Campaign on accelerated reduction of maternal mortality' <http://au.int/pages/carmma>.

117 As above.

118 As above.

119 As above.

120 As above.

121 As above.

122 ECOWAS Health Agency 'Resolution of 52nd Health Minister's conference on maternal child health/reproductive health/family planning' October 2010 Doc ECSA/HMC52/R3.

123 Communiqué by ECOWAS Health Ministers attending the 1st Extraordinary Assembly of Ministers of Health of the Economic Community of States of West Africa, 23 December 2009.

springboard for state parties to effectively provide safe abortion services as stipulated under the African Women's Protocol, including by mobilising technical and financial resources to ensure the wide availability of products and service providers. By so doing, African governments would be fulfilling the long-standing duty to respect, promote and fulfil the right to safe abortion as created under international and regional human rights systems. More importantly, they would be creating an enabling environment for safe abortion, which is fundamental to saving women's health and lives.

It is, therefore, not encouraging that the six countries studied – Ethiopia, Ghana, Malawi, Nigeria, South Africa and Zambia – are all yet to fully achieve the Maputo Plan of Action, though some are closer to the goals than others. Milestones that have been made in reducing maternal mortality due to unsafe abortion in countries with liberal laws, compared to countries with highly-restrictive laws and poorly-enforced moderate laws, are a cause for optimism. However, the reality is still that unsafe abortions of varying magnitudes in the study countries continue to be sustained by the unavailability of universal safe abortion services due to various country-specific reasons. African governments need to understand that investing in contraception and safe abortion services for poor women costs significantly less than paying for the complications of unsafe abortions.¹²⁴

Developments in the international human rights systems and regional human rights systems in other parts of the world indicate that abortion jurisprudence has a fundamental role to play in buttressing the right to safe abortion at national levels. Therefore, through the African Commission and the African Court, the African human rights system itself has to fortify the generation of jurisprudence in the area of reproductive health, including abortion. In particular, the African Commission is challenged to follow its 2011 groundbreaking concluding observations on abortion with regular jurisprudence. The important advocacy role that civil society would have to play at both national and regional levels to secure the right safe abortion in African human rights jurisprudence cannot be over-emphasised.

124 International Women's Health Coalition 'Access to safe abortion is a human right' January 2008 [http://www.iwhc.org/index.php?option=com_content&task=view&As above=2610&ItemAs above=509](http://www.iwhc.org/index.php?option=com_content&task=view&As%20above=2610&ItemAs%20above=509) (accessed 18 September 2012).

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CHAPTER 3

ACCESS TO LEGAL ABORTION FOR RAPE AS A REPRODUCTIVE HEALTH RIGHT: A COMMENTARY ON THE ABORTION REGIMES OF SWAZILAND AND ETHIOPIA

Simangele Mavundla and Charles Ngwena

Summary

A woman who becomes pregnant due to an act of rape is the victim of a violent and morally-reprehensible crime. The chapter revolves around the premise that abortion laws and practices that deny ready access to abortion are a violation of women's human rights. The chapter is a commentary on the abortion regimes of two countries – Swaziland and Ethiopia. Its focus is on highlighting their differences in terms of progress in implementing abortion law. Though both countries liberalised their abortion laws in 2005, they provide contrasting examples in commitment to implement abortion law, with Ethiopia demonstrating progress towards translating abortion rights into meaningful access, but Swaziland demonstrating a lack in this regard. The chapter highlights the importance of implementing abortion law so that it provides clearer guidance to service providers and tangible access to women seeking abortion services, not just as a matter of best practices in provision of health care, but also as a human rights duty incumbent on the state.

1 Introduction

According to Cook *et al*, sexual abuse affects both sexes but, while it should not be approached through simplistic stereotypes, its victims are overwhelmingly female, particularly young women.¹ Plummer and Njuguna note that child sexual abuse/rape is a significant problem in many African countries.² Girls experience sexual violence at a younger age than boys.³ This is partly a reflection of the gendered ways in which

- 1 RJ Cook *et al* 'Caring for victims of sexual abuse in ethical and legal issues in reproductive health' (2005) 91 *International Journal of Gynaecology and Obstetrics* 194-199.
- 2 CA Plummer & W Njuguna 'Cultural protective and risk factors: Professional perspectives about child sexual abuse in Kenya' (2009) 33 *Child Abuse and Neglect* 524-532.
- 3 Centre for Human Rights *The impact of the Protocol on the Rights of Women in Africa on violence against women in six selected Southern African countries: An advocacy tool* (2009) 5.

boys are socialised from a young age, through influences that undermine the equal dignity of females.⁴ Women and girls who are victims of sexual violence have a higher risk of contracting HIV.⁵

Denying victims of rape access to abortion and expecting them to become mothers compounds the injuries suffered. It violates women's human rights in several ways. This is because sexual and reproductive health rights are built around premises that recognise the right to attain the highest attainable standard of sexual and reproductive health.⁶ This entails recognising basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so. These rights also include the right to make decisions concerning reproduction free from discrimination, coercion and violence as occurs in rape.⁷

Victims of rape are often blamed for having attracted the crime, and are treated as if they are the offenders by the police, healthcare professionals, and the courts.⁸ Personal testimonies of rape victims clearly show that secondary psychological trauma is attributable to such blame-shifting attitudes and treatment.⁹ There is abundant clinical evidence regarding the physical and psychological suffering of rape victims, many of whom experience guilt, extreme depression, insomnia, exaggerated fears, and problems in resuming sexual relations.¹⁰ Rape is a crisis event that has psychological consequences which can be accentuated or diminished by the nature of the responses of health providers and the criminal justice system.

Thus, a woman who becomes pregnant due to an act of rape is the victim of a violent and morally-reprehensible crime. Yet, the issue of providing safe abortion to victims of rape is much neglected in the African region. Denying access to safe abortion services to victims of rape must be understood as a form of violence against women for the reason that it puts their health and lives in serious danger. On account of the highly-restrictive regimes of many African countries, the denial of abortion compels many women to seek unsafe terminations that can result in serious illness, disability or even death. Victims of rape suffer great psychological pain by

4 As above.

5 Centre for Human Rights (n 3 above) 7.

6 International Conference on Population and Development (ICPD) Programme of Action, 1994: Fourth World Conference on Women: Action for Equality, Development, and Peace, Beijing Declaration and Platform for Action, UN Doc A/CONF 177/20 1995 94.

7 ICPD (n 6 above).

8 E Horváth *et al* in collaboration with Centre for Reproductive Rights *Gender-based violence laws in sub-Saharan Africa* (2007) http://reproductiverights.org/sites/default/files/documents/GBV_Laws_in_Sub_Saharan_Africa.pdf (accessed 19 May 2014) 38-40.

9 As above.

10 As above.

being forced to become mothers, and may attempt suicide.¹¹ Becoming a mother prematurely or under circumstances of compulsion accentuates poverty, diminishes the possibility of continuing education and undermines the achievement of socio-economic independence. It also breeds conditions that are conducive to vulnerability to HIV.¹²

Given the trauma of rape, it is not surprising that women who are denied access to abortion go to lengths to procure abortion, including having recourse to unsafe abortion. Globally, Africa has the highest regional incidence of unsafe abortion.¹³ However, this should no longer be the case. Africa has begun to institute an enabling regional human rights framework that, given political will, countries should take advantage of. The African regional human rights system is the first to adopt a treaty that expressly acknowledges abortion as a human right. Among other grounds, article 14(2)(c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol) permits abortion on the ground of rape.¹⁴

Support for an enabling environment for access to safe abortion is also contained in soft law consensus documents, especially the African Women's Plan of Action,¹⁵ which commits African governments to review laws that constitute barriers to safe abortion, and to offer abortion services to the full extent of the law. In any event, in the particular circumstances of rape, an ever-increasing number of countries recognise rape as a ground for abortion, including Ethiopia and Swaziland. One of the persistent obstacles, though, is that the law is rarely implemented.

2 The law on abortion in Ethiopia

In 2005, the government of Ethiopia reformed its highly-restrictive abortion law to allow safe abortion services on broad life and health grounds.¹⁶ The Ethiopian Criminal Code recognises rape as a ground for

11 *LC v Peru*, Communication 22/2009, CEDAW/C/50/D/22/2009, Committee on the Elimination of Discrimination Against Women (2011).

12 BE Wodi 'Gender issues in HIV epidemiology in sub-Saharan Africa' (2005) 2 *Special Issue: Women in Global Environment*. <http://appweb.cortland.edu/ojs/index.php/Wagadu/article/viewArticle/245/454> (accessed 23 May 2014).

13 World Health Organisation *Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality 2008* (2011). According to these estimates, 61% of the unsafe abortion-related mortality occurs in the African region.

14 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, adopted by the 2nd ordinary session of the Assembly of the African Union, Maputo, 11 July – 13 August 2003 and entry into force 25 November 2005.

15 African Union *Maputo Plan of Action for the operationalisation of the continental policy framework for sexual and reproductive health and rights 2007-2010* (2006).

16 T Geressu *et al Availability and utilisation of comprehensive abortion services in five regional states in Ethiopia* (2007) 1.

abortion.¹⁷ Article 545 of the Code¹⁸ criminalises the intentional termination of a pregnancy, at whatever stage, except as otherwise provided under article 551. The liberalisation of abortion under article 551 is a change of heart on the part of national authorities.¹⁹ It came as part of the promulgation of the Criminal Code of 2004 which repealed the Criminal Code of 1957. Article 551 reflects official realisation that highly-restrictive laws under the Criminal Code of 1957 drove women to undergo abortion illegally and in unsafe conditions.²⁰ According to IPAS (a non-governmental organisation that seeks to address women's reproductive health and access to safe abortion), it took five years of advocacy to reform abortion law, and the ultimate objective was to reduce a high burden of unsafe abortion-related mortality.²¹

The Criminal Code contains a general prohibition on abortion, whether it is procured by the pregnant woman herself or by another person with or without her consent.²² Punishment for the crime depends on whether the abortion is procured by the pregnant woman or by another person.²³ Abortion that is performed illegally by healthcare professionals, such as doctors, pharmacists, midwives and nurses, is treated as an aggravating factor. Article 551 of the Criminal Code provides for the exceptions to the general prohibition on abortion. Article 551 provides that abortion is not criminally punishable where:

- (a) the pregnancy is the result of rape or incest;
- (b) the pregnancy endangers the life of the mother or the child or the health of the mother or where the birth of the child is a risk to the life or health of the mother;
- (c) the child has an incurable and serious deformity; or
- (d) the pregnant woman, owing to a physical or mental deficiency she suffers from or her minority, is physically as well as mentally unfit to bring up the child to be born.²⁴

Article 551 also provides for termination of pregnancy in the case of grave and imminent danger which can be averted only by an immediate intervention.²⁵ Furthermore, article 552 provides:

17 Federal Democratic Republic of Ethiopia, Proclamation 414 of 2004: The Criminal Code of the Federal Democratic Republic of Ethiopia of 9 May 2005 (Ethiopian Criminal Code).

18 Art 545(1) Ethiopian Criminal Code.

19 Geressu *et al* (n 16 above); see also M Roba 'Tripartite interest in abortion: The woman, the father and the fetus under Ethiopian law' unpublished LLB thesis, Addis Ababa University, 2000 9.

20 Roba, (n 19 above).

21 Geressu *et al* (n 16 above).

22 Art 546 Ethiopian Criminal Code.

23 Arts 546 & 547.

24 Arts 551(1)(a)-(d).

25 Art 551(2).

In the case of terminating pregnancy in accordance with sub-article (1)(a) of article 551, the mere statement by the woman is adequate to prove that her pregnancy is the result of rape or incest.²⁶

This provision on rape is clearly liberal. Significantly, there is no requirement for the rape victim to have reported the incident to the police or to have laid a formal charge with the courts. The victim is not required to produce evidence corroborating rape.

Guidelines for implementing safe abortion services in Ethiopia

In addition to the provisions of the Criminal Code which liberalise abortion, in 2006, the Ethiopian Ministry of Health developed guidelines for the provision of safe abortion.²⁷ The guidelines serve to implement the provision of safe abortion by clarifying the law and practice of providing abortion services under the Criminal Code. The guidelines clearly move away from a crime and punishment approach in favour of a reproductive health approach. They expressly adopt a 'woman-centred abortion care' approach with the aim of ensuring the availability of 'comprehensive' abortion services within the confines of what is permitted under domestic law, and that women with unwanted pregnancies are provided with 'choice, access and quality services'.²⁸ Accessible services mean 'easy-to-reach, affordable and non-discriminatory' services.²⁹ The guidelines state that when accessing abortion services, a pregnant woman's mental and physical health and her personal circumstances should be taken into account.³⁰

More pertinently, the Ethiopian guidelines dispense with burdensome certification requirements for rape and incest.³¹ In this sense, they reiterate and reinforce article 552 of the Ethiopian Criminal Code, which does not require corroboration when abortion is requested on the ground of rape or incest. In this connection, the guidelines state:

Termination of pregnancy shall be carried out based on the request and the disclosure of the woman that the pregnancy is the result of rape or incest. This fact will be noted in the medical record of the woman. Women who request termination of pregnancy after rape and incest are not required to submit

26 Art 552(2).

27 Family Health Department *Technical and procedural guidelines for safe abortion services in Ethiopia* (2006) http://phe-ethiopia.org/resadmin/uploads/attachment-161-safe_abortion_guideline_English_printed_version.pdf (accessed 23 May 2014).

28 Family Health Department (n 27 above) 6-7.

29 As above.

30 Family Health Department (n 27 above) 6.

31 Family Health Department (n 27 above) 8.

evidence of rape and incest and/or identify the offender in order to obtain an abortion service.³²

The emphasis is on timely access, with a requirement that a woman who is eligible for abortion be guaranteed access to safe abortion services within a period of three working days.³³ This period is intended to facilitate diagnostic procedures and non-directive counselling.³⁴ The fact that a request for abortion on the ground of rape does not require corroboration is an important advancement in removing law as a barrier, avoiding secondary victimisation and securing substantive equality for women.

The guidelines further stipulate that the provider of abortion services must secure informed consent for the procedure using a standard consent form.³⁵ The service provider will not be prosecuted if the information provided by the woman is subsequently found to be incorrect.³⁶ This proviso is of importance, as it provides reassurance to service providers who might otherwise be deterred from rendering lawful services for fear of prosecution.

Another important clarification brought by the guidelines is that they make it mandatory to treat a patient who is suffering from the effects of illegal abortion induced by her or another person. This practice offers meaningful assistance to women who are suffering from the effects of unsafe abortion and might be afraid to access health services. The healthcare professional is under a duty to respect patient confidentiality, unless compelled to breach confidentiality by a court.³⁷

Thus far, there have been no published studies carried out in Ethiopia to specifically determine access to abortion services for survivors of rape. Furthermore, there are no reliable estimates, as yet, on the number of unsafe abortions carried out annually before 2005 to allow an accurate assessment about the degree to which abortion law reform is making a difference.³⁸ At the same time it is significant that, following legal reform of abortion, the Ethiopian government has begun to establish abortion services on a broader scale.³⁹ Although there are yet no authoritative studies to show how the new law has impacted on access, nonetheless, there are indications that, although unsafe abortion-related mortality and

32 As above.

33 As above.

34 Family Health Department (n 27 above) 8-10.

35 Family Health Department (n 27 above) 9-10.

36 Family Health Department (n 27 above) 10.

37 Family Health Department (n 27 above) 11.

38 Guttmacher Institute *Making abortion services available in the wake of legal reforms* (2012) 16.

39 As above; H Gebreselassie *et al* 'Caring for women with abortion complications in Ethiopia: National estimates and future implications' (2010) 36 *International Perspectives on Sexual and Reproductive Health* 6; S Singh *et al* 'The estimated incidence of induced abortion in Ethiopia' (2010) 36 *International Perspectives on Sexual and Reproductive Health* 16-23.

morbidity remains a major public health danger, it has begun to drop as an increasing number of safe abortions are being performed.⁴⁰ However, progress in scaling up the provision of safe abortion services and requisite access appears to have been slow.⁴¹

Although access has increased, there are significant disparities. Ethiopia's population is largely rural and yet services are predominantly located in urban areas.⁴² For rural women, especially, public health facilities are often too far away from home and transport is either lacking or unaffordable.⁴³ There is also a public and private healthcare sector divide in the provision of access. One study revealed that only about 50 per cent of the health facilities eligible to offer abortion services were in fact offering services, with the majority of facilities in the private and non-governmental sector.⁴⁴ However, women used predominantly state facilities if they experienced complications from unsafe abortion.⁴⁵ The shortage of trained healthcare professionals and accessible facilities remain major barriers.⁴⁶ Nonetheless, despite subsisting barriers to access, it is significant that Ethiopia has made important strides in tangibly moving away from highly-restrictive law as well as mitigating administrative barriers. Ethiopia has taken the initial steps in implementing abortion law in a manner that has a great potential in enabling to women, including survivors of rape to access abortion services.

3 The law on abortion in Swaziland

Unlike Ethiopia, the abortion regime in Swaziland is conspicuous for its failure to implement the law, including rape as a ground for abortion. Section 15 of the Constitution of Swaziland of 2005, which guarantees the right to life, prohibits abortion, but subject to certain stipulated exceptions.⁴⁷ The exceptions are the following: where a doctor certifies that the continued pregnancy will endanger the life or seriously threaten the physical or mental health of the pregnant woman,⁴⁸ where there is a risk of serious physical or mental foetal defect as to result in 'irreparable serious handicap';⁴⁹ where the pregnancy results from rape, incest or

40 Singh *et al* (n 39 above) 23; Guttmacher Institute (n 38 above) 16.

41 Gebreselassie *et al* (n 39 above) 1.

42 Singh *et al* (n 39 above) 22.

43 Y Melkamu *et al* 'Utilisation of post-abortion care services in three regional states of Ethiopia' (2010) 24 (Special Issue 1) *Ethiopian Journal of Health Development* 123-129.

44 Singh *et al* (n 39 above) 20-21.

45 As above.

46 Guttmacher Institute (n 38 above) 16.

47 Sec 15(5) Constitution of Swaziland.

48 Secs 15(5)(a)(i) & (ii) .

49 Sec 15(5)(a)(iii).

unlawful sexual intercourse with a mentally-retarded female;⁵⁰ or on other grounds as parliament may prescribe.⁵¹

Prior to the constitutionalisation of abortion in 2005, Swazi abortion law was a relic of British colonial rule. Domestic abortion law was governed by Swazi common law which was received from the United Kingdom.⁵² Abortion was only permitted to save the life of the pregnant woman which, after the *Bourne* decision in 1938, was implicitly understood to cover the physical and mental health of the pregnant woman.⁵³ The *Bourne* case judicially liberalised the common law through its expansive interpretation of what constitutes saving the life of the pregnant woman.⁵⁴ At the same time, it serves well to note that the adherence of the Swazi legal system to the *Bourne* case was never tested in the courts.⁵⁵

However, notwithstanding the *Bourne* case, political debates on abortion in Swaziland prior the adoption of the Constitution of 2005 tended to proceed on the incorrect premise that abortion was illegal rather than restricted. Indeed, under this premise, attempts were made prior to 2005 to secure abortion law reform that, among other grounds, recognises rape. However, such moves were met with resistance, especially by conservative politicians. James Hall reported at the time that '[t]raditionalists, who hold sway over public opinion in Swaziland, have opposed women's right to abortion'.⁵⁶ A Bill in favour of legalising abortion was presented for the first time to the Swazi Parliament by Senator Mbho Shongwe, who argued that sharp gender inequalities in society have saddled Swazi women with unwanted children and unsafe abortions. The Bill was turned down.⁵⁷ One of the observations made by Shongwe was that some Swazi women were crossing the border into South Africa to have abortions, but those without means remained vulnerable to recourse to unsafe abortions.⁵⁸ Thus, Shongwe was highlighting that the injustice visited upon women was not merely a denial of access to safe abortion, but inequitable access, with poor women disproportionately bearing the brunt of the injustice and rendered more vulnerable to unsafe abortions. Organisations like the Swaziland Action Group Against Abuse and Swaziland AIDS Support Organisation have over the years pushed for access to legal abortion by rape survivors.⁵⁹

50 Sec 15(5)(b).

51 Sec 15(5)(c).

52 C Ngwena 'An appraisal of abortion laws in Southern Africa from a reproductive health rights perspective' (2004) 32 *Journal of Law, Medicine and Ethics* 708 712.

53 *R v Bourne* 1 Kings Bench 687 (Central Criminal Court, London).

54 RJ Cook & BM Dickens 'Abortion laws in African Commonwealth countries' (1981) 25 *Journal of African Law* 60-79.

55 Ngwena (n 52 above) 712.

56 J Hall *Rights-Swaziland: Traditionalists, reformists lock horns over abortion*. <http://ipsnews.net/africa/Focus/religion.shtml> (accessed 29 April 2012).

57 As above.

58 As above.

59 As above.

Given the clear constitutional mandate for the liberalisation of abortion law, it may appear that the Swazi Constitution has laid a stronger foundation for the implementation of access to abortion, including in cases of rape. However, in practice there is, as yet, no tangible change.⁶⁰ When accompanying laws or regulations are vague or non-existent regarding how the rape indication should be operationalised, medical and legal professionals tend to act more conservatively in order not to risk breaking the law.⁶¹ This is the situation obtaining in Swaziland. The new law does not lay down any steps at all for facilitating implementation, making it difficult for women to know their rights and obtain legal abortion, and for healthcare professionals to know their obligations.

In the absence of clear provisions within the law, health personnel are often uncertain about their duties. For example, if a pregnant rape victim presents at a hospital and requests an abortion, health personnel may question whether they are required to first contact law enforcement officials before attending abortion needs.⁶² Similarly, police may hesitate to assist the woman with proof of rape in the absence of a medical examination.⁶³ This scenario creates a catch-22 situation for the woman.

Human rights-based approach to ensuring access to safe abortion in Swaziland

A lack of transparency in abortion laws denies women substantive equality, as well as equal protection under the law.⁶⁴ It is what besets Swazi abortion law as framed by the Constitution. Consequently, the Swaziland general public still believes that the law is highly restrictive because neither the legislature nor the Ministry of Health has taken steps to issue guidelines to clarify the meaning and application of section 15 of the Constitution. This is not just a matter of best healthcare practices or compliance with domestic constitutional imperatives. It is also a human rights issue. The need for transparency in abortion laws and their effective implementation through tangible and accessible administrative mechanisms have been highlighted by the European Court of Human Rights in the interpretation of state obligation under the European

60 R Boland & L Katzive 'Developments in laws on induced abortion: 1998-2007' (2008) 34 *International Family Planning Perspectives* 110-120.

61 KI Teklehaimanot & CH Smith 'Rape as a legal indication for abortion: Implications and consequences of the medical examination requirement' (2004) 23 *Medicine and Law* 91-102.

62 As above.

63 As above.

64 RJ Cook & S Howard 'Accommodating women's differences under the Women's Anti-Discrimination Convention' (2007) 56 *Emory Law Journal* 1039 1069-1068; CG Ngwena 'Developing regional abortion jurisprudence: Comparative lessons for African Charter organs' (2013) 31 *Netherlands Quarterly of Human Rights* 9 20-25.

Convention on Human Rights and Fundamental Freedoms (European Convention).⁶⁵

For instance, the decision of the European Court of Human Rights in *Tysiac v Poland*⁶⁶ is persuasive authority for the proposition that the substantive abortion rights that are guaranteed by the Swazi Constitution impose obligations on the state to institute procedural safeguards. The safeguards include rendering the law transparent, so as to facilitate the tangible realisation of the rights guaranteed in the Constitution. The European Court held that Polish authorities had failed to put in place effective and fair procedural and institutional mechanisms for determining whether a woman seeking abortion met the criteria prescribed by domestic abortion law.⁶⁷ This failure constituted a breach of the procedural safeguards that are required by article 8 of the European Convention, which guarantees the right to privacy. The European Court emphasised that where the law regulates abortion, it must concomitantly seek to ensure that the pregnant woman is provided not just with clarity about her legal rights, but also with an accessible administrative framework for vindicating her rights, not least because time is of critical importance in decisions relating to abortion.⁶⁸ Implementing a clear administrative framework for access to abortion under domestic law alleviates the deterrent effect that the criminal regulation of abortion and the fear of possible prosecution otherwise have on women seeking abortion services as well as on providers of abortion services.⁶⁹

In *P and S v Poland*, the European Court specifically adjudicated on an application brought by a survivor of rape alleging violations of her human rights on account of the obstacles and delays she encountered when attempting to access domestic abortion services.⁷⁰ In its findings, the European Court castigated, in trenchant terms, the conduct of Polish authorities in repeatedly obstructing the applicant's right to access abortion under Polish law. The applicant, who was a very young minor, had become pregnant following a rape. With the support and consent of her mother and legal guardian, she sought to terminate the pregnancy at a state health facility. However, despite meeting legal eligibility for abortion on the ground of rape under Polish law,⁷¹ the applicant was met with a series

65 European Convention for the Protection of Human Rights and Fundamental Freedoms, opened for signature 4 November 1950, 213 UNTS 221, Europ TS 5 (entered into force 3 September 1953).

66 *Tysiac v Poland*, Application 5410/03, 45 EHRR 42 (2007). See also three other decisions of the European Court of Human Rights on the same point, namely, *A, B & C v Ireland*, EurCtHR, [2010] ECHR 2032; *RR v Poland*, EurCtHR Application 27617/04 (2011); *P & S v Poland*, EurCtHR Application 57375/08 (2012).

67 *Tysiac v Poland* (n 66 above) paras 115-118.

68 *Tysiac v Poland* (n 66 above) para 118.

69 *Tysiac v Poland* (n 66 above) para 116.

70 *P and S v Poland* (n 66 above).

71 Among other grounds, sec 4(a) of the Polish Law on Family Planning (Protection of the Human Foetus and Conditions Permitting Termination) Act of 1993 permits abortion where the 'pregnancy is the result of a criminal act'.

of administrative impediments and delays emanating from a combination of the domestic healthcare and criminal justice system.

Obstructions emanating from the Polish healthcare system included the refusal by numerous doctors to refer the applicant to a facility that could perform abortion; providing the applicant with misleading and contradictory information about the requirements for lawful abortion; and needlessly referring the applicant to a distant health facility when the facility that was first approached by the applicant and was within easy reach could have carried out the abortion. Furthermore, without the consent of the applicant, one of the state health facilities that the applicant had approached disclosed personal information about the applicant to the press, causing the applicant's case to become public knowledge. As a result, the applicant was subjected to repeated unwanted contacts by the general public, questioning and harassment by the press and was even accosted by anti-abortion activists.⁷²

From the criminal justice system side, one of the most serious obstructions was detention. At one point, a domestic court ordered the applicant to be removed from the custody of her mother and be involuntarily detained, with the mother being denied access to the applicant. The detention, which the European Court found to be unlawful, was ostensibly to protect the applicant's best interests by providing her with 'educational supervision' to allow the applicant to make a decision free from allegedly undue pressure from her mother.⁷³ In practice, however, the detention was part of an attempt by prosecuting authorities religiously opposed to abortion to dissuade the applicant from having an abortion, or at least to frustrate the applicant's timely access to abortion. Another serious shortcoming was that, instead of treating the applicant as a victim of sexual abuse, at first, a court had instituted criminal proceedings against the applicant to charge her with 'unlawful intercourse' (a charge which was later withdrawn), even though a public prosecutor had issued a certificate to confirm that the applicant was the victim of a sexual assault.⁷⁴

Although in the end the applicant was able to access abortion, it was only after repeated delays and under psychologically very distressing circumstances. The European Court found that the conduct of the Polish authorities had violated the applicant's fundamental rights in several ways. It found that there had been violations of the applicant's rights to privacy and liberty and the right not to be subjected to inhuman or degrading treatment under the European Convention.⁷⁵ Indeed, according to the

⁷² *P & S v Poland* (n 66 above) para 164.

⁷³ *P & S v Poland* (n 66 above) para 148.

⁷⁴ *P & S v Poland* (n 66 above) paras 42-43 & 165.

⁷⁵ The respective articles that were violated under the European Convention were art 8 (right to privacy); art 5 (right to liberty); and art 3 (right not to be subjected to inhuman or degrading treatment).

Court, the applicant had been treated in a ‘deplorable manner’.⁷⁶ The Court reiterated its pronouncement in earlier cases that, where the state permits abortion, it comes under ‘a positive obligation to create a framework enabling a pregnant woman to effectively exercise her right of access to lawful abortion’.⁷⁷ The Court also highlighted the importance of procedures which are responsive to time being of the essence, and said:

The nature of the issues involved in a woman’s decision to terminate a pregnancy or not is such that the time factor is of critical importance. The procedures in place should therefore ensure that such decisions are taken in good time. The uncertainty which arose in the present case despite a background of circumstances which under article 4(a) of the 1993 Family Planning Act there was a right to lawful abortion resulted in a striking discordance between the theoretical right to such an abortion on the grounds referred to in that provision and the reality of its practical implementation.⁷⁸

At the global level, in decisions made under respective optional protocols to the treaties, the Human Rights Committee⁷⁹ and the Committee on the Elimination of All Forms of Discrimination Against Women (CEDAW Committee)⁸⁰ have highlighted that once a state permits abortion, even if restrictively, it has a human rights obligation to institute an accessible and transparent administrative framework for accessing abortion services.

At a more practical level, the World Health Organisation (WHO) has developed guidelines, *Safe Abortion: Technical and Policy Guidance for Health Systems (Guidance)*⁸¹ for assisting healthcare systems in implementing abortion law in ways that transform law from being a barrier to an instrument that not only promotes access to safe abortion services but also women’s human rights. The Guidance is based on standards that have been developed from authoritative interpretation and application of human rights by global and regional human rights bodies as well as by national courts.⁸² WHO’s point of departure is that the state should organise its health system in a way that ensures abortion is ‘safe and accessible’, including training and equipping health service providers and mitigating the impact of law as an impediment to, rather than a facilitator

76 *P & S v Poland* (n 66 above) para 168.

77 *P & S v Poland* (n 66 above) para 99, citing *Tysiac v Poland* (n 66 above) paras 116-124 and *RR v Poland* (n 66 above) para 200.

78 *P & S v Poland* (n 66 above) para 111.

79 *KL v Peru*, Communication 1153/2003, adopted 24 October 2005, UN GAOR, HumRts Comm. 85th sess., UN Doc CCPR/C/85/D/1153/2003 (2005); *LMR v Argentina*, Communication 1608/2007, CCPR/C/101/D/168/2007, Human Rights Committee (2011).

80 *LC v Peru*, Communication 22/2009.CEDAW/C/50/D/22/2009, Committee on the Elimination of Discrimination Against Women (2011).

81 World Health Organisation *Safe abortion: Technical and policy guidance for health systems* (2012).

82 JN Erdman *et al* ‘Updated WHO guidance on safe abortion: Health and human rights’ (2013) 120 *International Journal on Gynaecology and Obstetrics* 200.

of, access to abortion.⁸³ Abortion laws should be interpreted and applied to promote and protect women's health.⁸⁴

In the particular instance of rape, WHO's Guidance highlights that requiring women to first report rape to law enforcement authorities or requiring forensic evidence of sexual penetration or a police investigation as the prerequisites for access constitutes barriers for many women.⁸⁵ Such requirements are oblivious to the reality that, in many contexts, survivors of rape may avoid reporting the rape for fear of being stigmatised by law enforcement authorities and others.⁸⁶ Furthermore, these prerequisites can result in delays that cause women to be denied abortion for the reason that pregnancy has exceeded the gestational limits for which abortion is permitted under domestic law.⁸⁷ To mitigate legal and administrative prerequisites as impediments to the request for abortion on the ground of rape, the Guidance states:

Prompt, safe abortion services should be provided on the basis of a woman's complaint rather than requiring forensic evidence or police examination. Administrative requirements should be minimized and clear protocols established for both police and health-care providers as this will facilitate referral and access to care.⁸⁸

It suggested that to avoid problems of uncertainty regarding the legality of abortion, the responsibility of formulating detailed regulations or guidelines that specify the role of health personnel and the steps they must follow before and after abortion procedures could be delegated to the Ministry of Health.⁸⁹ Implementing abortion laws through regulations is a flexible approach that accommodates changing circumstances.⁹⁰ Moreover, the Ministry of Health will need to disseminate any guidelines and monitor for their proper implementation in practice.

Effective access to abortion services by survivors of rape in Swaziland ultimately depends on political willingness to fulfil the obligations that are imposed by the Constitution. Effective implementation of domestic abortion laws requires, as Ngwena has highlighted, dispensing with excessive and burdensome certification procedures that make doctors the sole gatekeepers of access to abortion.⁹¹ It also entails recognising the competences of mid-level providers to perform early abortions as an

83 World Health Organisation (n 81 above) 87-103.

84 World Health Organisation (n 81 above) 87.

85 World Health Organisation (n 81 above) 92-93.

86 As above.

87 As above.

88 World Health Organisation (n 81 above) 93.

89 Teklehaimanot & Smith (n 61 above).

90 As above.

91 CG Ngwena 'Protocol to the African Charter on the Rights of Women: Implications for access to abortion at the regional level' (2010) 110 *International Journal of Gynaecology and Obstetrics* 163 166.

innovative way of assuring equitable access in countries where there is a scarcity of doctors, such as Swaziland. In low-resource settings where the high scarcity of doctors is a given fact, abortion laws that assume the ready availability of doctors guarantee a failure in equitable access to services.⁹² Evidence shows that restricting the range of providers or facilities impacts adversely on equitable access.⁹³ It serves to reduce the range of available services and their geographical distribution, requiring women to travel greater distances and in the process raising costs and delaying access.⁹⁴ Abortion law reform in South Africa has demonstrated that the liberalisation of abortion, which is accompanied by the recognition of the competence of appropriately-trained mid-level providers to perform abortions, substantially broadens access to safe abortion in a low-resource African setting.⁹⁵

4 Conclusion

The denial of access to abortion following rape is not only a violation in its own right under the African Women's Protocol, but also a form of violence against women. At state level, there is a need for legislation, regulations and policies which specifically allow abortion in cases of rape. These should be crafted in ways that go beyond mere paper rights so as to offer tangible access. Ethiopia demonstrates that, given political commitment, this can be done. Swaziland can take a leaf from Ethiopia and implement its constitutional commitment on abortion in a manner that is transparent and tangible to service providers and, ultimately, to women seeking abortion. Efforts should be made by governments, including the Swazi government, to promote a society where women are free to control access to their own bodies, guaranteeing their liberty and justice. This envisages a society where men and women have the same status in terms of equality under and before the law.

WHO's technical and policy guidance on the provision of safe abortion on the ground of rape as well as on other grounds offers countries, such as Swaziland that are conspicuously lagging behind, a road map for implementing abortion law with a focus, not just on access but also the respect, protection and fulfilment of human rights. Providing survivors of rape with ready access to abortion is ultimately about respecting women's dignity. Respect for dignity is fundamental to the realisation of all human rights. Dignity requires that individuals be free to make personal decisions

92 As above; W Koster-Oeyekan 'Why resort to illegal abortion in Zambia? Findings of a community-based study in Western Province' (1998) 46 *Social Science and Medicine* 1303-1312.

93 n 81 above.

94 As above.

95 K Dickson-Tetteh & DL Billings 'Abortion care services provided by registered midwives in South Africa' (2000) 28 *International Family Planning Perspectives* (2002) 144-150.

without interference from the state, especially in an area as important and intimate as sexual and reproductive health. It is imperative for African governments to unequivocally recognise the inhumane and degrading nature of requiring a woman to continue with a pregnancy that is the result of rape.

In many settings, of which Swaziland is an example, rape is rarely accompanied by regulations or guidelines which facilitate timely access to abortion. Where such regulations or guidelines are present, they are often conceived in conjunction with national laws that import medicalisation as well as judicialisation of rape as a ground for abortion.⁹⁶ The result is that victims of rape end up being put through a system that paradoxically treats them as if they are defendants who have to be acquitted before they can be permitted to have an abortion, in that they have to meet certain forensic and judicial standards for proving the fact of rape.⁹⁷ It is ironical that Swaziland, which has ratified the African Women's Protocol,⁹⁸ should be lagging far behind Ethiopia (which has yet to ratify the Women's Protocol) in mustering commitment to provide survivors of rape with transparent and administrative accessible framework for accessing safe abortion services.

96 CG Ngwena 'Inscribing abortion as a human right: Significance of the Protocol on the Rights of Women in Africa' (2010) 32 *Human Rights Quarterly* 783–864.

97 As above.

98 African Union List of Countries which have Signed, Ratified/Acceded to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, <http://www.au.int/en/sites/default/files/Rightspercent20ofpercent20Women.pdf> (accessed 24 May 2014).

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- Criminal Code of the Federal Democratic Republic of Ethiopia, Proclamation 414 of 2004

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- LC v Peru*, Communication 22/2009, EDAW/C/50/D/22/2009, Committee on the Elimination of Discrimination against Women (2011)
- LMR v Argentina*, Communication 1608/2007, CCPR/C/101/D/168/2007, Human Rights Committee (2011)
- P and S v Poland*, Eur Ct HR, Application 57375/08, European Court of Human Rights (2012)
- R v Bourne*, 1 Kings Bench 687 (Central Criminal Court, London) (1938)
- RR v Poland*, Eur Ct HR Application 27617/04, European Court of Human Rights (2011)
- Tysiac v Poland*, Application 5410/03, 45 EHRR 42, European Court of Human Rights (2007)

ABORTION AND THE EUROPEAN
CONVENTION ON HUMAN RIGHTS: A
LENS FOR ABORTION ADVOCACY IN
AFRICA

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Summary

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa is the only legally-binding human rights instrument that explicitly addresses abortion as a human right and affirms that women's reproductive rights are human rights. For a continent with the highest maternal mortality rate due to unsafe abortions and with the world's most restrictive abortion laws, this Protocol may prove critical to litigation and legal advocacy aiming to ensure greater access to lawful abortion in Africa. Nevertheless, the Women's Protocol's efficacy has yet to be tested in the context of abortion. United Nations (UN) and regional human rights systems, especially the European system, have addressed the right to women's access to abortion when assessing state compliance with international human rights norms and in finding human rights violations in the context abortion within individual complaints. While the African context is starkly different to that in Europe, in terms of maternal mortality rates and grounds for lawful abortion, recent abortion-related jurisprudence under the European Convention for the Protection of Human Rights and Fundamental Freedoms can nevertheless be useful for the development of national and regional law and policy reform strategies in Africa. Advocates and lawyers should also pay particular attention to the international standards developing within the UN human rights system, including through groundbreaking cases on abortion. While references are made to recent developments at the international level, the scope of this chapter is limited to analysis of recent European Convention jurisprudence that could be particularly useful for lawyers and advocates working towards transformative abortion reform in Africa.

1 Introduction

Every year, at least 47 000 women die from complications related to unsafe abortions.¹ It is further estimated that unsafe abortions account for around 13 per cent of all maternal deaths worldwide,² the majority of which occur in Africa.³ Recent research confirms that in 2008, 49 per cent of all abortions were unsafe.⁴ That same year, it was estimated that nearly all (97 per cent) abortions in Africa were unsafe,⁵ in contrast to Europe, where 91 per cent of abortions were safe.⁶

Notably, abortion rates are lower in countries with liberal abortion laws,⁷ and studies show a correlation between low maternal mortality rates related to unsafe abortion and liberal abortion laws.⁸ As noted by the World Health Organisation (WHO), the legal grounds for abortion in a given country largely lead women with unplanned pregnancies towards safe or unsafe abortion and '[t]he lawfulness of abortion does not have an effect on a woman's need for an abortion, but only on her access to a safe abortion'.⁹ A ban on abortions largely leads to clandestine abortions, which are more traumatic, increase maternal mortality, and delay the timing of abortion.¹⁰ While there has been a trend in some regions towards liberalising restrictive abortion laws,¹¹ maternal mortality and morbidity due to unsafe abortion continue to be a major global public health concern.¹²

As greater focus has been placed on the health implications of unsafe abortion worldwide, particularly in Africa, human rights advocacy for

- 1 See World Health Organisation *Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008* (2011).
- 2 As above; G Sedgh *et al* 'Induced abortion: Incidence and trends worldwide from 1995-2008' (2012) *The Lancet* 12.
- 3 Sedgh *et al* (n 2 above) 28.
- 4 Sedgh *et al* (n 2 above) 9.
- 5 As above.
- 6 As above.
- 7 Sedgh *et al* (n 2 above) 10 11 12. 'However, a liberal abortion law alone does not ensure the safety of abortions. Other necessary steps include the dissemination of knowledge about the law to providers and women, the development of health service guidelines for abortion provision, the willingness of providers to obtain training and provide abortion services, and government commitment to provide the resources needed to ensure access to abortion services, including in remote areas.'
- 8 R Boland & L Katzive 'Development in laws on induced abortion: 1998-2007' (2008) 34 *International Family Planning Perspectives* 110, citing A Guttmacher 'Sharing responsibility: Women, society and abortion worldwide' (1999).
- 9 WHO (n 1 above) 3 6.
- 10 WHO (n 1 above) 6; T Moraes 'Brazil's unsafe abortions impede development goal' *We News* 16 September 2011.
- 11 Centre for Reproductive Rights 'The world's abortion laws: 2011' http://reproductiverights.org/sites/crr.civicactions.net/files/documents/AbortionMap_2011.pdf (accessed 20 December 2011).
- 12 Sedgh *et al* (n 2 above) 12. 'Although research indicates that the annual number of maternal deaths has declined in recent years, the WHO estimates that the proportion of maternal deaths due to unsafe abortion remained at 13 percent in 2008 as in 2003', citing WHO (n 1 above).

abortion has gained greater momentum.¹³ The most explicit pronouncement of women's rights to access abortion in the text of any human rights instrument worldwide is found in the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol), adopted by the African Union (AU) in 2003.¹⁴ Intended to fill the gaps of the African Charter on Human and Peoples' Rights (African Charter),¹⁵ the Women's Protocol explicitly calls for state parties to 'take all appropriate measures to ... protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus'.¹⁶

The African Women's Protocol is the only legally-binding human rights instrument that explicitly addresses abortion as a human right and affirms that women's reproductive rights are human rights.¹⁷ Yet, the Women's Protocol's reach is limited to the African region and its efficacy in the sexual and reproductive rights context has yet to be fully tested. Critically important, however, are other international and regional human rights protections that support women's rights to safe, legal abortion that can be found in various international and regional human rights treaties around the world, including in the Africa and Europe regions. In addition to the rights to life and health, women's rights to abortion is bolstered by a broad panoply of human rights, including the rights to privacy, liberty, physical integrity and non-discrimination. In fact, it is the evolution of human rights interpretations and applications, fuelled by women's empowerment and participation in human rights movements, which have given force to women's human rights to abortion.

Considering the stark contrast between unsafe abortion and maternal mortality rates in Africa and Europe, and the gradually-increasing momentum to liberalise abortion laws and policies in some African countries, this chapter aims to provide a lens of abortion-related

13 See Human Rights Council 11th session, Promotion and protection of all human rights, civil, political, economic, social, and cultural rights, including the right to development: preventable maternal mortality and morbidity and human rights (16 June 2009) UN Doc A/HRC/11/L.16/Rev1.

14 See Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa 2nd ordinary session, Assembly of the Union, adopted 11 July 2003 (entered into force 25 November 2005). The African Women's Protocol entered into force in 2005, after being ratified by 15 African states.

15 See African Charter on Human and Peoples' Rights, adopted 27 June 1981 (entered into force 21 October 1986).

16 African Women's Protocol, art 14(2)(c).

17 Art 14(1) African Women's Protocol. At present, more than half of the AU countries have ratified the Women's Protocol. See African Commission on Human and Peoples' Rights List of countries which have signed, ratified/acceded to the African Union Convention on Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, http://www.au.int/en/sites/default/files/999Rights_of_Women.pdf (accessed 18 April 2012).

developments in Europe, to potentially shed some insight for further advocacy in Africa, while taking into consideration the divergent regional contexts. The chapter begins with an overview of the emergence of recognition of women's rights to abortion within international and regional human rights law, including groundbreaking political agreements reached in the 1990s, and a few landmark international human rights decisions that set foundational human rights principles and norms related to abortion.

The chapter then presents a brief description of the European and African legal contexts related to abortion and regional developments that have promoted or detracted from the recognition of women's rights to abortion. Finally, the chapter analyses jurisprudence under the European Convention on the Protection of Human Rights and Fundamental Freedoms (European Convention),¹⁸ as it relates to women's access to abortion, that generally comprises the human rights legal framework for abortion in Europe, with the eye toward highlighting potential lessons learned for the African context. The chapter concludes with insight that may be gained by advocates in Africa by reflecting upon both positive and negative normative developments within European Convention case law to craft strategic legal advocacy.

2 The foundations – emergence of women's rights to abortion within international and regional human rights law

Over the past two decades, the promotion of women's reproductive rights has gained momentum, in large part, due to the 1994 International Conference on Population and Development (ICPD), held in Cairo, and the 1995 Fourth World United Nations (UN) Conference on Women, held in Beijing.¹⁹

These two conferences led to the recognition that the protection of reproductive and sexual health is a matter of social justice, and that the realisation of such health can be addressed through the improved application of human rights contained in existing national constitutions and regional and international human rights treaties.²⁰

18 The European Convention on Human Rights is the Council of Europe's first convention protecting human rights. The European Court of Human Rights is one of the most powerful monitoring tools within the Council of Europe that holds states accountable for human rights violations. See generally Council of Europe 'A convention to protect your rights and liberties', <http://human-rights-convention.org/> (accessed 8 February 2012).

19 RJ Cook *et al* *Reproductive health and human rights: Integrating medicine, ethics, and law* (2003).

20 Cook *et al* 148-149.

The consensus statements, created at these conferences and adopted by nearly all states across the globe, touch on women's rights to abortion, and thus provide additional support for the recognition of women's reproductive rights as human rights.

Within the 1994 ICPD Programme of Action (PoA), states agreed to address the consequences of unsafe abortion on women's health, and committed to collaborate with relevant inter-governmental and non-governmental organisations (NGOs) to strengthen their commitment to women's rights to health, to directly address unsafe abortion as a major public health concern, and to reduce the incidence of abortion through expanded and improved family-planning services.²¹ States also affirmed that women faced with unwanted pregnancies should have expedient access to reliable information and compassionate counselling.²²

Notably, states further confirmed within the PoA that, where abortion is legal, the procedure should be accessible and safe.²³ While the PoA does not call for legalisation of abortion worldwide, states committed to ensuring that 'women should have access to quality services for the management of abortion-related complications, and [p]ost-abortion counselling, education and family-planning services should be offered promptly, which will also help to avoid repeat abortions'.²⁴ During the five-year review of the PoA's implementation, country delegates called on health systems to increase women's access to services where abortion is legal by training and equipping health care providers and taking other measures to safeguard women's health.²⁵ While international consensus documents are non-binding, the statements contained in these documents are persuasive and indicative of the world community's growing support for reproductive rights, and are often used to justify legislative and policy reform, as well as interpretations of national and international law.

2.1 International human rights system

UN treaty-monitoring bodies' interpretations and jurisprudence on state compliance with international treaty obligations have also played a major

21 Programme of Action of the International Conference on Population and Development (ICPD Programme of Action) (September 1994) 5-13 para 8.25, United Nations, Cairo, Egypt, Doc A/CONF.171/13/Rev1 (1995).

22 As above.

23 As above.

24 As above.

25 See Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development, report of the *Ad Hoc* Committee of the Whole of the Twenty-First Special Session of the General Assembly, New York (1 July 1999) UN Doc A/S-21/5/Add.1, para 63(iii).

role in advancing women's sexual and reproductive rights.²⁶ Since the ICPD PoA was adopted, treaty-monitoring bodies have increasingly applied human rights provisions, such as the rights to life, health, to be free from torture and inhumane treatment, privacy and non-discrimination, to the abortion context, including through finding violations of human rights in denying access to lawful abortion and calling on countries to liberalise restrictive abortion laws.²⁷

Notably, the UN Committee on the Elimination of Discrimination Against Women (CEDAW Committee) recently issued decisions in two cases directly and indirectly related to abortion access. One case found the state in violation of its human rights obligations related to the failure to ensure access to emergency obstetric care in the context of a maternal death,²⁸ and another called on a state to liberalise its abortion law to allow abortion in cases of rape – representing the first time an international or regional human rights body has within an individual complaint, called upon a state to liberalise its abortion law.²⁹ Moreover, the first ever UN

26 Communication 1153/2003, *KL v Peru*, UNHR Committee (24 October 2005) UN Doc CCPR/C/85/D/1153/200; Concluding Observations of the Human Rights Committee: Poland, UN Doc CCPR/CO/82/POL, para 8 (2004) (HRC 2004 Concluding Observations to Poland); Communication 17/2008, *Alyne da Silva Pimentel v Brazil*, UNHR Committee (25 July 2011), UN Doc CEDAW/C/49/D/17/2008.

27 See generally *KL v Peru* (n 26 above); see also HRC 2004 Concluding Observations to Poland (n 26 above). For more detailed information, see Centre for Reproductive Rights 'Bringing rights to bear: An analysis of the work of UN treaty-monitoring bodies on reproductive and sexual rights' (2008), <http://reproductiverights.org/en/press-room/bringing-rights-to-bear-anew-2008-update> (accessed 26 January 2012); C Zampas & JM Gher 'Abortion as a human right: International and regional standards' (2008) 8 *Human Rights Law Review* 249.

28 See *Alyne da Silva Pimentel Teixeira v Brazil* (n 26 above). The CEDAW Committee found numerous violations including violations of arts 2(c) and (e) and art 12. It involved a 28 year-old Afro-Brazilian woman from one of Rio de Janeiro's poorest districts who faced repeated delays in receiving access to emergency obstetric care when she was six months pregnant. CEDAW confirmed that Alyne's death was largely due to misdiagnosed pregnancy-related complications, denial of basic medical services and delayed provision of emergency care, and that she suffered a violation of her right to health and was discriminated against based on her sex, African descent and socio-economic background. In turn, the Brazilian government violated its human rights obligations related to access to health, access to justice, and in relation to its due diligence obligation to regulate the activities of private health service providers. CEDAW relied upon its General Recommendation 28 to note that states' healthcare policies 'must be action- and results-oriented as well as adequately funded' and that governmental bodies should implement such policies. The Committee further affirmed that states are directly responsible for the action of private institutions when they outsourced their medical services and that states have an ongoing 'duty to regulate and monitor private healthcare institutions'. Moreover, states have due diligence obligations to 'take measures to ensure that the activities of private actors in regard to health policies and practices are appropriate'. While the case did not involve abortion, the implications in regards to abortion are apparent given the high rate of maternal mortality due to illegal abortions.

29 See generally *LC v Peru*, UN Committee on the Elimination of Discrimination of Women (17 October 2011) CEDAW/C/50/D/22/2009 (2011). *LC* involved a young girl from a poor district of Lima who became pregnant at age 13 after being repeatedly raped by a man in her neighbourhood. Desperate and psychologically traumatised, LC unsuccessfully attempted to commit suicide by jumping off the roof

treaty decision related to abortion was issued by the Human Rights Committee (HRC) in 2005, where the Committee found violations of state obligations under the International Covenant on Civil and Political Rights (ICCPR), for failing to ensure access to abortion services.³⁰ The HRC specifically called for the positive realisation of a right to access legal abortion on grounds of health protection when a woman is carrying a severely-impaired foetus. Additionally, the HRC deemed the denial of such access in this case cruel, inhumane and degrading treatment,

of a building. While doctors determined that she needed immediate spinal surgery to regain her mobility, they refused to perform this surgery upon learning of her pregnancy. As rape or sexual assault was not a legal basis for abortion in Peru, LC requested a legal therapeutic abortion under the health exception based on several medical reports demonstrating the pregnancy's harm to her mental health and that LC's likelihood of regaining mobility was diminishing as each day passed without treatment. After LC miscarried and three and a half months after it was determined that she needed spinal surgery, she finally received the required operation. Unfortunately, the procedure had little effect and LC was left paralysed from the head down, with partial movement of her hands. CEDAW found that by denying LC's access to an effective and accessible procedure enabling her to establish her entitlement to medical services, both spinal surgery and a therapeutic abortion, that her physical and mental health required, the Peruvian government violated LC's right to non-discrimination in healthcare. The doctors' decision to postpone LC's spinal surgery due to pregnancy which was 'influenced by the stereotype that protection of the fetus should prevail over the health of the mother', was also deemed a violation of the state's obligation to eliminate stereotyped roles and prejudicial cultural patterns based on the inferiority or superiority of a certain sex. The Committee further observed that the hospital medical board's delayed decision regarding LC's request for an abortion (42 days) and LC's request for reconsideration (20 additional days), and the absence of laws and regulations governing access to therapeutic abortion, amounted to a violation of LC's right to an effective remedy. CEDAW then confirmed that upon legalising abortion, the state assumed the obligation to establish an appropriate legal framework to enable women to 'exercise their right to it under conditions that guarantee the necessary legal security, both for those who have recourse to abortion and for the health professionals that must perform it'. CEDAW found that the state had violated LC's art 2(c), (f), art 3, art 5, and art 12 rights. Finally, and one of the most groundbreaking aspects of the *LC* case, CEDAW called upon a state to consider amending its law to decriminalise abortion when the pregnancy was the result of rape or sexual assault.

- 30 See generally *KL v Peru* (n 26 above). *KL* involved a 17 year-old Peruvian girl (*KL*) who became pregnant with an anencephalic foetus. Doctors confirmed that her foetus would likely be born without major portions of its brain leading to stillbirth or death, which posed risks to *KL*'s life if the pregnancy continued. A social worker advised *KL* to get an abortion as continuing the pregnancy would 'prolong the distress and emotional instability of [*KL*] and her family', and a psychiatrist concluded that 'the so-called principle of the welfare of the unborn child has caused serious harm to the mother ... [which] has substantially triggered the symptoms of depression', severely impacting *KL*'s development and future mental health. Abortion is permissible in Peru only in the limited exception for women's life or health. Despite this legal exception and medical recommendations to terminate the girl's pregnancy, Peru's state hospitals ultimately denied *KL*'s request for an abortion because they claimed it fell outside the health and life exceptions, as there is no explicit right to abortion in cases of severe foetal impairment. *KL* was forced to carry her pregnancy to term and gave birth to an anencephalic girl. After she was forced to breastfeed the baby for four days, the baby, as medically expected, died and *KL* became severely depressed, requiring psychiatric treatment. The HRC ultimately held Peru in breach of its Covenant obligations under the rights to respect for and guarantee of rights, freedom from torture and cruel, inhumane or degrading treatment or punishment, privacy and special measures for minors, for denying access to a therapeutic abortion permitted by its own domestic law. With respect to the right to be free from torture or cruel, inhuman or degrading treatment or punishment, the HRC reasoned that *KL*'s

regardless of the legality of the medical procedure.³¹ It also called for necessary measures to guarantee adolescents' access to reproductive health services, and accessible, economically-feasible procedures to appeal a doctor's refusal to perform a legal abortion.³²

While an in-depth discussion of landmark UN human rights case law is beyond the scope of this chapter, the decisions are relevant to the abortion context in Africa, particularly given the rates of unsafe abortion leading to maternal mortality, restrictive laws and generally weak healthcare systems management in the region. Additionally, almost all African countries are a party to one or more UN human rights treaties and are thus bound by interpretive jurisprudence issued by treaty-monitoring bodies. As such, in addition to glean insight from European jurisprudence, advocates in Africa can rely upon continuing developments at the UN level to develop strategic abortion-related advocacy.

2.1.1 The domestic European legal context related to abortion

European countries have experienced a noteworthy, yet disjunctive progression of women's sexual and reproductive health and rights that includes access to abortion. Generally, the European region has fairly liberal abortion laws and regulations. However, there are some countries with very restrictive legal regimes, such as Ireland and Poland, where the former only allows abortion when a pregnant woman's life is in danger and the latter when a woman's life or health is threatened, in cases of severe foetal impairment and when pregnancy is the result of a crime.³³ In addition, the microstates of Andorra, Malta and San Marino have complete bans on abortion with no explicit exceptions, including when a

depression and emotional distress were foreseeable and the state's omission in 'not enabling [KL] to benefit from a therapeutic abortion was ... the cause of the suffering she experienced'. It followed that a state's obligation to respect the right requires it to guarantee women's access to abortion in cases where pregnancy threatens her physical and mental health, including due to severe foetal impairment. With respect to the right to privacy, the HRC relied on the WHO's holistic definition of health to read mental health into Peru's health exception, and find that since KL was legally entitled to an abortion, 'the refusal to act in accordance with the author's decision to terminate her pregnancy was not justified'. Infringing on KL's rights in this regard, in turn, violated her right to privacy. As to special protection for minors, the HRC noted KL's 'special vulnerability' as a minor girl, by recognising the unique barriers and susceptibility to rights violations that adolescents face when attempting to access abortion. HRC found that Peru violated arts 2, 7, 17 and 24 of the Optional Protocol to the Covenant. Finally, as to respect for and guarantee of rights, the Committee held that the state had a duty to provide legal and administrative mechanism to prevent or redress rights violations.

31 *KL v Peru* (n 26 above) paras 6.3-6.6.

32 As above.

33 Poland, Law of 7 January 1993 on Family Planning, Human Embryo Protection, and Conditions of Legal Pregnancy Termination (amended 23 December 1997) art 4a.1 (1-3).

woman's life is in danger.³⁴ The overwhelming majority of the 47 Council of Europe member states allow abortion on request ranging from 10 to 18 weeks of gestation, and other states allow the termination of pregnancy on broad social and economic grounds. Beyond abortion on request periods, almost all European countries permit abortion on grounds of health and life until the end of pregnancy, and have extended periods for termination on grounds of foetal impairment. For the most part, there are low maternal mortality and morbidity rates in Europe.³⁵

Despite Europe's relatively liberal legal framework with regard to abortion, women's access to the medical procedure is impeded in some countries by barriers to accessing lawful abortion, such as the growing practice of conscientious objection and biased counselling requirements, lack of access to accurate and reliable information, and mandatory waiting periods. While barriers to lawful abortion are particularly pronounced in countries with restrictive laws, such as in Ireland and Poland, women are increasingly facing such barriers in countries with more liberal legislation.³⁶ For example, Russia and Slovakia recently passed legislation mandating waiting periods before women can access abortion, with Russia's being the longest waiting period in Europe. Slovakia also passed biased counselling requirements.³⁷

Reflecting some of the challenges European countries face in terms of access to abortion, a ground-breaking pronouncement regarding women's rights to abortion was recently adopted by the Parliamentary Assembly of the Council of Europe (PACE),³⁸ which provides guidance to member states on abortion and abortion-related issues. The Access to Safe and

34 See Boland & Katzive (n 8 above) 111 (Table 1). However, in these countries, it is presumed that the criminal defence of necessity would apply in cases where an abortion was performed to save a woman's life. See United Nations, Population Division *Abortion policies: A global review* (2001) 1, 2, 3 respectively 25, 126, 142, 72. Note that, in 1981, Malta removed from its Criminal Code specific provisions allowing life-saving abortions, possibly eliminating the grounds of a necessity defence in that country. See Malta Criminal Code, arts 241-243.

35 WHO, UNICEF, UNFPA and the World Bank *Trends in maternal mortality: 1990-2008* (2010) 39, Appendix 6. Estimates of maternal mortality ratio – MMR, deaths per 100 000 live births – number of maternal deaths and lifetime risk by WHO regions, 2008.

36 See Council of Europe Parliamentary Assembly (PACE) Resolution 1607 (16 April 2008) 15th sitting 'Access to safe and legal abortion in Europe', <http://www.assembly.coe.int/Main.asp?link=/Documents/AdoptedText/ta08/ERES1607.htm> (accessed 12 February 2012); PACE Report 'Women's access to lawful medical care: The problem of unregulated use of conscientious objection', <http://assembly.coe.int/Main.asp?link=/Documents/WorkingDocs/Doc10/EDOC12347.htm> (accessed 19 February 2012). Liberal abortion laws are under attack throughout the region, mainly due to increasing influence of religious institutions, such as the Catholic and Orthodox churches, on state matters.

37 Law on Basics of Health Protection of the Citizens of the Russian Federation (1 January 2012) Russia; Slovenia Act 345/2009 Coll of Laws Amending Act 576/2004 Coll on Healthcare, Healthcare-related Services and Amending and Supplementing Certain Acts, as amended 2009.

38 The PACE is a body of parliamentarians representing 47 European states to, in part, protect and promote human rights and democracy in Europe.

Legal Abortion in Europe Report calls upon member states to decriminalise abortion, guarantee women's effective exercise of their rights to safe and legal abortion, remove restrictions that hinder the *de jure* and *de facto* provision of abortion, and adopt evidence-based sexual and reproductive health strategies and policies, such as access to contraception at a reasonable cost and of a suitable nature, and compulsory age-appropriate and gender-sensitive sex and relationship education for young people.³⁹

2.2 The African legal context related to abortion

In contrast to Europe, the African region has some of the most restrictive abortion laws in the world. Only Cape Verde, South Africa, Tunisia and Zambia⁴⁰ allow abortion on socio-economic grounds, up to certain gestational limits, despite the fact that the majority of women living in Africa seek abortions for socio-economic reasons.⁴¹ In addition, only around 14 African countries permit abortion when the pregnancy is the result of rape or incest,⁴² and approximately less than one-third of African countries have abortion laws that explicitly permit abortion on grounds of foetal impairment, while others do not speak to this.⁴³ Notably, while nearly one-half of African countries allow abortion on grounds of health,⁴⁴ and only nine of those countries explicitly permit mental health as a basis for abortion or interpret the national law to include such.⁴⁵ This under-inclusive distinction between physical and mental health is limiting, particularly because a mental health exception could encompass abortion

39 PACE Resolution 1607 (n 36 above). This Report's adoption is particularly significant in a region peppered with starkly divergent sexual and reproductive health laws and policies. While not legally binding, it is the most progressive pronouncement on the right to abortion within any international or regional human rights system.

40 See Centre for Reproductive Rights (n 11 above). Cape Verde, South Africa and Tunisia permit abortion without restriction and Zambia permits abortion on socio-economic grounds.

41 As above; C Ngwena 'An appraisal of abortion laws in Southern Africa from a reproductive health rights perspective' (2004) 32 *Journal of Law, Medicine and Ethics, International and Comparative Health Law and Ethics* 708.

42 See Centre for Reproductive Rights (n 11 above). The following African countries permit abortion when the pregnancy was the result of rape or incest: Benin, Botswana, Ethiopia, Ghana, Guinea, Liberia, Mali, Namibia, Seychelles, Swaziland, Togo and Zimbabwe. The following countries permit abortion when the pregnancy was the result of rape: Benin, Botswana, Burkina Faso, Cameroon, Ethiopia, Ghana, Guinea, Liberia, Mali, Namibia, Seychelles, Swaziland, Togo and Zimbabwe.

43 As above; see generally also Ngwena (n 41 above); Boland & Katzive (n 8 above) 110. The following African countries permit abortion on grounds of foetal impairment: Benin, Botswana, Chad, Ethiopia, Ghana, Guinea, Liberia, Namibia, Niger, Seychelles, Swaziland, Togo, Zambia and Zimbabwe.

44 See Centre for Reproductive Rights (n 11 above). The following African countries permit abortion on grounds of health: Algeria, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Chad, Comoros, Djibouti, Equatorial Guinea, Eritrea, Ethiopia, The Gambia, Ghana, Guinea, Kenya, Liberia, Morocco, Mozambique, Namibia, Niger, Rwanda, Seychelles, Sierra Leone, Swaziland, Togo and Zimbabwe.

45 As above. The following African countries permit abortion on the grounds of mental health: Algeria, Botswana, The Gambia, Ghana, Liberia, Namibia, Seychelles, Sierra Leone and Swaziland.

on grounds of rape or for foetal impairment when not explicitly provided for in the abortion law.⁴⁶ Finally, while abortion laws in Africa are generally interpreted to explicitly or implicitly permit abortion to save a woman's life; many countries fail to implement such laws.⁴⁷

Africa has experienced both positive and negative developments in terms of abortion law and policy reform.⁴⁸ While many African states have dated abortion laws that were imposed by and are vestiges of, their former colonisers,⁴⁹ there has been some promising progressive legal reform. For example, South Africa engaged in radical reform in 1996 by decriminalising abortion and making a genuine effort to ensure that all women have access to abortion.⁵⁰ Additionally, Tunisia became the first Muslim country to liberalise its abortion law when it legalised abortion without any restrictions within the first three months of pregnancy.⁵¹ After three months, pregnant women may access abortion when their lives are at risk or if the foetus is impaired. More recently, in 2003, experts and stakeholders at a regional consultation on unsafe abortion noted that 'restrictive and outdated laws and policies that were out of step with global commitments, including human rights commitments, were major contributory factors to the disproportionately high mortality and morbidity of African women from unsafe abortion', and urged African governments to review existing criminal abortion legislation,⁵² much of which was imposed and inherited by their former colonisers.⁵³

Beyond domestic law reform, the African regional human rights system is trail-blazing the normative recognition of reproductive rights with its recent adoption of the African Women's Protocol, the only human rights instrument to explicitly pronounce women's rights to access abortion when pregnancy 'endangers the ... life of the mother or the

46 While some countries in Europe, for example, do not have explicit foetal impairment exceptions, the law is interpreted to permit access to abortion on such as a matter that impacts a pregnant woman's psychological health. See Abortion Act of 1974, Sweden.

47 See Centre for Reproductive Rights (n 11 above). 'Laws that make no explicit exception to save a woman's life are normally interpreted to permit life-saving abortions on grounds of the general criminal law defence of "necessity". In this situation, although laws do not expressly permit abortion, the procedure could be performed on the rationale that it is necessary to preserve the life of the woman.' AU and IPAS *Interpreting and implementing existing abortion laws in Africa* (2013).

48 See generally Boland & Katzive (n 8 above) 110; Ngwena (n 41 above).

49 See Ngwena (n 41 above) 709.

50 Ngwena (n 41 above) 715.

51 See Centre for Reproductive Rights (n 11 above); see also International Planned Parenthood Federation, Arab World Region, 'Abortion: legal status in the region' <http://www.ippfawr.org/en/What-we-do/Abortion.htm> (accessed 28 January 2012).

52 See Ngwena (n 41 above) 709.

53 As above.

foetus'.⁵⁴ The Women's Protocol also explicitly calls upon state parties to 'authoris[e] medical abortion ... [when] the continued pregnancy endangers the mental and physical health of the mother'.⁵⁵ Similar to the Women's Protocol's preservation of life grounds for abortion, the health grounds merely require a woman's health to be 'endangered'.⁵⁶ As health is not merely the absence of disease, but rather includes a more holistic sense of social well-being, as defined by the WHO,⁵⁷ the African Women's Protocol's health grounds should be interpreted broadly. Finally, the Women's Protocol explicitly articulates women's rights to abortion, calling on state parties to 'take all appropriate measures to ... authoris[e] medical abortion in cases of sexual assault, rape, incest ...'.⁵⁸ The Protocol's inclusion of sexual assault as a legal basis for abortion is particularly notable, as sexual assault covers a broader range of sexual conduct, thus potentially further expanding women's abortion rights.

Despite the African Women's Protocol's clear language, the extent to which the Protocol's provisions will be applied remains to be seen. To help states implement the provisions, the African Commission on Human's and Peoples' Rights (African Commission) has drafted a General Comment that outlines states' specific obligations to respect, protect, promote and fulfil the rights contained article 14 (health and reproductive rights) to the Women's Protocol. Among other things, this General Comment explicitly affirms that the right to be free from discrimination requires that women not be subjected to criminal proceedings or legal sanctions for utilising health services such as abortion and post-abortion care, and that the rights to privacy and confidentiality are violated when women who are entitled to legal abortion are interrogated or charged or detained for suspicion of illegal abortion when they seek post-abortion care. The General Comment further clarifies that assessments of women's health as a ground for legal abortion should align with the WHO's broad definition of health ('state of complete physical, mental and social well-being and not merely the

54 African Women's Protocol art 14(2)(c). A plain reading of the Protocol's language appears to only require access to abortion where there is a threat of foetal mortality, as opposed to simply foetal impairment. If that is the case, a woman carrying a severely-impaired foetus, but which is not incompatible with life, could potentially be forced to carry the pregnancy to term. In any case, countries that do not have a foetal impairment exception may still seek to ensure access to abortion in these circumstances under a health exception.

55 As above. It is unclear, however, whether the Women's Protocol's health-related provision will be interpreted as separate mental or physical health grounds, or conjunctively, requiring endangerment to both physical and mental health. In any case, the interpretation should be guided by international medical standards and law.

56 As above.

57 Constitution of the World Health Organisation. 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.'

58 African Women's Protocol art 14(2)(c).

absence of disease or infirmity') and that psychiatric evaluations are not necessary to establish a risk to mental health.⁵⁹

Such guidance is much needed in the African region where, despite a range of law and policy advances, the region continues to have the most restrictive abortion legal framework in the world.⁶⁰ Annually, unsafe abortion accounts for the highest number of maternal deaths worldwide, due, in part, to extremely restrictive abortion laws, which cause women to undergo clandestine abortions, using dangerous interventions in unhygienic conditions.⁶¹

2.3 The international human rights law landscape: Some observations

To date, no human rights body has ever found an abortion law allowing abortion on request or on any other ground, in contravention of international human rights law. In fact, criticism has fallen on states with restrictive abortion laws, particularly with regard to the implications of such laws for women's health and human rights and general lack of implementation of abortion laws.

In 2011, for the first time in a decision on an individual complaint by a UN body, CEDAW explicitly called on a member state to liberalise its restrictive law to allow abortion in cases of rape⁶² and, in 2005, the HRC found that the failure to allow abortion in a case of severe foetal impairment was a violation of the non-derogable right to be free from cruel, inhumane and degrading treatment.⁶³ Both of these decisions also found the non-implementation of the health exception in the existing abortion laws to be in violation of state obligations to ensure access to lawful abortion.⁶⁴ Furthermore, in 2003, the African Women's Protocol became the first human rights instrument to explicitly recognise women's

59 The African human rights system primarily includes the African Commission on Human and Peoples' Rights and the African Court on Human and Peoples' Rights which were established under the African Charter on Human and Peoples' Rights to hold member states to account for violations of the Charter. General Comments on arts 14(1)(a), (b), (c) and f) and arts 14(2)(a) and (c) of the African Women's Protocol, paras, 32, 34 & 38 (forthcoming, 2014).

60 See C Ngwena 'Access to abortion services and the Protocol to the African Charter on the Rights of Women in Africa: Opportunities and challenges' (23 August 2007) paper delivered at the Centre for Reproductive Rights 7 (document on file with the Centre for Reproductive Rights).

61 See Access to abortion services and the Women's Protocol 6, 28 (Table 6) '[W]here abortion laws are the least restrictive there is no or very little evidence of unsafe abortion, while legal restrictions increase the percentage of unlawful and unsafe procedures.' See also Joint Estimates Maternal Mortality 1990-2008 (n 35 above) 18; WHO (n 1 above) 2.

62 *LC v Peru* (n 29 above).

63 *KL v Peru* (n 26 above).

64 As above; *LC v Peru* (n 29 above).

rights to abortion in cases of rape, foetal impairment and when pregnancy threatens a woman's life and health.⁶⁵

By contrast, no human rights body has explicitly recognised that women have a right to abortion on request or for economic and social reasons. They have also failed to explicitly call for the legalisation of abortion on those grounds.⁶⁶ Nevertheless, as a whole, significant progress has recently been made within international and regional human rights systems in terms of calling upon states to liberalise abortion laws and actualise women's rights to lawful abortion and abortion-related services.

3 Scope of women's rights to abortion under the European Convention on Human Rights

Europe's regional human rights system, the Council of Europe (COE), was founded in 1949 and currently has 47 member states spanning the European continent. The COE seeks to promote human rights, the rule of law and democracy in Europe.⁶⁷ The European Convention on Human Rights (European Convention) is an international treaty adopted by the COE to protect human rights in the region. It entered into force in 1953. The European Convention establishes the European Court of Human Rights (European Court) to which complaints about individual human rights violations can be made and for which remedies for such violations can be pursued.⁶⁸ Each member state of the COE must ratify the European Convention and is automatically subject to the jurisdiction of the Court.⁶⁹

The European Convention is a civil and political rights treaty that does not expressly guarantee a right to health or specific reproductive rights,⁷⁰

65 African Women's Protocol (n 14 above).

66 However, in 2004, the UN HRC, during the state reporting process, called upon the Polish government in Concluding Observations to liberalise its abortion law, as well as women's access to legal abortion; See HRC 2004 Concluding Observations to Poland (n 26 above) para 8. The Polish law permits abortion in cases where women's lives and health are at risk and in cases of severe foetal impairment and when pregnancy is the result of a crime. This recommendation impliedly called for expansion of the law to include other grounds, including economic and social grounds.

67 The Council of Europe is a separate body from the European Union, which has only 27 member states. Unlike the EU, the Council of Europe cannot make binding laws.

68 Protocol 11 (1998) European Convention on Human Rights. The European Commission, which was part of the monitoring process along with the Court, was abolished in 1998.

69 The European Court does not conduct a country reporting procedure and, thus, the Court is the only source of interpretative jurisprudence of the European Convention. The European Commission was abolished under Protocol 11 in 1998.

70 See M Krzyanowska-Mierzevska 'How to use the European Convention for the protection of human rights and fundamental freedoms in matters of reproductive law: The case law of the European Court of Human Rights' (2004) *Astra* 16. Health-related rights have been read into the European Convention – art 2, right to life; art 3, freedom from inhumane and degrading treatment; and art 8, right to respect for private and family life – by Convention bodies. With respect to art 2, again, member states have an obligation to ensure that procedures are in place to protect lives when

or any determined standard of medical care.⁷¹ However, existing Convention provisions, particularly the right to respect for private life (article 8), have been interpreted to encompass issues related to pregnancy and its continuation or termination. As interpreted by Convention bodies – the European Court and the European Commission on Human Rights (European Commission) – the right to respect for private life extends to the physical and moral integrity of a person and legislation regulating the termination of pregnancy touches upon the sphere of private life, thus falling under the scope of article 8.⁷²

European Convention jurisprudence has affirmed, however, that not every restriction on abortion is a violation of the Convention.⁷³ In addition, Convention bodies have carefully avoided stating the extent and conditions to which abortion is protected under the European Convention requiring abortion to be legally available under domestic law.⁷⁴ Under current Convention case law, member states have a positive obligation to ensure that measures are in place to guarantee women's access to abortion where legal.⁷⁵ The European Court has applied its long-standing standard that '[t]he Convention is intended to guarantee not rights that are theoretical or illusory, but rights that are practical and effective' to the context of implementation of abortion laws.⁷⁶

With regard to direct challenges to restrictive laws, as opposed to their lack of implementation, only two cases have been decided contesting a state's legal restrictions on abortion. The cases are over 30

threatened. The European Court has interpreted this to include hospital regulations for the protection of patients' lives, including to prevent maternal deaths, and an effective system to determine the cause of death which occurs in a hospital and which may pose civil and/or criminal liability. See *Tavares v France* ECHR (12 September 1991). With respect to art 3, '[f]ailure to afford adequate medical care may be a breach of the prohibition of torture, inhumane or degrading treatment'. *Krzyanowska-Mierzewska* (n 70 above). The European Court for the first time found such a violation in a case dealing with a denial of access to genetic prenatal examination in connection to abortion. See *RR v Poland* ECHR (26 May 2011) paras 159-162.

71 See *Krzyanowska-Mierzewska* (n 70 above) 17.

72 See *X & Y v The Netherlands* ECHR (26 March 1985) Ser A 91; *Tysic v Poland* ECHR (20 March 2007) para 106.

73 See *Briggemann & Scheuten v Federal Republic of Germany* (1977) 10 DR 100.

74 As above, 26; see also *Tysic v Poland* (n 72 above); N Prialux 'Testing the margin of appreciation: Therapeutic abortion, reproductive 'rights' and the intriguing case of *Tysic v Poland*' (2008) 15 *European Journal of Health Law* 370. The European Court distances itself from the facts that served as the basis for applicant's substantive claims to explore the 'general context of the failings of the Polish abortion regime' to substantiate its finding of an art 8 – right to respect for private life – violation. The Court did not interpret the applicant's claims to require it to determine whether there was an abstract 'right to abortion'; J Erdman 'Procedural turn in transnational abortion law' (2010) *Family, Sex, and Reproduction: Emerging Issues in International Law: ASIL Proceedings* 377. Erdman notes the procedural turn in transnational abortion law, a favouring of procedural over substantive human rights limitations on the criminalisation of abortion.

75 *Tysic v Poland* (n 72 above); *RR v Poland* (n 70 above).

76 *Tysic v Poland* (n 72 above) para 113; see also Prialux (n 74 above) 378. Prialux suggests that 'rather than guaranteeing substantive rights, the Convention is more concerned with procedural fairness'.

years apart and are quite diverse in terms of the restrictions challenged. Both cases indicate, however, the European Convention bodies' unwillingness to address the compatibility of restrictive abortion laws with the Convention. In the first case, the European Commission found that restrictions on abortion after 12 weeks of pregnancy, where abortion was generally available upon request within the first 12 weeks, did not violate the European Convention.⁷⁷ In the second case, decided in 2010, the European Court was directly faced with the issue of whether an *extremely restrictive* abortion law, prohibiting abortion on grounds of health and for other reasons, was incompatible with the European Convention. In that case, the Court applied the margin of appreciation doctrine, a discretionary and unique doctrine to the European Convention system, which allows Convention bodies to avoid a judgment on the merits by deferring to the state on the issue.⁷⁸ A series of cases has also affirmed that the European Convention does not require spousal or partner consent requirements for abortion.⁷⁹

77 *Brüggenmann & Scheuten v Germany* (n 73 above). In this 1977 case, the applicants asserted that a German statute criminalising abortion after the 12th week of pregnancy violated their privacy interests under art 8. The European Commission affirmed the privacy interests at stake by stating that '[w]henver a woman is pregnant her private life becomes closely connected with the developing foetus', but held that not every restriction on termination of unwanted pregnancies constitutes an interference with a woman's privacy rights under art 8(1). In rendering this decision, the Commission relied upon the German statute's exception for women's health or life, implying that an absolute abortion ban that does not make exceptions for the health or life of pregnant woman may be an impermissible interference with art 8 privacy rights.

78 See generally Council of Europe 'The margin of appreciation: An introduction', http://www.coe.int/t/dghl/cooperation/lisbonnetwork/themis/ECHR/Paper2_en.asp (accessed 18 September 2011); see Prialux (n 74 above) 363. The European Court generally accords states a wide margin of appreciation in determining their positions on the ethics and legality of abortion. See *A, B & C v Ireland*, 16 December 2010 (Appl 25579/05), [2010] ECHR 2032 paras 4 & 8 Concurring Opinion (Judge Finlay Geoghegan). The margin of appreciation doctrine allows for different approaches in the application of the European Convention in different member states, and is applied in considering the proportionality of an interference with a Convention right. Under this doctrine, state authorities are, in principle, in a better position to decide on the measures necessary in a particular area. The scope of the margin varies, however, according to a number of criteria, including the degree of consensus among member states on the issue at hand, the extent to which the interference violates a fundamental aspect of the ability to exercise one's human rights. A broader consensus in Europe leads to a narrower margin of appreciation. In invoking the margin of appreciation, the Court does not decide on the merits of the case but defers to the state. However, the Court has complete discretion to apply the doctrine or not and has not applied it even when there is absolutely no consensus in Europe. The scope of the margin is not unlimited. The margin of appreciation doctrine has been criticised as a way for the Court to avoid deciding claims based on controversial issues. See *Handyside v United Kingdom* ECHR (7 December 1976) Ser A 24; *Sunday Times v the United Kingdom* ECHR (26 April 1979) Ser A 30; *EB v France* ECHR (22 January 2008).

79 Eg, *Paton v United Kingdom* ECHR (13 May 1980), *RH v Norway* ECHR (19 May 1992), and *Boso v Italy* ECHR (5 September 2002) involved claims by 'fathers' that they were entitled to rights related to the foetus under art 8, when the women sought to terminate their pregnancies. The European Court denied the claims in each of these cases and confirmed that women's pregnancy-related privacy rights trumped the 'fathers' purported Convention rights because a pregnant woman is 'the person primarily concerned by the pregnancy and its continuation or termination'.

The following discussion focuses on a recent series of judgments that reflect the European Court's approach to abortion. The Court has consistently found violations against a member state for failing to implement its own abortion law due to the absence of laws or procedural safeguards within the healthcare and legal systems that ensure women access to lawful abortions. For example, in *Tysi*ac v Poland, *RR v Poland*, and in *ABC v Ireland*, the European Court found violations of the state's positive article 8 (right to respect for private life) obligations for failure to ensure that legal and other measures are in place for women to access lawful abortion. In *RR*, the Court also found an article 3 (right to be free from inhumane and degrading treatment) violation. The Court, however, has yet to find a violation of this kind on grounds of non-discrimination. These cases may provide insight for potential strategic approaches to challenging African countries' failure to ensure access to abortion.

3.1 European Convention jurisprudence

3.1.1 *Tysi*ac v Poland

In 2007, the European Court issued its landmark judgment in *Tysi*ac v Poland, addressing whether Poland's failure to apply its abortion law, which permits abortion on grounds of life and health, foetal impairment and if pregnancy is the result of a crime, violated the European Convention.⁸⁰ *Tysi*ac is the first case where the European Court found that state failure to implement its abortion law is a violation of article 8 and that a state's positive obligations under the right to private life requires the government to provide a comprehensive procedural framework for ensuring access to lawful abortion.⁸¹ The applicant, Alicja Tysi

80 See *Tysi*ac (n 72 above) para 83.

81 *Tysi*ac (n 72 above) para 80. A significant judicial pronouncement from a Northern Ireland domestic court, *Family Planning Association of Northern Ireland v Minister for Health Social Services & Public Safety* also reflects the approach taken by the European Court. In 2004, the Court of Appeal of Northern Ireland held that the Department of Health, Social Services and Public Safety of Northern Ireland failed to perform its statutory duties to provide women seeking to undergo lawful abortion with satisfactory integrated health services. Specifically, the Court found that the Department failed to provide guidelines on local availability of legal abortion services and to investigate whether women were receiving satisfactory abortion-related services. As a result, medical providers were confused on the status of abortion in Northern Ireland and fearful of being held liable for potentially breaking the law and, thus, women were being denied access to abortion services to which they are legally entitled. The Court required that the state investigate whether guidelines on the lawfulness of abortion should be issued to mitigate the chilling effect of the criminal law. *Family Planning Association of Northern Ireland v Minister for Health, Social Services & Public Safety* (8 October 2004) NICA 27-39 42 44 115. As noted by Cook & Ngwena, since the laws in anglophone African countries have common derivation, the implications of this decision for Africa are significant: '[W]here ministries of health

eyesight.⁸² While Polish law permits abortion for health reasons, doctors initially refused to give Tysiak the requisite health certificate to terminate her pregnancy.⁸³ Tysiak sought further medical advice and finally received a certificate confirming the dangers pregnancy posed to her health but, again, she was denied permission to terminate her pregnancy.⁸⁴ As predicted, Tysiak's eyesight greatly deteriorated after delivery.⁸⁵

Tysiak filed a criminal complaint against state authorities, but was unsuccessful. She then filed a petition with the European Court alleging that the government had violated Convention articles 3, 8, 13 and 14 by denying her an abortion and thus failing to apply Poland's abortion law.⁸⁶ With respect to article 3 (the right to be free from inhumane or degrading treatment), the Court found, with little explanation, that the facts alleged did not amount to a violation of article 3. Rather, the Court deemed Tysiak's complaints more appropriately examined under article 8 (the right to respect for private life).⁸⁷ With regard to that claim, Tysiak argued that her rights had been 'violated both substantively, by failing to provide her with a legal abortion, and [procedurally] ... by the absence of a comprehensive legal framework to guarantee her rights by appropriate procedural means'.⁸⁸ Notably, the European Court did not address the alleged substantive violation of article 8,⁸⁹ although it recognised that she 'suffered severe distress and anguish when contemplating the possible negative consequences of her pregnancy and upcoming delivery for her health'.⁹⁰

The Court did find that Poland had violated its positive obligation to establish an effective procedure through which Tysiak could have appealed her doctors' refusal to grant her abortion request and capable of determining whether the conditions for obtaining a lawful abortion had been met in her case. In other words, where Polish law accords women the right to legal abortion, the government must establish procedures enabling women to exercise that right. The European Court noted some of the key components of such a procedure, including (i) a guarantee that a pregnant woman has the right to be heard in person and have her views considered;

fail to investigate whether women are actually receiving reproductive and other health-care services to which they are lawfully entitled, and, where women are not, that fail to provide the necessary guidance in order that they may receive such services, the ministries too might be held legally liable for violations of their local laws and/or international human rights duties.' RJ Cook & CG Ngwena 'Women's access to health care: The legal framework' (2006) 94 *International Journal of Gynaecology and Obstetrics* 220-221.

82 *Tysiak* (n 72 above) paras 8–9.

83 Para 9.

84 Paras 10–13.

85 Paras 16–17.

86 Para 3.

87 Para 66.

88 Para 76.

89 As above, para 108.

90 Para 124.

(ii) a body to hear the woman's appeal; (iii) that the body reviewing her appeal should issue written grounds for its decision; and (iv) that the government recognise that 'the time factor is of critical importance' in decisions involving abortion and therefore the hearing and appeals process should ensure that such decisions are timely.⁹¹

As to *Tysiac's* article 13 (right to an effective remedy) claim, the European Court found that Poland's positive obligations under that article overlapped with those under article 8 and, thus, there were no outstanding issues to merit a separate article 13 violation.⁹² Finally, the Court declined to examine *Tysiac's* article 14 (prohibition of discrimination) claim based on its previous finding of an article 8 violation.⁹³

Tysiac is significant because it confirms that women's right to access legal abortion may not be illusory. The European Court's article 8 analysis holds states to their procedural obligation to make abortion practically available where it is legally available. The *Tysiac* decision reflects the Court's propensity to find on procedural violations, as opposed to substantive, to remedy the wrong.⁹⁴ It may also indicate the Court's unwillingness to decide substantive rights claims when there are arguably undecided medical issues in a case, even when state action has caused the applicant 'severe distress'. As to the discrimination claim, the decision exemplifies the European Court's overarching unwillingness to address reproductive rights violations specifically as a form of discrimination against women.⁹⁵

3.1.2 *ABC v Ireland*

The European Court's judgment three years later, in *ABC v Ireland*, mirrors its decision in *Tysiac* by reaffirming that states have a positive obligation to ensure that when legal, abortion must be as practically accessible, including through enacting legislative and other measures to ensure women's access to lawful abortion. The judgment also exposed the European Court's hesitancy to require states to ensure access to abortion beyond grounds already provided for by law.⁹⁶ Applicants A, B and C had

91 Paras 118, 125-130 & 118.

92 Para 135.

93 Paras 130 & 136.

94 See generally Erdman (n 74 above), generally noting a trend of favouring procedural over substantive limitations on criminalisation of abortion, as well as the strategic benefits of procedural abortion claims.

95 In the landmark case *Opuz v Turkey*, the European Court held that the Turkish government violated its obligations to protect women from domestic violence, and for the first time found that gender-based violence was a form of discrimination under the European Convention. The *Opuz* case could signal a potential-increasing willingness by the Court to recognise gender-based discrimination and may potentially serve as an opening for similar recognitions within the reproductive rights context. *Opuz v Turkey* ECHR (9 June 2009) paras 199-202.

96 *A, B & C* (n 78 above).

various health-related concerns, but could not obtain legal abortions in Ireland due to the country's restrictive abortion regime, which only allows abortion when a woman's life is in danger. In seeking redress from the European Court, the applicants asserted numerous Convention rights violations, including violations of the right to life and right to respect for private life, and to non-discrimination. The Court addressed each of the applicants' claims separately, except for the non-discrimination claim on grounds of sex which, in line with previous case law, the Court deemed unnecessary to examine the article 14 (health and reproductive rights) claims separately.⁹⁷

3.1.2.1 Applicant C

The Grand Chamber⁹⁸ of the European Court found Ireland in violation of the right to respect for private life (article 8) with regard to applicant C for failing to provide a clear legal framework for the constitutional right to access abortion when a woman's life is in danger.⁹⁹ Applicant C was in remission from a rare form of cancer.¹⁰⁰ Unaware that she was pregnant, she underwent a series of medical exams contraindicated during pregnancy. When she discovered she was pregnant, she believed that there was a risk that her pregnancy would cause a relapse of the cancer and was thus concerned for her health and life. Despite this, applicant C was unable to find a doctor willing to determine whether her life would be at risk if she continued the pregnancy to term or how the foetus might have been affected by the tests. Believing that her pregnancy put her life at risk, applicant C had no recourse to any law or effective procedure, which she could exercise her right to an abortion in Ireland. She thus travelled to England and underwent the procedure.¹⁰¹

In Ireland, abortion is prohibited under criminal law, carrying a penalty of life imprisonment for the pregnant woman or a third party who acts with intent to provoke an abortion. A 1983 amendment to the Constitution¹⁰² and a 1992 judicial interpretation,¹⁰³ however, created an exception to the ban when there is a 'real and substantial' risk to the life of the pregnant woman. Nevertheless, parliament never enacted legislation

97 *A, B & C* (n 78 above) para 270.

98 The initiation of proceedings before the Grand Chamber takes two different forms – referral and relinquishment: European Court 'The ECHR in 50 questions' (January 2012) 6. Eg, a party can request referral of a Chamber decision for reconsideration by the Grand Chamber or a Chamber can relinquish its case to the Grand Chamber. In both circumstances, the Grand Chamber only accepts such requests on an exceptional basis. A panel of Grand Chamber judges decides whether or not the case should be referred to the Grand Chamber for further consideration. If the request for referral is accepted, the case will be reconsidered and a public hearing will be held if necessary. The Grand Chamber's judgment is considered a final judgment.

99 *A, B & C* (n 78 above) para 267.

100 An analysis of the claims brought by applicants A and B in *A, B & C* is discussed below in section 3.1.2.2.

101 *A, B & C* (n 78 above), para 25.

implementing this constitutionally-guaranteed right, despite judicial calls to do so.¹⁰⁴

The European Court found a violation of Ireland's positive obligations under article 8. In doing so, it addressed several barriers making lawful abortion inaccessible, including the chilling effect the criminal penalty of lifetime imprisonment has on both women and doctors and the resulting overall lack of accessibility of even medical consultations.¹⁰⁵ It also addressed the lack of effective remedies, noting that women should not be forced to proceed with complex constitutional challenges to determine their eligibility for a legal abortion.¹⁰⁶ Moreover, the Court noted that the government had failed to provide it with information on lawful abortions in Ireland and/or an explanation as to why the existing constitutional right had not been implemented.¹⁰⁷ In the end, the Court found Ireland in violation of its positive obligations under article 8 for failing to implement the existing Constitutional right to a lawful abortion when a woman's life is danger, and called on Ireland to pass legislation doing so.¹⁰⁸

The applicant also claimed a violation of article 2, (right to life), which the Court found inadmissible on grounds of being 'manifestly ill-founded' – that the situation did not give rise to an arguable claim under the article.¹⁰⁹ This ruling is troublesome, as the Court rejected her right to life claim by relying, in part, on the fact that applicant C could travel abroad to obtain the abortion.¹¹⁰ The Court did not address her claim that the failure to implement her constitutional right led her to undertake her own measures to protect her life and ensure her right to life in another state. Rather, it simply noted that there was no evidence of any relevant risk to

102 Art 40.3.3 of the Irish Constitution (Eighth Amendment): 'The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right.'

103 See generally *Attorney-General v X & Others* (1992) 1 IR 1 401.

104 *A, B & C* (n 78 above) paras 154-156, 253, 258 & 264.

105 *A, B & C* (n 78 above) para 178. 'Accordingly, none of her doctors could inform the third applicant of any official procedures to assist her. The doctors, who had treated her for cancer, were unable to offer her basic assistance as to the impact her pregnancy could have on her health. She stated that her own general practitioner had failed to advise her about abortion options and had not referred to the fact that she had been pregnant when she visited him several months later. This hesitancy on the part of doctors was explained by the chilling effect of a lack of clear legal procedures combined with the risk of serious criminal and professional sanctions. It was not a problem that could be reduced, as the government suggested, to the dereliction by doctors of their duties. Accordingly, the normal medical consultation process relied on by the government to establish an entitlement to a lawful abortion was simply insufficient given the lack of clarity as to what constitutes a 'real and substantial risk' to life combined with the chilling effect of severe criminal sanctions for doctors whose assessment could be considered *ex post facto* to fall outside that qualifying risk.'

106 *A, B & C* (n 78 above) para 258.

107 Para 265.

108 Paras 267-268.

109 Para 159.

110 Paras 157-158. The Court also noted that her post-abortion complications, which she sought care for in Ireland, were not claimed to be life threatening.

her life due to the fact that there was no legal impediment for her to travel abroad to undergo the abortion.¹¹¹ The European Court's reasoning in this respect contradicts the fundamental principle of human rights law, that states have an obligation to respect, protect and fulfil human rights obligations within their borders. In this case, it is Ireland that has the obligation to guarantee the right to life within its borders.¹¹²

3.1.2.2 Applicants A and B

With regard to the claims brought by applicants A and B, the European Court, for the first time since *Brüggemann and Scheuten v Federal Republic of Germany*,¹¹³ was faced with a challenge to a member state's restrictive grounds for abortion, in this case Ireland's abortion ban, which only allows abortion in cases when a pregnant woman's life is in danger.¹¹⁴

Applicants A and B faced various health and 'well-being' problems.¹¹⁵ Applicant A had four children, all of whom were in foster care. She was a single, unemployed, former alcoholic struggling with depression and living in poverty. When applicant A became pregnant, she decided to have an abortion to avoid jeopardising her chances of reuniting her family and for her continued recovery. She had to borrow money from a moneylender to travel to the UK to have an abortion.¹¹⁶ Applicant B was single woman unprepared to raise a child alone. She also initially feared an ectopic pregnancy and was preparing to undergo an abortion in the UK.

Prior to travelling to the UK for the procedure, applicant B learned that her pregnancy was not ectopic.¹¹⁷

Applicants A and B directly challenged Ireland's restrictions on abortion, arguing violations of article 8 (right to respect for private life), amongst other rights.¹¹⁸ The European Court declined to make an article 8 determination, however, relying upon the margin of appreciation

111 *A, B & C* (n 78 above) para 158.

112 The Court also fell short of addressing the greater systemic ongoing problem which forces approximately 5 000 women each to travel to the neighbouring United Kingdom and other European countries to undergo abortions that they could not obtain in their home country. Some, as in the case of C, are abortions that women should be legally entitled to receive in Ireland. See Human Rights Watch *A state of isolation, access to abortion in Ireland* (2010).

113 See *Brüggemann & Scheuten v Federal Republic of Germany* (n 73 above).

114 The case was relinquished to the Grand Chamber of the European Court, as it raised a serious question affecting the interpretation of the Convention, namely, the degree to which the Convention guarantees abortion.

115 Both the applicants and the European Court in the *A, B & C* case refer to the applicants' health and 'well-being' claims, yet, throughout the Court's analysis, it fails to define the term 'well-being'. As such, the authors of this article address the applicants' 'well-being' claims within the health portion of this article. An analysis of Applicant C's claim can be found in section 3.1.2.1.

116 *A, B & C* (n 78 above) paras 14-15.

117 Para 19.

118 Paras 167-168.

doctrine.¹¹⁹ While the Court acknowledged that Ireland's abortion prohibition fell within the scope of the applicants' article 8 right to respect for private life, it deemed the issue (that is, the illegality of abortion on health and well-being grounds) to fall within the state's margin of appreciation.¹²⁰ The Court came to the conclusion primarily based on the grounds that the state is in a better position to regulate on this issue since it touches on the 'profound moral values of the Irish people as to the nature of life and consequently as to the need to protect the life of the unborn'.¹²¹

While the margin of appreciation doctrine itself is arguably inherently flawed, leaving too much discretion to the European Court to avoid deciding potentially-controversial cases,¹²² the Convention jurisprudence generally confirms that when there is a broad consensus on the relevant matter at issue in a specific case amongst European member states, a narrow margin of appreciation should be applied.¹²³ However, the Court in *ABC* accorded the state a broad margin of appreciation, despite evidence before it that there is a strong consensus in European member state legislation that entitles women to undergo abortions when their health is in danger. When balancing the rights of pregnant women with the state's interest in protecting prenatal life, European domestic legislation and jurisprudence undeniably value the health and life of the pregnant women over that of the foetus.¹²⁴ To that end, the dissenting judges lamented that the *ABC* case represented 'one of the rare times in the Court's case law' that such consensus did not narrow the margin of appreciation, and was 'the first time that the Court has disregarded the consensus on the basis of 'profound moral views'.¹²⁵

119 Paras 229-231.

120 Paras 230 & 242.

121 Para 230.

122 See C Feingold 'The doctrine of margin of appreciation and the European Convention on Human Rights' (1977) 53 *Notre Dame Law Review* 90 95; Y Shany 'Toward a general margin of appreciation doctrine in international law?' (2005) 16 *European Journal of International Law* 907-940.

123 *A, B & C* (n 78 above) para 5, Joint Partial Dissenting Opinion (Rozakis, Tulkens, Fura, Hirvela, Malinverni & Poalelungi JJ) and para 9 & 10 Concurring Opinion (Finlay Geoghegan J).

124 There was disagreement among the European Court judges on this issue. While Finlay J concurred with the decision, he emphasised that the asserted European consensus relied upon to narrow states' margin of appreciation must be relevant to the issue at hand, and that the Court misplaced its focus in this regard. Instead of focusing on whether there was a consensus among European states on when life begins, the Court should have focused on whether 'the right to life of the foetus can be balanced against the right to life of the mother, or her right to personal autonomy and development, and possibly found to weigh less than the latter rights or interests', to which the dissenting judges stated there was 'undeniably strong consensus among European states'; *A, B & C* (n 78 above) paras 2, 6 & 9. Joint Partial Dissenting Opinion (Rozakis, Tulkens, Fura, Hirvela, Malinverni & Poalelungi JJ); see also Centre for Reproductive Rights and International Reproductive Health and Sexual Law Programme, University of Toronto, Third Party Intervention (focusing on the broad consensus in Europe on the issue and arguing for a narrow margin of appreciation).

125 *A, B & C* (n 78 above) paras 6 & 9 Joint Partial Dissenting Opinion (Rozakis, Tulkens, Fura, Hirvela, Malinverni & Poalelungi JJ).

Despite the limitations of the *ABC* judgment, the decision is a critical step forward in the decades of advocacy and litigation in Ireland to implement the life exception to the criminal abortion ban and an important step towards health systems reform. The judgment is also important as it reinforces the growing European Court jurisprudence confirming that, where domestic law accords women the right to legal abortion, the state must establish clear procedural and legislative measures so that women can exercise that right.

While the European Court's denial of applicants A and B's claims shows the Court's propensity against carving exceptions to restrictive laws, by granting deference to the state, an inadmissibility decision by the Court in an earlier case against Ireland, *D v Ireland*,¹²⁶ arguably indicates that it may show less deference to member states in situations where restrictive laws lead to clearer and more detrimental harm to women's health and lives, more so than the experience of A and B.¹²⁷

3.1.3 *RR v Poland*

Almost a year later, in another abortion-related case, *RR v Poland*, the European Court, in keeping with the decisions in *Tysiac v Poland* and *ABC v Ireland*, found Poland in violation of its positive obligations under article 8, the right to respect for private life.¹²⁸ The Court also took an important step forward, for the first time in an abortion-related case, by finding a violation of the right to be free from inhumane and degrading treatment, article 3.¹²⁹

RR was repeatedly denied a genetic prenatal examination after her doctor had discovered foetal irregularities during a sonogram.¹³⁰ The exam would have informed RR's decision on whether or not to terminate her pregnancy, yet doctors, hospitals and administrators repeatedly denied

126 See generally *D v Ireland* ECHR (5 May 2006).

127 The *D* case involved a fatal foetal anomaly pregnancy where D, due to Ireland's restrictive abortion regime, which does not permit abortion in cases of foetal impairment, travelled the United Kingdom to obtain an abortion. Like A and B, in the *A, B & C*, case she did not pursue domestic remedies since the termination clearly fell outside the legal framework. However, unlike A and B, where the European Court invoked the margin of appreciation doctrine, deferring to the state to decide on the legal grounds for abortion in A and B's case, the Court, in *D v Ireland*, found the case inadmissible on grounds of the failure to exhaust domestic remedies. Unlike the situation facing A and B, the Court seemed to think that D's pregnancy situation was severe enough for the Irish Courts to be able to take the case and possibly find in her favour, noting that the Irish courts had addressed in the past cases where pregnancy posed severe and potentially-irreparable harm to women. The *D* decision indicates that, given the severity of the harm in this case – a fatal foetal anomaly – the Court might have, had the applicant exhausted domestic remedies, been willing to find Ireland in violation of the Convention for failing to provide, in its domestic law, access to abortion in cases of severe foetal anomalies.

128 *RR* (n 70 above).

129 As above.

130 *RR* (n 70 above) paras 144-147.

RR information and diagnostic tests until abortion was no longer a legal option.¹³¹ While Poland has one of the most restrictive abortion laws in Europe, the law does allow for abortion in cases of foetal abnormality and also entitles women to receive genetic prenatal examinations in this context.

In finding an article 3 violation, the European Court recognised the humiliation and suffering RR endured both before and after the results of her tests had been known, due to her position of vulnerability and poor treatment by doctors, and that this was aggravated by the fact of their availability and her entitlement to them under the law.¹³² The Court characterised RR's access to genetic testing as being 'marred by procrastination, confusion and lack of proper counselling and information given to [her]' and that ultimately she only obtained admission to a hospital where the genetic tests were conducted 'by means of subterfuge'. The Court noted:

The applicant was in a situation of great vulnerability. Like any other pregnant woman in her situation, she was deeply distressed by information that the foetus could be affected with some malformation ... As a result of the procrastination of the health professionals as described above, she had to endure weeks of painful uncertainty concerning the health of the foetus, her own and her family's future and the prospect of raising a child suffering from an incurable ailment. She suffered acute anguish through having to think about how she and her family would be able to ensure the child's welfare, happiness and appropriate long-term medical care.¹³³

With regard to article 8 (respect for private life), the European Court noted that the effective implementation of abortion laws is important for ensuring a right to lawful abortion and found that Poland's failure to do so was a violation of RR's right to respect for private life. It noted that the *RR* case was different from *Tysiack* in that 'it was not access to abortion which was primarily at issue but essential timely access to a medical diagnostic service that would, in turn, make it possible to determine whether the conditions for lawful abortion' were met.¹³⁴ The Court emphasised that the Polish abortion law provided for access to prenatal information and testing. It also noted that other Polish laws placed a general obligation on doctors to provide comprehensive information to patients on all possible diagnostic and therapeutic methods, and their benefits and side effects.¹³⁵ The Court made it clear that access to diagnostic services was decisive for the 'possibility of exercising her right to take an informed decision as to whether to seek an abortion or not'.¹³⁶ The Court further noted the crucial

131 Para 115.

132 Paras 159-160.

133 Para 153.

134 Para 196.

135 Para 157.

136 Para 208.

importance of timely access to information on one's health condition by stating that 'in the context of pregnancy, the effective access to relevant information on the mother's and foetus's health, where legislation allows for abortion in certain situations, is directly relevant for the exercise of personal autonomy'.¹³⁷

The European Court also addressed the practice of conscientious objection in *RR*, recognising it as a barrier to accessing lawful abortion. For the first time, the Court explicitly set forth states' positive obligations to regulate the practice of conscientious objection in the healthcare context.¹³⁸ In *RR*'s case, her right to prenatal examinations and abortion was repeatedly denied, in part, due to the practice of conscientious objection and state failure to regulate its exercise; an ongoing problem in Poland.¹³⁹ The Court noted that freedom of conscience does not protect 'each and every act or form of behaviour motivated or inspired by a religion or a belief', and made it clear that states have an obligation 'to organise the health services system in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals in the professional context does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation'.¹⁴⁰

RR v Poland is the first European Court decision to find an article 3 violation in an abortion-related case, and is also ground-breaking in that it recognised that states have an obligation under the Convention to regulate the practice of conscientious objection in healthcare settings in order to guarantee patients access to lawful healthcare services. The judgment obligates Poland to ensure that its laws on access to abortion and genetic prenatal examinations are fully implemented and reaffirmed its previous decision in *Tysiac v Poland*, that an effective and timely appeals mechanism exists to ensure women can appeal a health provider's decision to refuse services.

3.2 Foetal rights claims and the impact on the right to abortion

While jurisprudence covering a plethora of issues can directly or indirectly influence laws related to access to abortion, one body of jurisprudence that plays a particularly influential role concerns the extent to which human rights apply before birth. While international human rights law generally

137 Para 197. While *RR v Poland* concerned access to information on one's individual condition in relation to accessing abortion, two judgments by the European Court have addressed the issue of state prohibition on dissemination of information of a general nature related to abortion. In both cases, the Court has found violations of art 10, the right to receive and impart information; see *Open Door & Dublin Well Woman v Ireland* ECHR (29 October 1992) and *Women on Waves v Portugal* ECHR (2 March 2009).

138 *RR* (n 70 above) paras 107-108 & 129.

139 Paras 85-86.

140 Para 206.

provides for human rights protection at birth, with limited prenatal protections,¹⁴¹ attempts to apply right to life provisions found in international and regional human rights treaties to fetuses are increasingly being instigated by anti-abortion groups, including religious institutions. These assertions are incompatible with women's fundamental human rights to life, health and autonomy, by imposing involuntary motherhood on to women, and in essence, requiring women to jeopardise their own lives.¹⁴² While such contentions have been defeated on various occasions within both international and regional human rights fora, attempts have been successful at the national level in countries in Europe and Africa.¹⁴³ For example, 'foetal rights' assertions have emerged in constitutional reform processes or legislative initiatives that attempt to explicitly confer the right to life from conception, or at later stages, to an embryo or foetus.¹⁴⁴ Set forth below are the standards that have evolved under European Convention jurisprudence affirming the European Court's refusal to affirmatively apply the Convention's right to life protections before birth.

Foetal right to life claims brought to the European system have largely been ineffective. As noted above, there are substantive and procedural elements to the right to life (article 2) under the European Convention. When 'foetal rights' claims have been asserted based on article 2's substantive protections, the Convention bodies repeatedly conclude that fetuses do *not* enjoy an absolute right to life. For example, the European Commission confirmed in *Paton v United Kingdom* that the use of the term 'everyone' in article 2, protecting the right to life, does *not* include fetuses.¹⁴⁵ The husband-applicant in *Paton* asserted that his pregnant wife should be prevented from aborting the foetus based on the foetus's right to

141 See generally R Copelon *et al* 'Human rights begin at birth: International law and the claim of foetal rights' (2005) 13 *Reproductive Health Matters* 120-129.

142 Copelon *et al* (n 141 above) 126.

143 The passage of art II of the Hungarian Constitution in 2011 explicitly protects 'foetal rights'. 'Human dignity shall be inviolable. Every human being shall have the right to life and human dignity; embryonic and foetal life shall be subject to protection from the moment of conception.' Art II Hungary Constitution (amended 18 April 2011).

144 In 2010, Kenya completed a constitutional review and had a new Constitution come into force. Kenya's new Constitution states that '[e]very person has the right to life. The life of a person begins at conception.' See Constitution of Kenya (2010) arts 26(1)-(2). This conception language was proposed in an effort to further limit access to abortion in Kenya, which currently has one of the most restrictive regimes in the world, only allowing abortion to save a woman's life and to preserve a woman's physical health and to make reform or liberalisation of the abortion law especially challenging. Introducing this language served to further complicate an already unclear and restrictive legal regime around abortion in Kenya, where the new Constitution's 'life of a person begins at conception' clause is accompanied by an explicit clause on abortion, stating that abortion, although generally not permitted, is allowed in certain circumstances. Having these clauses exist side by side creates a unique set of challenges and feeds into an existing lack of clarity around Kenya's abortion law. While the African Women's Protocol does not provide any explicit support for protecting the right to life of a foetus or prior, international human rights standards should guide the interpretation of right to life protections.

145 *Paton* (n 79 above) paras 7-9.

life under article 2. The European Commission dismissed the complaint and confirmed that a foetus's potential right to life did *not* outweigh the interests of the pregnant woman, since the foetus is intimately connected with, and cannot be isolated from, the life of the pregnant woman.¹⁴⁶ The European Commission went on to say that '[i]f article 2 were to cover the foetus and its protections under this article were, in the absence of any express limitation, seen as absolute, an abortion would have to be considered as prohibited even where the continuance of the pregnancy would involve a serious risk to the life of the pregnant women', and this would mean that the 'unborn life' of the foetus would be regarded as of higher value than the life of the pregnant woman.¹⁴⁷ The European Commission found the article 2 claim inadmissible, as 'manifestly ill-founded.'¹⁴⁸ The Court reiterated this standard in *Boso v Italy*, where an article 2 claim was made in similar context as in *Paton*, and was also deemed inadmissible as 'manifestly ill-founded'.¹⁴⁹

While the Convention bodies earlier affirmed that there was no arguable article 2 right to life claim on behalf of aborted foetuses and found such claims inadmissible, more recently, the European Court has been more equivocal in its position and instead has invoked the margin of appreciation doctrine.¹⁵⁰ In *Vo v France*, despite reaffirming European Court jurisprudence on abortion laws which recognises that 'the unborn child is not regarded as a 'person' directly protected by article 2 of the European Convention on Human Rights and that if the unborn do have a 'right' to 'life', it is implicitly limited by the mother's rights and interests', the Court avoided explicitly confirming whether article 2 applied to foetuses, by noting that '[t]here is no European consensus on the scientific and legal definition of the beginning of life', and hence deferred to the margin of appreciation accorded to states.¹⁵¹

The applicant in *Vo* argued that her foetus was denied the right to life based on medical negligence, which led to her unanticipated therapeutic abortion. After unsuccessfully pursuing a criminal prosecution against the

146 Paras 7-9 & 19.

147 Para 19.

148 Para 24.

149 *Paton* (n 79 above).

150 See *Vo v France* ECHR (2004) paras 32 & 80; *Evans v United Kingdom* (2007) ECHR para 54.

151 *Vo* (n 150 above) paras 80, 82 & 84; see also G Loiseau 'Histoire d'une vie volée: Le foetus n'est pas une personne' *Droit Et Patrimoine*, November 2001, *Chron. Droits des Personnes* 99 (summarising the 2001 case) The *Cour de cassation* confirmed that a 'human being' is a biological concept in France, and 'human beings' are understood to exist from the beginning of life, generally considered as conception, although there is no firm agreement on when life begins. Contrarily, a 'person' is a legal term, which is attached to a legal category whose rights take effect and are perfected by birth, although in certain circumstances the rights acquired at birth will be retroactive to conception. The decision was based on the distinction made in French law between the concepts of 'human being' and 'person', which scholars assert is deeply founded in principles of French civil law.

negligent doctor within the French court system, *Vo* filed a petition with the European Court alleging that France, in refusing to treat the foetus as person and to prosecute the doctor for unintentional homicide, violated her foetus's article 2 right to life.¹⁵² The European Court ultimately declined to treat the foetus as a 'person' or require a homicide prosecution, by deferring the issue to France, in line with the margin of appreciation doctrine.¹⁵³ This was a marked departure from earlier case law, mentioned above, which found article 2 foetal claims to be manifestly ill-founded, and is thus indicative of the European Court's increasing ambivalence towards discussions on the extent the Convention protects foetal interests, such as in its reluctance to pose challenges to member states' restrictive abortion laws.¹⁵⁴

More recently, the European Court was asked to consider, in *Evans v The United Kingdom*, whether embryos are entitled to article 2 right to life protections under the European Convention.¹⁵⁵ The case concerned an English law requiring that embryos be destroyed once a partner withdrew consent to their continued storage and usage. Claims by one of the partners included that the destruction violated the embryos' article 2 right to life. Affirming its decision in *Vo*, the European Court declined to extend article 2 protections to the embryos.¹⁵⁶ Noting the lack of European consensus on the scientific and legal definition of when human life begins, the Court deferred to the state.¹⁵⁷ In that regard, it recalled English law under which 'an embryo does not have independent rights or interests and cannot claim – or have claimed on its behalf – a right to life under article 2 [of the Convention]'.¹⁵⁸ Additionally, within the European Court's extensive analysis under article 8 (the right to respect for private life) and balancing of the applicant's rights to preserve the embryos and the rights of her partner to have them destroyed, it did not include any 'embryonic interests' into this balancing test, thus indicating that the Convention does not require protection of such interests.¹⁵⁹

While *Vo* and *Evans* did not directly challenge abortion laws, any decision by the European Court on the extent to which the Convention protects prenatal life could impact abortion laws. While the Court's recent judgments were ultimately favourable towards member states' liberal

152 *Vo* (n 150 above) para 48.

153 Paras 84, 89, 92 & 93.

154 See generally B Hewson 'Dancing on the head of a pin? Foetal life and the European Convention' (2005) 13 *Feminist Legal Studies* 363–372. Note that the European Court's failure to take a bright-line stance on art 2 arguably opens the door for anti-abortion advocates to rely upon the Court's consistent deference to member states to assert that, if the tables were turned, and a state-determined life commenced at conception, the European court would have to employ similar deference. See *A, B & C* (n 78 above).

155 *Vo* (n 150 above).

156 *Vo* (n 150 above) paras 54–56.

157 Para 54.

158 As above.

159 *Vo* (n 150 above) paras 71–92.

abortion laws, by deferring decisions on whether or not foetal life should be protected to the states, the Court leaves the door open for such deference when foetal life and interests are protected by national law.¹⁶⁰ And, as noted above, the European Court did just that in its 2010 judgment in *ABC v Ireland*.

4 Conclusion

While international and regional human rights standards regarding women's rights to abortion are far from complete, human rights advocacy is catalysing the evolution of international human rights norms that more accurately reflect the reality of women's lives. A review and analysis of recent European Convention case law, in particular, can prove useful in developing and influencing legal reform and litigation strategies for the African region, either at the national level or at the regional or international level, in terms of both broadening the grounds for lawful abortion and ensuring that barriers to accessing lawful abortion and abortion-related services are dismantled. However, sensitivity to the context in the African region, where maternal mortality due to unsafe abortion is the highest in the world due, in part, to restrictive abortion laws and the non-implementation of existing laws, must foremost shape the development of legal strategies in Africa. For example, caution should be heeded regarding the extent to which European Convention jurisprudence may be applicable in the African region, given the vast differences in maternal mortality rates and legality and availability of abortion, generally, between the regions. That said, as the world continues to globalise and international and regional human rights bodies and national courts increasingly rely upon comparative analysis, there is much to be learned from the European experience.

It is clear from recent judgments that the European Court considers state failure to ensure access to *lawful* abortion a violation of the European Convention within the context of states' positive obligations. This is

160 However, a particularly compelling case pending before the Court will test its views on this issue. The Court is faced with the question of whether the Convention requires states to ensure that foetal protection does not supersede protection for the pregnant women in the context of access to life-saving healthcare treatment. The case regards the preventable death of a woman who was refused treatment for colon disease because doctors feared it would harm her pregnancy. The woman was 27 years old and carrying a wanted pregnancy when she was diagnosed with the painful colon disease. She sought medical care in her Polish hometown and other cities. However, hospital after hospital and doctor after doctor denied her proper diagnostic care and treatment for her illness, only because she was pregnant. The doctors repeatedly expressed concern that diagnostic care and treatment could harm the foetus. Her symptoms grew worse until she miscarried and, finally, after months of extreme pain and humiliation, she died of a condition that could have been controlled with adequate and timely treatment. Polish law grants a foetus protection and also criminalises actions taken by third parties, which lead to the demise of foetal life. It also does not regulate the practice of conscientious objection. *Z v Poland* ECHR (filed 16 September 2008) App 46123/08 (pending).

important in ensuring systemic reform in the healthcare systems, so as to prevent similar violations in the future. It is also important for bolstering efforts to address the increasing barriers in accessing lawful abortion.

In its recent case law, the European Court has unequivocally stated that where abortion is legal, states must ensure that procedural and legislative measures are in place to ensure women access to abortion. Again, in *Tysiack v Poland*, the European Court held that Poland's positive obligations under article 8 (the right to respect for private and family life) require it to establish effective appeals procedures when women are denied access to abortion, and set forth several characteristics of an effective appeals procedure.¹⁶¹ In *ABC v Ireland*, the Court held that the failure of the state to legislate on the lawful grounds for abortion in Ireland violated a human right and that the Convention requires the state to ensure legislation is in place to ensure clarity on women's access to abortion.¹⁶²

Aside from obligations to ensure legislative and procedural measures are in place to guarantee access to lawful abortion, the European Court has addressed specific laws or practices that lead to violations and state obligations to remove such barriers. These include state obligations to regulate the practice of conscientious objection,¹⁶³ ensuring that patients' right to information and medical providers' obligations to provide such information, including information on the health status of a pregnancy, diagnosis, prognosis and all available treatment options, including diagnostic and other care that could inform the woman on whether to terminate a pregnancy.¹⁶⁴ The Court has also addressed the chilling effect the criminalisation of abortion has on providers' willingness to provide abortion and abortion-related services.¹⁶⁵

The European Court's finding of a violation of inhumane and degrading treatment in *RR v Poland* is also ground-breaking and reflects a growing understanding by the Court that the denial of such services can have continuous harmful effects on the mental health of women and that states are under an obligation to prevent such harm.¹⁶⁶ While the victories

161 *Tysiack* (n 72 above) paras 80 & 125-130.

162 *A, B & C* (n 78 above) para 193.

163 See *Tysiack* (n 72 above).

164 The recent judgment in *A, B & C* also highlights the European Court's unwillingness to address whether restrictive abortion laws violate the European Convention and the propensity to grant deference to the state. However, as demonstrated in *D v Ireland*, the *A, B & C* decision should not be read as confirming of the Court's wholesale refusal to deem a restrictive abortion law in contravention of the Convention, particularly when a pregnancy poses a severe and grave health risk or in cases of fatal foetal malformations or rape. Rather, the admissibility decision in *D*, involving a woman who was carrying an anencephalic foetus, indicates the Court's belief that the Irish legal system could have addressed this issue and that the complainant should have attempted to exhaust domestic remedies, as opposed to giving deference to the state.

165 *A, B & C* (n 78 above) para 178; see also *Tysiack* (n 72 above); *RR* (n 70 above).

166 *RR* (n 70 above) para 159.

in these cases are formidable, it is unfortunate that the Court has consistently failed to address the discriminatory gender norms that persist in denying women access to abortion. Additionally, despite the article 8 (right to respect for private life) finding in *ABC*, the case reveals the European Court's tendency to focus on states' procedural obligations and continued reluctance to address substantive challenges to restrictive abortion laws on their face.

While there is much insight to be gained from European Convention jurisprudence, the African region, in its own right, has experienced the most significant pronouncement of women's human rights with the ratification of the African Women's Protocol, which provides textual guarantees of women's reproductive rights and a quasi-judicial procedure to enforce those rights, and the African Commission's new General Comment on article 14. While the effectiveness of the Women's Protocol has yet to be tested in the area of reproductive rights, it undoubtedly signifies the winds of change in a region where women's reproductive capacities has led to high rates of maternal mortality, discrimination and grave abuse.

Advocates seeking to build upon the bold new pronouncements in the African region and to operationalise African women's sexual and reproductive rights can reflect upon both the positive and negative normative developments within the European region to craft strategic advocacy. For example, as the European Court generally circumvents substantive, facial challenges to restrictive abortion laws by focusing on states' procedural obligations to enforce existing laws, African human rights bodies may also attempt to shy away from direct challenges to national legislation. Nevertheless, the high rates of maternal mortality combined with the world's most restrictive abortion laws may lead the African human rights system to boldly confront the restrictive laws, especially given the explicit language in the African Women's Protocol on abortion. Regardless, advocates could call for clearer regulations, greater enforcement mechanisms, and public education initiatives to improve the public's and medical practitioners' legal awareness and compliance with existing legislation. As evidenced by European jurisprudence, human rights enforcement in the context of abortion has gained greater traction when addressing states' procedural and legislative obligations to apply existing laws. For example, while almost all abortion laws in Africa are generally interpreted to explicitly or implicitly permit abortion to save a woman's life,¹⁶⁷ some countries do not have clear regulations

167 See Centre for Reproductive Rights (n 11 above). 'Laws that make no explicit exception to save a woman's life are normally interpreted to permit life-saving abortions on grounds of the general criminal law defence of "necessity". In this situation, although laws do not expressly permit abortion, the procedure could be performed on the rationale that it is necessary to preserve the life of the woman.'

implementing these laws, and the ability to access abortion on this ground is challenging, if not impossible.¹⁶⁸

As mistreatment within some African healthcare facilities is being documented with greater frequency, advocates could also rely upon inhuman and degrading treatment prohibitions and protections as a means to personalise the grave harms often suffered in the context of abortion. Moreover, while the European Court generally fails to find discrimination within reproductive rights cases, perhaps Africa's socio-political backdrop and colonial legacies better equip African advocates and human rights bodies to conceptualise women's impeded access to abortion as a form of discrimination.

Finally, it is critically important to keep in mind what has been confirmed by the WHO - that restrictions on abortion do not reduce the number of induced abortions, as women will seek terminations regardless of its legal status and lawful availability. The issue is one of safety. While abortion is a safe procedure when performed by skilled health care providers in sanitary conditions, clandestine and illegal abortions are generally unsafe and lead to high rates of complications. According to the WHO, the first steps for avoiding maternal deaths is to ensure that women have access to family planning and safe abortion. This will reduce unwanted pregnancies and unsafe abortions.¹⁶⁹ From Romania to South Africa to Nepal and Colombia, the positive impact of the liberalisation of abortion laws on maternal mortality and morbidity are well-documented.¹⁷⁰

In sum, advocates seeking to protect and promote women's abortion rights in Africa have much to gain by not only looking forward, but by looking to lessons learned from their colleagues in other regions similarly fighting for women's lives, health and sexual and reproductive autonomy.

168 Centre for Reproductive Rights and Women's Advocate and Documentation Centre (WARDC) *Broken promises: Human rights, accountability, and maternal death in Nigeria* (2008); see Centre for Reproductive Rights *In harm's way: The impact of Kenya's restrictive abortion law* (2010).

169 WHO *Safe abortion: Technical and policy guidance for health systems* (2012) 23 47-49. The WHO defines unsafe abortion as a procedure for terminating a pregnancy that is performed by an individual lacking the necessary skills, or in an environment that does not conform to minimal medical standards, or both.

170 See M Berer 'National laws and unsafe abortion: The parameters of change' (2004) 12 *Reproductive Health Matters* 1; LA Bartlett *et al* 'Risk factors for legal induced abortion-related mortality in the United States' (2004) 103 *Obstetrics and Gynaecology* 729; R Jewkes *et al* 'The impact of age on the epidemiology of incomplete abortions in South Africa after legislative change' (2004) 112 *British Journal of Obstetrics and Gynaecology* 355.

Postscript

The European Court of Human Rights issued its first judgment regarding a minor's access to abortion in October 2012. The case, *P & S v Poland* (57375/08), concerns a 14 year-old who became pregnant as a result of rape and who faced numerous barriers and delays in accessing a lawful abortion, including coerced and biased counselling by a priest, the divulgence of confidential information on her pregnancy to the press and to others, the unregulated practice of conscientious objection and removing her from the custody of her mother who supported her decision to undergo an abortion. The procedure eventually took place but in a clandestine manner and without proper post-abortion care.

The Court held Poland in violation of its positive duty to safeguard the respect for the teenager's and her mother's private life when it failed to ensure their effective access to legal abortion. The teenager's right to respect for her private life was further breached when her health and other confidential information were released to the press by a hospital. The Court also found Poland in breach of the Convention for failing to properly regulate the exercise of conscientious objection and found a violation of the teenager's right to liberty when the government placed her under state custody for the primary purpose of preventing the abortion. In addressing the state's false claims that the removal from her mother's custody was based on belief that her mother was coercing her to undergo the abortion, the Court noted that regardless, states must recognise adolescent autonomy and decision making around reproductive choices. The Court held that '[i]t is of the view that legal guardianship cannot be considered to automatically confer on the parents of a minor the right to take decisions concerning the minor's reproductive choices, because proper regard must be had to the minor's personal autonomy in this sphere. This consideration applies also in a situation where abortion is envisaged as a possible option.' It is the first time any international or regional human rights body has addressed this issue in an individual complaint. The Court further considered the minor's entire experience, especially having regard to her young age, and held that the government had infringed her right to be free from inhuman or degrading treatment.

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CHAPTER 5

ACCOUNTABILITY FOR NON-FULFILMENT OF HUMAN RIGHTS OBLIGATIONS: A KEY STRATEGY FOR REDUCING MATERNAL MORTALITY AND DISABILITY IN SUB-SAHARAN AFRICA

Onyema Afulukwe-Eruchalu

Summary

Complications with pregnancy and childbirth constitute a major cause of disability and mortality for women in Africa – a result of multiple violations of a wide range of human rights. Although international and African regional human rights mechanisms are increasingly framing maternal disability and mortality as human rights issues and crafting laws and commitments that take this framework into account, far too many preventable deaths and injuries continue to occur. Sub-Saharan Africa continues to have the highest maternal mortality ratios in the world despite recent statistics that point to global reductions in the number of maternal deaths and maternal mortality ratio. This chapter contends that African states should be held accountable for failing to implement these human rights obligations and making safe motherhood a reality for women in the sub-region. It advances litigation as a key accountability strategy and analyses how it has been and could be further used. Additionally, it assesses how applicable human rights laws and initiatives could be deployed to promote accountability. It also discusses the role of national human rights institutions in ensuring accountability for poor maternal health outcomes, including through public inquiries. In concluding, the chapter reiterates that governments must implement pertinent human rights obligations in order to effectively address the prevalence of maternal disability and death in sub-Saharan Africa.

1 Introduction

Complications with pregnancy and childbirth constitute a major cause of disability and mortality for women in Africa.¹ Common direct causes are haemorrhage, high blood pressure, obstructed labour, infections, and

1 WHO 'Health statistics and information systems' <http://www.who.int/healthinfo/statistics/indmaternalmortality/en/index.html> (accessed 19 August 2012).

unsafe abortion.² These direct factors are mostly sustained by underlying political and socio-economic factors which create obstacles that limit access to maternal healthcare. Obstacles such as high user fees and informal fees, bad roads, long distances and a lack of reliable transportation to the hospital, and inadequately equipped and staffed hospitals, generate circumstances that daily expose pregnant women to unnecessary disability and death.³ Additional obstacles, such as inadequate access to family planning and restrictive laws on abortion, also increase women's exposure to maternal disability and mortality.⁴ These obstacles constitute or point to violations of human rights guarantees.⁵

Although international and African regional human rights laws and mechanisms are increasingly framing maternal disability and mortality as human rights issues and crafting laws that take this framework into account,⁶ far too many preventable deaths and injuries continue to occur in the region. Sub-Saharan Africa continues to have the highest level of maternal deaths in the world, in spite of recent statistics that point to global reductions in the numbers of maternal deaths and maternal mortality ratio (MMR). According to the most recent statistics from the World Health Organization (WHO) in its report 'Trends in maternal mortality: 1990 to 2010', of the approximately 287 000 maternal deaths that occurred in 2010, 99 per cent of them were in the developing world, with 85 per cent of these deaths occurring in sub-Saharan Africa and Southern Asia.⁷ Specifically, 56 per cent of all maternal deaths occur in sub-Saharan Africa,⁸ and 10 per cent of the maternal deaths in the sub-region were HIV-related – the highest HIV-related maternal death percentage in the world.⁹ Of the 40 countries that had high MMR, the first ten on the list were all in sub-Saharan Africa: Chad, Somalia, Central African Republic, Sierra Leone, Burundi, Guinea-Bissau, Liberia, Sudan, Cameroon and Nigeria. Indeed, 36 of the 40 countries were from the African region.¹⁰

WHO statistics indicate that at the odds of 1 in 39, sub-Saharan Africa has the world's highest adult lifetime risk of maternal death – the probability that a 15 year-old female will eventually die from a maternal cause.¹¹ This probability is even higher in some countries in the sub-

2 WHO 'Maternal health' http://www.who.int/topics/maternal_health/en/ (accessed 20 August 2012).

3 See eg Center for Reproductive Rights *Broken promises: Human rights, accountability and maternal death* (2008); WHO 'Making pregnancy safer – Maternal mortality' http://www.who.int/making_pregnancy_safer/topics/maternal_mortality/en/index.html (accessed 20 August 2012).

4 WHO (n 2 above).

5 Discussed in detail in subsequent sections of this chapter.

6 Discussed in detail in subsequent sections of this chapter.

7 WHO *Trends in maternal mortality: 1990 to 2010* (2012) 1 22.

8 As above.

9 WHO (n 2 above) 1.

10 WHO (n 2 above) 1 22. Note that the statistics were derived from data which were obtained from 180 countries.

11 WHO (n 2 above) 22.

region.¹² To put the enormity of the situation in further perspective, the adult lifetime risk in Southern Asia is 1 in 160.¹³ Even more telling, the same risk in developed countries is estimated at 1 in 3800.¹⁴ Moreover, for each maternal death, approximately 20 other women experience serious and often permanent pregnancy-related injuries.¹⁵ These injuries, which include damage to reproductive organs, severe anaemia, post-partum disability (such as obstetric fistula), chronic pain and infertility, carry serious physical and mental health, social, and economic consequences for affected women and jeopardise the well-being of their children and other family members.¹⁶ With each maternal death, the risk that any child left behind, who is six weeks or less, will die before the age of two, is ten times higher than that of a child whose mother is alive.¹⁷ The higher risk of death extends to the older surviving children who are more likely to lack access to sufficient healthcare. Such children are also more likely not to receive adequate education.¹⁸

States have a three-fold obligation to respect, protect and fulfil human rights guarantees. Generally, states' obligation to *respect* human rights requires them to refrain from interfering with its enjoyment. The obligation to *protect* imposes a duty on states to take steps to prevent private actors from interfering with the enjoyment of human rights guarantees, while the obligation to *fulfil* compels states to undertake legislative, judicial, administrative and other appropriate measures to ensure the realisation of human rights.¹⁹ This chapter argues that impunity for the non-fulfilment of human rights commitments by African governments sustains preventable maternal mortality and disability. It also identifies litigation of violations as an important strategy for reducing these injuries and deaths. It assesses states' implementation of human rights obligations and the core human rights standards developed by treaty-monitoring bodies (TMBs) and reiterated in recent global efforts to improve maternal health. It then analyses recent decisions – global and comparative – dealing with maternal

12 Eg, Chad and Somalia had the world's highest adult lifetime risk at 1 in 15 and 1 in 16, each; Nigeria, which has one of the strongest economies in the region, had a lifetime risk of 1 in 29 (n 7 above) 23 and 34. Statistics from the previous year – 2009 – showed that a woman in Nigeria had a 1-in-18 lifetime risk of dying in childbirth or from pregnancy-related causes. See United Nations Children's Fund (UNICEF) *The state of the world's children 2009* (2008) 148.

13 WHO (n 2 above) 22.

14 As above.

15 WHO 'Why do so many women still die in pregnancy and childbirth?' <http://www.who.int/features/qa/12/en/index.html> (accessed 16 August 2012).

16 United Nations Population Fund (UNFPA) 'Maternal morbidity' <http://www.unfpa.org/public/mothers/pid/4388> (accessed 1 August 2012).

17 WHO Regional Office for Africa *The health of the people: The African regional health report* (2006) 19.

18 As above.

19 See ESCR Committee General comment 14: The Right to the highest attainable standard of health (art 12) (22nd session, 2000), in *Compilation of general comments and general recommendations by human rights treaty bodies 9-12*, paras 33-36 E/CN.4/2000/4, for an in-depth explanation of the three-fold nature of human rights obligations imposed on states within the context of the right to health.

mortality and disability, both to highlight the serious consequences of the failure to fulfil these obligations as well as to draw attention to how litigation can be an effective tool for giving meaning to the normative content of human rights standards by holding governments accountable. It also discusses public inquiries as a strategy for supporting and strengthening litigation.

2 Failure to fulfil human rights standards applicable to maternal mortality and disability

Several human rights guarantees, such as the rights to life, health, equality, non-discrimination and information are pertinent to safe motherhood.²⁰ United Nations (UN) and regional TMBs charged with interpreting these guarantees have developed their content to clarify states' obligations. These standards, taken together, constitute a yardstick for measuring the sufficiency of steps taken by states to reduce maternal disability and mortality. They impose legally-enforceable obligations on states for which they can be held accountable.

The discussion below focuses on these human rights standards and on the obligations they impose, many of which governments have not fulfilled.

2.1 International and regional human rights framework

2.1.1 Right to life

At the international level, states have a legal obligation to protect the right to life guaranteed under the International Covenant on Civil and Political Rights (ICCPR).²¹ In keeping with this obligation, they are required to make all necessary efforts to increase life expectancy.²² This goes beyond their obligation to merely refrain from taking any action that would violate the right to life and, instead, imposes a positive obligation to take all necessary action to protect this right. TMBs that monitor states' compliance with relevant treaties have not only expressed concern about high MMR in African countries, but have highlighted their causes,²³ putting states on notice about what steps they must take.

20 R Cook *et al* *Advancing safe motherhood through human rights* (2001) 6.

21 Art 6.

22 Human Rights Committee, General Comment 6: art 6 (16th session, 1982) para 5, UN Doc HRI/GEN/1/Rev5 .

23 See Concluding Observations of the Human Rights Committee on Zambia para 18, UN Doc CPR/C/ZMB/CO/3 (2007); Concluding Observations of the CEDAW Committee on Eritrea, para 22 UN Doc CEDAW/C/ERI/CO/3 (2006); Concluding Observations of the CRC Committee on Benin, para 51, UN Doc CRC/C/BEN/CO/2 (2006).

TMBs have confirmed that the lack of access to emergency obstetric care and other reproductive health services escalates the risk of maternal death.²⁴ They have also reiterated that barriers to access to reproductive healthcare, including costly treatment expenses with regard to pregnancy,²⁵ and poor access to antenatal services,²⁶ increase women's risk of maternal mortality and disability. They have mandated states to reduce maternal death rates,²⁷ by providing sufficient resource allocation,²⁸ enhancing women's access to maternal healthcare services,²⁹ providing skilled attendants during delivery,³⁰ developing awareness-raising campaigns on the importance of family planning,³¹ and providing antenatal care.³²

At the regional level, the African Charter on Human and Peoples' Rights (African Charter) guarantees the right to life in article 4. In similar terms, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol) states in article 4(1) that '[e]very woman shall be entitled to respect for her life'.³³ The African Commission on Human and Peoples' Rights (African Commission), charged with monitoring states' implementation of both the African Charter and the African Women's Protocol, has expressed concern at the high occurrence of maternal death, for instance in Nigeria,³⁴ and has mandated it to adopt suitable measures to reduce maternal death.³⁵

There is well-documented evidence to show that governments have not taken adequate action to protect the right to life in this regard; a wide range of political and socio-economic factors, as well as financial, institutional and infrastructural barriers, such as long distances to hospitals, bad roads and a lack of reliable transportation, which they have

24 See Concluding Observations of the Human Rights Committee on Mali, para 14, UN Doc CCPR/CO/77/MLI (2003); Concluding Observations of the CEDAW Committee on Burundi, para 36, UN Doc CEDAW/C/BDI/CO/4 (2008).

25 See Concluding Observations of the CRC Committee on Central African Republic, para 54 UN DocCRC/C/15/Add.138 (2000).

26 As above.

27 See Concluding Observations of the CRC Committee on Niger, para 47(b), UN Doc CRC/C/15/Add.197 (2002).

28 See Concluding Observations of the CRC Committee on Djibouti, para 42, UN Doc CRC/C/15/Add.131 (2000).

29 See Concluding Observations of the CRC Committee on Mozambique, para 51(b), UN Doc CRC/C/15/Add.172 (2002).

30 See Concluding Observations of the CRC Committee on Botswana, para 49, UN Doc CRC/C/15/Add.242 (2004).

31 See Concluding Observations of the CRC Committee on Zambia, para 47(b), UN Doc CRC/C/15/Add.206 (2003).

32 As above.

33 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol) 32 (11 July 2003).

34 Concluding Observations of the African Commission on Human and Peoples' Rights on the 3rd Periodic Report of the Federal Republic of Nigeria, 44th session para 24 (2008).

35 Concluding Observations (n 34 above) para 36.

a duty to address and which still contribute to preventable maternal deaths.³⁶ As a result, Africa continues to account for most of the world's maternal deaths.

2.1.2 Right to health

The right to health is entrenched in international human rights law, and particularly extensively under article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR).³⁷ The UN Committee on Economic, Social and Cultural Rights (ESCR Committee), which oversees states' implementation of the ICESCR, has elaborated that the right to health includes a right to maternal, child and reproductive health, and has asked states to improve maternal and reproductive health services, including access to family planning, pre- and post-natal care, and emergency obstetric care.³⁸ It has further stated that fulfilling the right to health requires that governments guarantee to all its availability, accessibility, acceptability and quality.³⁹ The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), which also guarantees the right to health under article 12, obligates states to ensure that women access adequate services in connection with pregnancy, confinement and the post-natal period.⁴⁰

At the regional level, the African Charter obligates states to guarantee to every individual the right to health.⁴¹ It also mandates them to ensure that this includes access to medical attention during sickness.⁴² Likewise, article 14 of the African Women's Protocol requires states to promote women's right to health, specifically recognising that this includes their sexual and reproductive health, and stresses that this right calls for the provision of adequate, affordable and accessible health services.⁴³ In article 14(2)(b), it expressly obligates states to establish and strengthen existing pre-natal delivery, and post-natal health services⁴⁴ while article 14(2)(c) charges states to legalise medical abortion in cases of sexual assault, rape, incest, or where the woman's mental and physical health is at risk, or the life of the woman or the foetus is at risk. The African

36 See Center for Reproductive Rights (n 3 above); Center for Reproductive Rights *Claiming our rights: Surviving pregnancy and childbirth in Mali* (2003); Center for Reproductive Rights *Failure to deliver: Violations of women's human rights in Kenyan health facilities* (2007) Human Rights Watch *Stop making excuses: Accountability for maternal health care in South Africa* (2011); Amnesty International *Giving life, risking death: Maternal mortality in Burkina Faso* (2009).

37 ESCR Committee <http://www2.ohchr.org/english/law/cescr.htm>.

38 ESCR Committee (n 19 above) para 14.

39 ESCR Committee (n 19 above) para 12; P Hunt & J B de Mesquita *Reducing maternal mortality: The contribution of the right to the highest attainable standard of health* (2010) 6.

40 Convention on the Elimination of All Forms of Discrimination Against Women.

41 Art 16.

42 As above.

43 Art 14(2)(a) African Women's Protocol.

44 Art 14(2)(b).

Women's Protocol stands out as the first legally-binding human rights instrument to expressly articulate women's reproductive rights as human rights, and to expressly guarantee a woman's right to control her fertility - an important factor in reducing the risk of maternal injury or death. It remains the only treaty at the international or regional level that explicitly guarantees the right to abortion under specified circumstances. Despite these broad protections, which could address the factors that increase the risk of maternal mortality, many governments in the sub-region have either not ratified or implemented it. Consequently, unsafe abortion is still a leading cause of maternal mortality and disability in sub-Saharan Africa, and poor maternal health outcomes, easily preventable with timely and adequate pre- and post-natal care, continue to be tragically common. The failure to take the required steps to ensure the right to health means that barriers impacting the availability, accessibility, acceptability and quality of maternal healthcare services remain.

2.1.3 Right to non-discrimination

At the international level, the right to non-discrimination is provided for by article 2(1) of ICCPR. It mandates states to guarantee to all individuals the rights in the Covenant 'without distinction of any kind such as race, colour, sex ...'.⁴⁵ Article 26 of ICCPR also requires states to make certain that all persons are equal before the law and are entitled without any discrimination to the equal protection of the law. The right is further guaranteed by the Convention on the Rights of the Child (CRC)⁴⁶ and CEDAW, which proscribes discrimination specifically in the field of healthcare,⁴⁷ and mandates governments to provide appropriate maternal healthcare services.⁴⁸ At the regional level, both the African Charter⁴⁹ and the African Women's Protocol require states to eliminate discrimination against women.⁵⁰

The obligations imposed by the right to non-discrimination are immediate and transcend beyond this right to the manner in which other rights are fulfilled.⁵¹ Its immediate nature requires that even the poorest of countries, with the least resources, fulfil this right instantaneously, particularly for the most vulnerable amongst them. Yet, as the statistics in the introduction shows, some of the wealthiest countries in the region have the world's highest incidence of maternal death. For instance, Nigeria, which has one of the strongest economies in the sub-region and is one of

45 Art 2(1).

46 As above.

47 Art 12(1).

48 Art 12(2).

49 Art 18(3).

50 Art 2.

51 ESCR Committee General Comment 20, non-discrimination in economic, social and cultural rights, para 7, UN Doc E/C.12/GC/20 (2009).

the world's major petroleum exporters, was one of two countries that accounted for one-third of maternal deaths worldwide, and was tenth on the list of the 40 countries considered to have a high MMR.⁵² In the very recent past, it had the second-highest number of maternal death in the world, due largely to violations of multiple human rights,⁵³ sustained by a lack of political will to address the problem.⁵⁴ WHO identified South Africa as one of five countries in the region which, between 1990 and 2008, had the highest percentage increases in MMR, with an increase of 80 per cent.⁵⁵ The country's MMR went from approximately 150/100 000 to 625/100 000 within this time frame – over a four-fold increase – due, as in the case of Nigeria, to high levels of human rights violations. The latest statistics from WHO show that between 1990 and 2010, South Africa was one of the 11 countries globally, and one of eight regionally, that made 'no progress' towards improving maternal health.⁵⁶

The far-reaching nature of obligations under the right to non-discrimination means that all other rights must be guaranteed on an equal basis to all. Accordingly, barriers that prevent women from accessing maternal healthcare services, which only women need, violate not only their right to health, but also their rights to non-discrimination on the basis of sex, and equality.

2.1.4 Right to information

At a global level, the right to information is protected in ICCPR.⁵⁷ It is also guaranteed by CEDAW.⁵⁸ Moreover, article 16(1)(e) of CEDAW requires states to guarantee women the right to decide on the number and spacing of their children and to have access to the information required to exercise this right. Clarifying the connection between this right and maternal health, the CEDAW Committee has stated that low access to family planning services and information heightens women's susceptibility to maternal mortality.⁵⁹ Likewise, the CRC Committee has mandated states to make available to adolescents information on contraceptives,⁶⁰ and to

52 WHO (n 7 above) 1 & 23. It defines 'high MMR' as greater than or equal to 300 maternal deaths per 100 000 live births.

53 See Center for Reproductive Rights (n 3 above).

54 J Shiffman 'Generating political priority for maternal mortality reduction in five developing countries' (2007). 97 *American Journal of Public Health* 798.

55 See WHO *Trends in maternal mortality: 1990 to 2008* (2010) 19, for information on the five countries with the highest percentage increases in MMR. See Human Rights Watch (n 36 above) for the data that confirms that it was at least a four-fold increase within the specified timeframe, and for details about the implications for women.

56 WHO (n 7 above) 44.

57 Art 19(2) ICCPR.

58 Arts 10(h) & 14(2)(b).

59 Concluding Observations of the Human Rights Committee on Kenya, para 14, UN Doc CCPR/CO/83/KEN (2005).

60 CRC Committee General comment 4: Adolescent health and development in the context of the Convention on the Rights of the Child (33rd session, 2003), para 28, UN Doc HRI/GEN/1/Rev7.

ensure access to information necessary for their health and development.⁶¹ At a regional level, the right to information is guaranteed by the African Charter in article 9(1), and the African Women's Protocol in article 14.

The failure to ensure this right constitutes a major reason why women experience multiple pregnancies due to a lack of awareness and information about family-planning services, increasing their risk of maternal morbidity or disability.

2.2 National human rights framework

The rights discussed above are further protected as fundamental human rights under the constitutions of African countries, except that in some, the right to health is not guaranteed as a fundamental human right and instead may be identified as a national objective and deemed non-justiciable.⁶² Uganda serves as a pertinent example. The fundamental rights section of its Constitution does not guarantee the right to health. However, the National Objective and Principles of State Policy contained in the Constitution requires the government to ensure access to health services and to provide basic medical services.⁶³ This notwithstanding, violations of the right to health can be legally enforced by the courts, given that they invariably lead to the violation of other rights which have traditionally been deemed justiciable. For instance, as noted above, unnecessary delays in accessing maternal healthcare implicate not just the right to health, but the right to non-discrimination. In addition, certain constitutional rights provisions regarding specific groups, such as children, may include references to access to health for such groups.

Most countries have also developed legislative frameworks to govern access to healthcare services, including maternal healthcare services. These range from general provisions, such as national health guidelines and policies, which require governments to ensure access to health services and to uphold a broad range of health-related rights, to healthcare provider-specific provisions, such as patients' charters and professional codes of conduct for pharmacists, nurses, midwives and medical practitioners, which impose similar obligations. Uganda again provides a good example. Its National Adolescent Health Policy calls for the ratification, and incorporation into national law, of international and regional laws that deal with the health of adolescents.⁶⁴ In its 2009 Patients' Charter, the government reiterates its commitment to ensuring

61 CRC Committee (n 62 above) para 39.

62 See, eg, Constitution of the Federal Republic of Nigeria, 1999 sec 17(3)(d).

63 Republic of Uganda Constitution, 1995 XIV.

64 Uganda Ministry of Health, National Adolescent Health Policy 2004, 31-32.

access to high-quality healthcare services and to progressively realising the right to health.⁶⁵

Additionally, the global and regional guarantees of the right to health, discussed above, are all justiciable at those levels and compel governments to uphold this right.

3 Failure to implement global and regional efforts to combat preventable maternal disability and mortality from a human rights perspective

As previously highlighted, sub-Saharan Africa continues to have the highest level of maternal deaths in the world.⁶⁶ A number of global efforts aimed at addressing the problem from a human rights perspective outline not just the actions governments must take, but also specify a timeframe within which they must take them – in the realisation that African governments have had sufficient time to implement the requisite human rights standards but have failed to do so. Despite the sense of urgency behind these efforts, African governments have persistently failed to uphold their obligations. For instance, although the UN adopted eight Millennium Development Goals (MDGs) in September 2000, with MDG 5 targeting maternal health,⁶⁷ as of 2010, among countries that had MMR which was greater than or equal to 100/100 000 in 1990, only one country in the sub-region – Equatorial Guinea – has met, and just two – Eritrea and Egypt – are on track to meet MDG 5, which requires states to reduce their MMR⁶⁸ by 75 per cent by 2015.⁶⁹ Based on the most recent WHO statistics, nine of the 14 countries that have made ‘insufficient progress’ in reducing their MMR are in Africa; likewise, eight of the 11 that have made ‘no progress’ are from the region.⁷⁰

With the MDGs’ deadline fast approaching, the human rights community is increasingly making even more urgent efforts to force governments to take the necessary action. At the international level, the UN Human Rights Council has adopted three resolutions on maternal

65 The Republic of Uganda, Patients’ Charter, Ministry of Health, Department of Quality Assurance, December 2009.

66 See introductory section.

67 Further information can be obtained at <http://www.un.org/millenniumgoals/bkgd.shtml> (accessed 11 August 2012.)

68 WHO (n 7 above) 2 27.

69 United Nations Millennium Development Goals, ‘Improve maternal health’ <http://www.un.org/millenniumgoals/maternal.shtml> (accessed 19 August 2012).

70 Burundi, Central African Republic, Djibouti, Gabon, Guinea-Bissau, Kenya, Sierra Leone, Sudan and Zambia made ‘insufficient progress’, while Botswana, Chad, Congo, Namibia, Somalia, South Africa, Swaziland and Zimbabwe made ‘no progress’. See WHO (n 7 above) 37-45.

mortality every year since 2009: The first was adopted on 17 June 2009;⁷¹ the second on 27 September 2010;⁷² and the third on 28 September 2011;⁷³ each new resolution necessary because preventable maternal deaths and injuries continue unabated, and all three singularly focused on ultimately compelling states to reduce poor maternal health outcomes by implementing human rights standards.

At the regional level, the African Commission adopted a resolution on maternal mortality in 2008, which called on governments to address maternal mortality by fulfilling the pledge to allocate 15 per cent of their national budgets to the health sector, and ensuring that strategies to reduce maternal mortality adopt a human rights-based approach.⁷⁴ In May 2009, the African Union (AU) initiated the region-wide Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA), which requires member states to identify and implement concrete measures to improve women's health and to reduce maternal mortality. Most states in the region have still not addressed the role that inadequate resource allocation to the health sector plays in impeding access to maternal healthcare services. Although CARMMA has been in place for over two years, in reality, it has provided very limited protection for women in sub-Saharan Africa.

Without a concerted move to hold governments accountable for not fulfilling their commitments, these unnecessary deaths will continue.

4 Key strategies for securing accountability for preventable maternal disability and death

Various forms of accountability strategies for the violation of the right to health, in general, and specifically for preventable maternal deaths, exist.⁷⁵ Two of these strategies, litigation and public inquiries by national human rights institutions (NHRIs), form the focus of this chapter.

71 Human Rights Council, Resolution 11/8 'Preventable maternal mortality and morbidity and human rights' A/HRC/RES/11/8.

72 Human Rights Council 'Preventable maternal mortality and morbidity and human rights: Follow-up to Council resolution 11/8' paras 1 & 10.

73 Human Rights Council, Resolution 18/2 'Preventable maternal mortality and morbidity and human rights' A/HRC/RES/18/2.

74 African Commission on Human and Peoples' Rights, Resolution on maternal mortality in Africa, ACHPR/Res.135 (XXXXIII) 08.

75 For further reading on using accountability strategies to secure the right to health, see H Potts *Accountability and the right to the highest attainable standard of health* (2008); Cook *et al* (n 20 above).

4.1 Litigation

Emerging and pending decisions on maternal mortality and morbidity show that courts and other bodies are decisively compelling states to fulfil their commitments. While most of the cases analysed below come from other regions, the underlying circumstances are similar to those faced by women in the sub-region. As such, they identify windows of opportunity for litigating comparable cases in the sub-region and could be relied on as persuasive precedents.

4.1.1 International

Alyne da Silva Pimentel v Brazil

In a historic decision delivered by the CEDAW Committee in August 2011, states' obligations to ensure to women adequate access to maternal health services, as a fundamental right, has been clearly affirmed.⁷⁶

On 11 November 2002, Alyne, a Brazilian woman of African descent who was then six months pregnant with her second child, went to a local health centre to complain of vomiting and severe abdominal pain.⁷⁷ The doctor she consulted did not perform any tests, and sent her home with vitamins and medicine. She returned two days later, still having severe pain, and only then did the doctors admit her and established the absence of a foetal heartbeat.⁷⁸ Alyne had a stillbirth but, against prevailing medical standards which prescribe that surgery should be performed urgently to ward off any bleeding or infection, she did not receive surgery for over 14 hours.⁷⁹ After surgery, she had severe haemorrhaging and low blood pressure, yet the doctors did not decide to transfer her to a hospital with better-equipped facilities until her condition had worsened.⁸⁰ When they did attempt a transfer, only one hospital – a municipal hospital – had space.⁸¹ The local health centre did not own an ambulance and the municipal hospital, which owned only one, would not use it to facilitate the transfer.⁸² Alyne's family attempted but was unable to arrange for a private ambulance. During the resulting eight-hour delay in getting her to the municipal hospital, she fell into a coma.⁸³ When she was eventually

76 Communication 17/2008, *Alyne da Silva Pimentel v Brazil*, CEDAW Committee 10 August 2011 UN Doc CEDAW/C/49/D/17/2008.

77 *Alyne da Silva Pimentel* (n 79 above) paras 2.1-2.14.

78 Paras 2.3-2.4.

79 Para 2.6.

80 Paras 2.6-2.8.

81 Para 2.8.

82 As above.

83 As above.

transported to the municipal hospital, her medical records were not sent along.⁸⁴ Ultimately, Alyne was left in the hallway of an emergency room in the municipal hospital until she died on 16 November 2002, 21 hours later.⁸⁵ Her daughter was five years old at the time.⁸⁶

Due to the undue delays in obtaining a remedy in Brazil, substantiated through evidence that women who belong to vulnerable groups in Brazil, such as those who are poor and those who are of African descent, stand little chance of obtaining a remedy in the courts,⁸⁷ the case was initiated before the CEDAW Committee in 2007. The main claims were that the government of Brazil had violated Alyne's rights to life, health and legal redress, guaranteed by its Constitution as well as international human rights treaties, including CEDAW.⁸⁸ The claims highlighted the poor quality of care at an inadequately-equipped health centre, the delay in recommending a referral, the lack of space at better-equipped hospitals, the lack of reliable transportation to effect the transfer, the failure to transfer her medical records along with her to ensure appropriate and timely care, and the lack of access to emergency obstetric care as the main factors that caused her death.

In its decision, the CEDAW Committee determined that Alyne died principally due to the low-quality care she received.⁸⁹ It also found that Brazil had violated Alyne's right to health under article 12 of the Convention. Responding to the government's assertion that it could not be held responsible for the actions of a private health institution, the Committee emphasised that governments could not relinquish their responsibilities by outsourcing medical services. Instead, they must supervise and regulate the health practices and policies of private health facilities.⁹⁰ It also found that Brazil had violated Alyne's right to access to justice guaranteed in article 2(c), due to the delays and ultimate lack of redress. It further determined that the government had failed in its obligation to exercise due diligence in ensuring that private healthcare providers deliver sufficient care as provided for in article 2(e) of the Convention.⁹¹ It also held that Alyne's right to non-discrimination, defined by article 1, had been violated.⁹²

The Committee mandated Brazil to provide reparation to Alyne's family, including financial compensation 'commensurate with the gravity of the violations against her',⁹³ and to '[e]nsure women's rights to safe

84 *Alyne da Silva Pimentel* (n 79 above) para 2.10.

85 Paras 2.12 & 3.6.

86 Para 3.14.

87 Para 5.3.

88 Paras 3.1-3.15; see arts 1, 2 & 12 of CEDAW.

89 *Alyne da Silva Pimentel* (n 79 above) paras 7.3-7.5.

90 Para 7.5.

91 Para 8.

92 As above.

93 *Alyne da Silva Pimentel* (n 79 above) para 8.1.

motherhood and affordable access for all women to adequate emergency care'.⁹⁴ It further urged the government to '[p]rovide adequate professional training for health workers, especially on women's reproductive health rights, including quality maternal treatment during pregnancy and delivery, as well as timely emergency obstetric care'.⁹⁵ It also urged Brazil to provide effective remedies for violations of women's reproductive rights,⁹⁶ to make certain that health centres respect reproductive healthcare standards,⁹⁷ to punish providers who violate women's reproductive rights,⁹⁸ and to implement a national law aimed at reducing maternal mortality and disability.⁹⁹

The case, the first of its kind to be brought before any international TMB, clearly confirms governments' duty to address preventable maternal death. It also establishes state responsibility for private healthcare facilities, and has far-reaching implications for women in the sub-region.

4.1.2 Regional

In an unprecedented decision, the Inter-American Court of Human Rights (Inter-American Court) determined that Paraguay was responsible for maternal deaths within an indigenous community in the country.

Inter-American Court of Human Rights: Xákmok Kásek Indigenous Community v Paraguay

This case was first brought before the Inter-American Commission of Human Rights (Inter-American Commission) in 2001.¹⁰⁰ It ultimately submitted the case to the Inter-American Court in 2009 when the state failed to implement its recommendations.¹⁰¹ In the Commission's submission, it noted that the case focused on Paraguay's non-fulfilment of its obligation to ensure to the Xákmok Kásek Indigenous Community (Community) their right to their ancestral property.¹⁰² This failure had subjected the Community to limited access to food, sanitation and medical care, and threatened their survival and integrity.¹⁰³ The Community had contended that most women gave birth at home due to unreliable

94 Para 8.2(a).

95 Para 8.2(b).

96 Para 8.2(c).

97 Para 8.2(d).

98 Para 8.2(e).

99 Para 8.2(f).

100 *Xákmok Kásek Indigenous Community v Paraguay*, Inter-American Commission of Human Rights. Application with the Inter-American Court of Human Rights, para 10, <http://www.cidh.oas.org/demandas/12.420percent20Xakmokpercent20Kasekpercent20Paraguaypercent203jul09percent20ENG.pdf> (accessed 12 August 2012).

101 *Xákmok Kásek Indigenous Community v Paraguay* (n 100 above) para 69.

102 Para 1.

103 Para 5(a).

transportation and long distances to hospitals,¹⁰⁴ and recounted a history of being denied access to medical care,¹⁰⁵ which was exacerbated by being poor.¹⁰⁶ The Community had provided the Commission with a list of its members who had died from preventable causes because they could not access sufficient health services, among whom was Remigia Ruíz, who died during childbirth in 2005 at the age of 38.¹⁰⁷

In its submission to the Court, the Commission recalled the Court's statements with respect to the right to life, noting that, in highlighting the distinction between the negative and positive obligations of the state,¹⁰⁸ the Court had determined that the state should not only ensure 'that no person shall be deprived of his life arbitrarily (negative obligation)', but also that '[s]tates shall adopt appropriate measures to protect and preserve the right to life (positive obligation) of all those who are under its jurisdiction'.¹⁰⁹ The Commission also referred to the Court's statement in a previous decision that, while 'a state cannot be held responsible for all situations in which the right to life is at risk', the positive obligation would attach if 'at the moment of the occurrence of the events, the authorities knew or should have known about the existence of a situation posing an immediate and certain risk to the life of an individual ... and that the necessary measures were not adopted ... which could be reasonably expected to prevent or avoid such risk'.¹¹⁰ It concluded that the state knew that the Community lacked access to adequate health services and lived under abject poverty,¹¹¹ and that the Community had high levels of preventable diseases.¹¹² It further noted that the state had not shown that it made an effort to address these problems.

The Commission discussed the importance of the obligation to provide reparations,¹¹³ stressing that they are 'crucial to ensuring that justice is done'.¹¹⁴ It further emphasised that reparation called for full restitution¹¹⁵ and that, in situations where it was impossible to provide this remedy, it was the Court's role to impose measures to, among other things, 'ensure that the violated rights are respected'.¹¹⁶ It declared that preventing future violations constituted a crucial reason for providing reparations.¹¹⁷ It urged the Court to mandate the state to immediately provide, among other

104 Para 88.

105 Paras 101-102.

106 Para 106.

107 Para 103.

108 Paras 182-184.

109 Para 181.

110 Para 184.

111 Para 185.

112 Para 190.

113 Paras 252-258.

114 Para 257.

115 As above.

116 *Xákmok Kásek Indigenous Community v Paraguay* (n 100 above) para 258.

117 As above.

things, healthcare services to the Community,¹¹⁸ and to take appropriate steps to prevent future violations.¹¹⁹

The Inter-American Court delivered its decision in August 2010, and determined that the state had contravened members of the Community's rights to life, personal integrity, humane treatment and non-discrimination, among other rights. The Court reiterated its statements – relied on by the Commission – regarding the negative and positive obligations that states have with respect to the right to life.¹²⁰ It confirmed that a state would only incur responsibility for violating the right to life if a situation it knew about and allowed to exist caused death.¹²¹ It determined that the state knew of the immediate risks to the Community's right to life and should have prevented them, and was thus responsible for Remigia Ruíz's death.¹²² Focusing on the factors that led to her death, it mandated the state to 'put in place adequate healthcare policies that allow it to offer care through personnel who are adequately trained to handle births, policies to prevent maternal mortality with adequate prenatal and postpartum care, and legal and administrative instruments regarding healthcare policy that allow for the adequate documentation of cases of maternal mortality'.¹²³ The Court also ordered Paraguay to 'establish immediately a system of communication in the said settlement that allows the victims to contact the competent healthcare authorities for attention to emergency cases [and] provide transportation for the individuals who require this'.¹²⁴

The Court's statements regarding state responsibility for violating the right to life is very relevant to the African region, where virtually all governments have been put on notice that the dire state of the infrastructure and inadequate resource allocation cause and contribute to preventable maternal injuries and deaths.

4.1.3 National – African and comparative jurisdictions

For the first time in the sub-region, attempts have been made to hold a government accountable for preventable maternal deaths.

118 Para 291(d).

119 Para 291(i).

120 *Xákmok Kásek Indigenous Community v Paraguay* IACHR (24 August 2010) Ser C No 214 para 188, http://www.corteidh.or.cr/docs/casos/articulos/seriec_214_ing.pdf (accessed 12 August 2012).

121 *Xákmok Kásek Indigenous Community v Paraguay* (n 123 above) para 227.

122 Para 234.

123 Para 233.

124 Para 306.

Uganda

Like most countries in the sub-region, Uganda has a high incidence of preventable maternal mortality and disability. WHO indicates that between 2005 and 2009, Uganda had a maternal mortality ratio of 440 per 100 000 live births¹²⁵ – a ratio that must be reduced to 132 deaths per 100 000 live births for the country to meet MDG 5.¹²⁶ For each maternal death in Uganda, at least six women experienced serious maternal injuries.¹²⁷ The core reasons include the well-known barriers that hinder women from seeking timely maternal health services, the high number of women giving birth away from the hospital, and the lack of access to skilled attendants during childbirth.¹²⁸ Women who are able to access maternity care are still susceptible to preventable injuries and death, due to institutional barriers, such as inadequately-equipped and understaffed hospitals.¹²⁹ The government's efforts to address the problem have been inadequate, evident in the grossly-insufficient allocation of funds to health, in general, and maternal health, in particular.¹³⁰

In July 2011, the Constitutional Court of Uganda started hearing a case about the deaths of Sylvia Nabalowa and Jennifer Anguko, while giving birth in public hospitals.¹³¹ When Sylvia, a mother of seven and a farmer, who was pregnant with twins, went into labour on 10 August 2009, she went to a health centre but did not receive medical care because the only midwife there was not available. She went to another health facility where they delivered her of one baby and decided to transfer her to a superior facility that could deliver the second baby safely. However, Sylvia and her husband were left to arrange for a means of transportation to that hospital because they did not have an ambulance. When she eventually arrived at the hospital, which was a long distance away, she was asked to pay a fee to purchase a 'Mama kit' containing supplies for the delivery. She could not afford the fee. Sylvia and the second baby died at the hospital without receiving care.

125 UNICEF & WHO 'Statistics: Uganda' http://www.unicef.org/infobycountry/uganda_statistics.html#70 (accessed 20 April 2012).

126 CEDAW Committee, *Consideration of combined 4th, 5th, 6th and 7th reports for Uganda*, UN Doc CEDAW/C/UGA/7 (25 May 2009) 133.

127 UNFPA *Maternal mortality update 2002: A Focus on emergency obstetric care 6* (2003), http://www.unfpa.org/upload/lib_pub_file/201_filename_mmupdate-2002.pdf (accessed 16 August 2012).

128 PP Okong *et al* 'Audit of severe maternal morbidity in Uganda: Implications for quality of obstetric care' (2007) 85 *Acta Obstetrica et Gynecologica Scandinavica* 797-804.

129 As above.

130 S Koenig & B Atim *German Foundation for World Population and Action for Global Health, health spending in Uganda: The impact of current aid structures and aid effectiveness* (2010) 6.

131 E Lirri 'Activists take maternal death fight to court' *The Monitor* 11 June 2011; 'Ugandan Constitutional Court to begin hearing on groundbreaking case that challenges state failure to protect maternal health' *International ProBono.com*, 26 July 2011.

Jennifer, a government official and mother of three, went into labour in December 2010 and was made to wait for an obstetrician-gynaecologist for more than 15 hours at a hospital where she was to undergo a Caesarian section. She suffered a lot of pain while waiting, and ultimately bled to death due to a uterine rupture. About four pregnant women also died in that hospital on that day.

The case, which was filed by a civil society organisation in Uganda on behalf of the women's families, contended that both women had died because the hospitals did not provide them with critical services. This failure, they noted, led to the violation of their rights to health and life, guaranteed by the Constitution of Uganda. Some of the remedies being sought include compelling the government to ensure that healthcare facilities are adequately equipped to provide essential maternal health care, that staff members are appropriately trained and remunerated, and that adequate funding is provided for the health sector in the national budget.

Although the government has called for the dismissal of the case on the ground that it would amount to the judiciary taking over the roles of the executive and legislative arms of government if the courts were to hear it,¹³² the case involves questions of constitutional law and provides the Constitutional Court of Uganda with a rare opportunity to clarify the government's obligations with respect to women's rights to safe motherhood as part of their fundamental human rights. As previously noted, under the right to life, which is guaranteed in the Constitution of Uganda,¹³³ and in regional and international laws which the country has ratified,¹³⁴ states must ensure access to emergency obstetric care and other reproductive health services in order to reduce maternal deaths.¹³⁵ Also, they are to remove the barriers preventing access to reproductive health care, such as expensive maternal healthcare treatments,¹³⁶ and inadequate access to antenatal services,¹³⁷ which increase women's risk of maternal mortality and disability. Further, with respect to the right to health, the Ugandan Constitution expressly requires the government to ensure access to health services as a national objective.¹³⁸ Various Ugandan laws and policies, such as the Patients' Charter,¹³⁹ also acknowledge the

132 E Kasozi & B Ndagire 'Government wants maternal health case dismissed' *The Monitor* 23 October 2011.

133 Republic of Uganda Constitution, 1995.

134 See art 4 of the African Charter. Uganda ratified the African Charter on 10 May 1986; art 4 African Women's Protocol; art 6 ICCPR. Uganda acceded to ICCPR on 21 June 1995.

135 See Concluding Observations of the Human Rights Committee on Mali para 14, UN Doc CCPR/CO/77/MLI (2003); Concluding Observations of the CEDAW Committee on Burundi para 36, UN Doc CEDAW/C/BDI/CO/4 (2008).

136 See Concluding Observations of the CRC Committee on Central African Republic para. 54, UN Doc CRC/C/15/Add.138 (2000).

137 As above.

138 Republic of Uganda Constitution, 1995 XIV

139 The Republic of Uganda, Patients' Charter, Ministry of Health, Department of Quality Assurance, December 2009.

government's obligation to realise the right to health and, as highlighted above, Uganda is obligated to fulfil the right to health as guaranteed in regional and international laws. Had these obligations been fulfilled, Jennifer would have received the life-saving emergency obstetric care she needed, and Sylvia would not have been left to die because she could not pay for delivery supplies.

An appropriate interpretation of the Constitution and other human rights provisions could lead to a decision which confirms that the rights to health and life of Sylvia Nabulowa and Jennifer Anguko were indeed violated. The Court's recent decisions regarding certain cases dealing with human rights, including women's rights specifically, indicate that this Court might be willing to uphold the rights and standards enshrined both in the Constitution and in applicable international laws, if afforded the opportunity.

In *Uganda Association of Women Lawyers and 5 Others v The AG*,¹⁴⁰ the Court held that a national law, the Divorce Act, which provided different grounds for divorce for men than for women, amounted to discrimination on the ground of gender and a violation of the right to non-discrimination, and was therefore unconstitutional.¹⁴¹ In a later decision in *Law Advocacy for Women in Uganda v AG*,¹⁴² the Constitutional Court similarly held that both the Penal Code, which allowed for a different punishment for men than for women found to have committed adultery, and the Succession Act, under which women's inheritance rights were limited and were unequal to men's rights, violated the right to non-discrimination and were, therefore, unconstitutional.¹⁴³

Kenya

A case pending before a Kenyan High Court deals with serious injuries perpetrated on a woman during childbirth and represents one of the first reproductive rights cases to be deliberated on by a court in Kenya.¹⁴⁴ MNN went to a private hospital in Kenya to give birth to her second child, in June 2005, and was examined by a man who was a healthcare provider there. He handled her roughly and verbally abused her but, being in labour,

140 Constitutional Petition 2 of 2003 [2004] UGCC 1(3/10/2004) Uganda, Constitutional Court.

141 See Center for Reproductive Rights *Legal grounds: Reproductive and sexual rights in African commonwealth courts, Volume II* (2010) 26, for a summary of the decision as well as an analytical commentary.

142 Constitutional Petitions 13/05 & 05/06 [2007] UGCC 1 (5 April 2007) Uganda, Constitutional Court.

143 Center for Reproductive Rights (n 144 above) 27-28.

144 Center for Reproductive Rights, Litigation briefing series, '*MNN v Attorney-General of Kenya: Female genital mutilation in health facilities*' <http://reproductiverights.org/en/node/2435>; (accessed 17 August 2012); see also n 36 above, 35-36.

she was unable to seek help. After delivering her of a baby girl, he cut her in the vaginal area, causing her untold pain.

MNN eventually discovered that her genitals had been forcibly mutilated, but did not receive any remedies despite several attempts. The hospital where she gave birth was unsupportive; doctors at other hospitals confirmed the mutilation but refused to issue a medical report because they did not want to be involved. The Medical Practitioners and Dentists Board dismissed her complaints without providing any reasons. A women's hospital, which ultimately gave her a medical report, countered their findings because she intended to inform the police. When she did go to the police, she was required to bear the cost of transporting an officer to a police doctor who would examine her. Even when this examination confirmed what had happened to her, the police dismissed her complaint, noting that, under Kenyan law, female genital mutilation (FGM) performed on adults was not a crime. Yet, a study conducted by WHO found that women who had undergone FGM are more likely to experience complications during delivery, including post-partum haemorrhage – one of the major causes of maternal mortality – and longer admissions in hospital after delivery.¹⁴⁵ She eventually brought her claim to the court, contending that her rights to health, dignity, non-discrimination and freedom from cruel and degrading treatment, guaranteed by the Constitution and by regional and international laws, had been violated, and seeking damages for her pain and changes in the law.

The Constitution of Kenya imposes an obligation on the government to respect, fulfil and protect the rights of its citizens to be free from cruel and degrading treatment, and the rights to health, dignity and non-discrimination.¹⁴⁶ The government also has similar obligations under regional and international laws, which have clearly denounced harmful practices, such as FGM, as a violation of women's rights.¹⁴⁷ It must provide adequate remedies for violations of human rights and prosecute and punish the perpetrators, including private persons or non-state actors.¹⁴⁸ It would seem that the government failed in its responsibility to ensure the protection of human rights in private health facilities, to investigate and punish violators, and to establish a law prohibiting the performance of FGM on adult women. Had the Kenyan government provided adequate laws prohibiting the performance of FGM on adult women, the police might not have refused to investigate what happened to

145 WHO 'Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries' (2006) 367 *Lancet* 1835-41, <http://www.who.int/reproductivehealth/publications/fgm/fgm-obstetric-study-en.pdf> (accessed 18 August 2012).

146 Arts 43(1)(a), 29(d) & (f), 28 & 27 2010 Constitution of Kenya.

147 See art 2 of the African Women's Protocol, General Recommendation 14 of the CEDAW Committee, and General Comment 14, para 33 of the ESCR Committee.

148 See eg art 2 of ICCPR.

MNN and to prosecute the perpetrators. Unless it is held accountable, such violations will continue.

MNN's experience is symptomatic of the serious abuse that women experience while seeking maternal healthcare services in the sub-region. While the experiences of other women may not be categorised as FGM, the impact is just as damaging, and a violation of their human rights.¹⁴⁹

India

India was not only one of the 11 countries that made up 65 per cent of all maternal deaths in 2008 according to the latest WHO statistics,¹⁵⁰ but it also had the world's highest number of maternal deaths.¹⁵¹ The main causes of maternal mortality in India are much like those in sub-Saharan Africa.¹⁵² Indian courts, through a number of notable cases, have long recognised the interdependence of all human rights, and have drawn connections between civil and political rights, which are always guaranteed, and deemed justiciable, by constitutions, and social and economic rights, which are frequently located in sections of constitutions - national objectives or directive principles - that contain guarantees which are considered non-justiciable, including health. The Supreme Court has in fact determined that the directive principles in the Constitution impose obligations on the government which are equal to those imposed by fundamental human rights guarantees.¹⁵³ A number of recent decisions by courts in India highlight the willingness of Indian courts to deliver decisions and grant remedies that compel the government to fulfil its human rights obligations; they further showcase the effectiveness of using litigation to compel governments to reduce preventable maternal deaths and injuries, including by issuing declarations and interim orders to address urgent requests.

Court on its own Motion v Union of India (Laxmi's case)

This maternal mortality case was initiated by the Delhi High Court *suo moto* – upon its own initiative – in 2010, due to a woman's death a few days after giving birth on a Delhi street.¹⁵⁴ Laxmi, who was homeless and destitute, delivered a baby girl on 26 July 2010. She only received assistance from another woman who was also homeless. Lacking information about available services, she did not receive medical care and

149 See the findings in fact-finding reports that were earlier referenced.

150 WHO (n 7 above) 1 17.

151 WHO (n 7 above) 17.

152 See examples in Center for Reproductive Rights *Maternal mortality in India: Using international and constitutional law to promote accountability and change* (2008) 13-21.

153 n 155 above, 39.

154 *Court of Its Own Motion v Union of India*, WP (C) 5913/2010 <http://www.indiankanoon.org/doc/1229591/> (accessed 15 November 2012).

died from septicaemia four days later, although government hospitals provided free maternal health services. The baby girl barely survived.¹⁵⁵

The Court heard about Laxmi and initiated a petition, upon its own initiative. It confirmed that the right to life of pregnant women should be ensured by the government. It then ordered the state to undertake interim measures, including establishing shelters equipped to provide to destitute and pregnant women 24-hour medical care, and to set up mobile medical units and raise awareness about their existence.¹⁵⁶ The Court has since then issued follow-up orders to provide further protections.¹⁵⁷

This case further emphasises the need to implement human rights standards. For instance, had the state provided Laxmi with access to the requisite information, she would have sought free care.

Snehalata (Salenta) Singh v State of Uttar Pradesh

One of the first of its kind before a state High Court in India, this case centres on Salenta, who was in labour and who went to a public hospital to give birth to her sixth child, but was denied care for several hours because she could not pay an informal fee.¹⁵⁸ Due to the delay, she developed obstetric fistula. She was subjected to a nine-month delay in receiving surgery to repair the fistula, until a non-governmental organisation (NGO) assisted her, because the hospitals she went to either demanded fees that she could not afford or did not have any space. After the surgery, she continued to experience pain and could no longer work.

In 2009, she sued the state of Uttar Pradesh, contending that her rights to life, health, dignity, equality and non-discrimination, guaranteed by the Constitution of India, had been violated due to the poor quality of care she received. She sought remedies, which included compensation for her medical expenses, and a court order mandating the state to provide free medical care to low-income women, to implement healthcare guarantees relating to ante-natal and post-natal care, to ensure effective referrals from one hospital to another, when necessary, and to set up a system to track and audit maternal deaths. The case is pending and could potentially obligate the government to make extensive changes to improve maternal healthcare services.

The outcomes of these cases carry persuasive authority within legal jurisdictions in the sub-region. In seeking remedies for violations,

155 For additional facts, see Center for Reproductive Rights *Maternal mortality in India: 2011 Update: Accountability in action* (2011) 21.

156 As above.

157 As above; Order 12.01.2011.

158 Center for Reproductive Rights (n 155 above) 49-50; Center for Reproductive Rights (n 158 above) 24-25.

advocates could require African courts to also order interim measures that would address problems with maternal healthcare access in an urgent and yet systemic manner.

4.2 Public inquiries

In keeping with a 1993 UN General Assembly resolution,¹⁵⁹ national human rights institutions (NHRIs) have become institutionalised in the region. Tasked with protecting human rights,¹⁶⁰ most are empowered to conduct public hearings to investigate claims of human rights violations.¹⁶¹ Although many of them are not yet functioning as intended, due to funding and staffing challenges, efforts are underway to change this, including establishing the Network of African Human Rights Institutions in 2007.¹⁶² Their important role in promoting transparency and accountability for rights violations, through public inquiries, is well recognised. Such inquiries can support litigation by identifying victims and witnesses and verifying evidence, and can put governments on notice about ongoing violations. The recommendations that come out of such inquiries can also shape subsequent measures undertaken by the government to eliminate violations of pertinent human rights.

4.2.1 *South African Human Rights Commission's public inquiry on access to healthcare services*

In 2007, the South African Human Rights Commission (SAHRC), one of the well-functioning NHRIs in the region and among a handful to have conducted public inquiries into rights violations in general and on the right to health in particular, conducted a public inquiry into access to healthcare services. Among the key findings were that the lack of reliable transportation to, and long waiting periods at, health facilities – the same obstacles that prevent women from accessing maternal health care in the rest of the region – were core barriers to health care access. The findings were documented in a report which also provided critical recommendations related to access for vulnerable groups, such as the poor, measures to be undertaken to improve the health system and relevant infrastructure, and to address staff shortages and inadequate provision of equipment.¹⁶³ In a 2011 report regarding maternal mortality and disability, the SAHRC

159 UN General Assembly Resolution A/RES/48/134 'National institutions for the promotion and protection of human rights'.

160 As above.

161 Kenya National Commission on Human Rights 'KNCHR to launch a public inquiry' http://www.knchr.org/index.php?Itemid=89&id=24&option=com_content&task=view (accessed 21 August 2012).

162 See the vision and mission statements of the Network of African Human Rights Institutions at http://www.nanhri.org/index.php?option=com_frontpage&Itemid=1 (accessed 10 January 2012).

163 South African Human Rights Commission *Public inquiry: Access to health care services* (2007).

noted that the recommendations had been sent to the legislature and would form part of a monitoring and evaluation database.¹⁶⁴ Giving adequate priority to these recommendations would provide the South African government with an opportunity to reduce preventable maternal mortality and morbidity.

4.2.2 Kenya National Commission on Human Rights's public inquiry on sexual and reproductive health

In June 2011, the Kenya National Commission on Human Rights (KNCHR) embarked on a national inquiry on the state of sexual and reproductive health in the country,¹⁶⁵ due to a complaint by the Center for Reproductive Rights and the Federation of Women Lawyers-Kenya,¹⁶⁶ regarding the findings in their report, which exposed a systemic denial of services to, and grave abuses of, pregnant women in Kenyan health facilities.¹⁶⁷ The inquiry, the first in the country, focused on determining the nature and scope of human rights abuses of women seeking sexual and reproductive healthcare services in healthcare facilities.¹⁶⁸ During the public hearings, it became evident that the inquiry had already served as an invaluable tool for witness identification and had put the government on notice about the violations: Women had come forward to describe serious abuses leading to severe and permanent injuries.¹⁶⁹ In the results of the inquiry, released in May 2012, the KNCHR confirmed that preventable maternal injuries and death were occurring in Kenya due to serious rights violations, including the non-existence of necessary sexual and reproductive health services; the inaccessibility of pertinent services based on long distances and their lack of affordability; and the poor quality of available services, weak referral systems, and unsafe abortion - the same factors and barriers that sustain the high levels of preventable maternal morbidity and mortality in the region.¹⁷⁰ Relying on national, regional and international human rights law obligations, it outlined a number of recommendations, including urging the government to implement the Human Rights Council resolution on preventable maternal mortality by taking a human rights-based approach in all its efforts, to ensure that hospitals are adequately equipped and staffed, that maternal healthcare services are affordable; that complaints mechanisms exist and function to

164 South African Human Rights Commission *National human rights institution report on initiatives that exemplify good or effective practices in adopting a human rights based approach to eliminating preventable maternal mortality and morbidity* (2011) 5.

165 Catholic Information Service for Africa 'Kenya: Rights body launches sexual and reproductive health enquiry' *CISA News Africa* 7 June 2011.

166 Kenya National Commission on Human Rights *Realising sexual and reproductive health rights in Kenya: A myth or a reality* (2012) ii.

167 See Center for Reproductive Rights *Failure to deliver: Violations of women's human rights in Kenyan health facilities* (n 36 above).

168 n 169 above, ii.

169 D Kiarie 'Kenya: Denial of reproductive health rights' *Africa News* 24 August 2011.

170 n 169 above, iii 67.

receive and resolve maternal healthcare-related complaints; and that referral systems are strengthened.¹⁷¹ The recommendations issued by the KNCHR would, if implemented, effectively address the preventable maternal mortality and morbidity in the country and could enable the government to fulfil its obligations under the right to health.

5 Conclusion

Despite the high incidence of preventable maternal mortality and disability in sub-Saharan Africa, and the obvious violation of human rights which they constitute, accountability for these violations remains elusive. There is not a single decision holding the government of a country in the region responsible, yet there is clear evidence that the failure to implement relevant human rights standards sustains the factors and barriers that fuel these unnecessary injuries and deaths. As such, African governments have not only failed to implement relevant human rights standards, but have not suffered any consequences.

Until a government in the region is clearly held accountable and compelled to implement and monitor concrete measures toward eliminating the barriers to safe motherhood, women in Africa will continue being exposed to severe risks during pregnancy and childbirth. Moreover, international and other commitments aimed at reducing maternal mortality and morbidity will have limited impact in the region if the governments do not accept their role in sustaining the problem and undertake to eliminate them.

Public inquiries conducted by NHRIs can serve as crucial first steps in exposing the causes and consequences of poor maternal health outcomes, collating best practices, and facilitating government action. They can also help in documenting evidence and identifying witnesses needed to hold states as well as perpetrators of human rights violations accountable. As such, strengthening NHRIs and ensuring that their mandate allows them to independently conduct inquiries and to take cases to court would further promote accountability.

Although litigation may require time and resources, it has proved to be an effective strategy for holding states accountable and compelling them to take action to prevent future deaths. Advocates must now develop strategies for successful litigation and the implementation of decisions. They must consider the full range of factors – political and socio-economic, as well as the resulting barriers, financial, infrastructural and institutional – which must be addressed. They should also consider intersecting issues that increase women’s risk of preventable maternal death, such as HIV.

171 n 169 above, 67-70.

Advocates will need to think strategically to surmount likely obstacles, such as inadequate data collection and maintenance systems, difficulties with obtaining consent to litigate, procuring relevant evidence from health facilities which may have an interest in not providing them, and long delays in obtaining judgment from a court. They should look beyond the obvious facts of a case to obtain the full picture. For instance, although none of the highlighted cases of maternal mortality implicated inadequate access to family-planning services as a direct cause of poor maternal health outcomes, the number of children already born to some of the victims might suggest that inadequate access to family-planning methods played a role.

Finally, while the forum of litigation might pose a challenge, particularly when domestic remedies are either non-existent or have been exhausted, maternal health cases could be taken before sub-regional and regional courts or bodies. To this end, the Inter-American Court decision discussed in this chapter provides strategic insight into how advocates can overcome restrictions with accessing the African Court, which is not as accessible to individuals as the African Commission, but can make binding decisions and issue effective remedies. They could consider bringing a case to the Commission, urging it to refer it to the Court, given the magnitude of any decision on state responsibility for maternal mortality in sub-Saharan Africa.

Postscript

Uganda Case

In June 2012, the Constitutional Court upheld the government's preliminary objection that the case raised political questions and, consequently, dismissed it (*Centre for Health, Human Rights and Development (CEHURD) & 3 Others v Attorney-General*, Constitutional Petition 16 of 2011). The civil society organisation, as petitioners, had contended that there was no political question involved and had highlighted the inadequate health budget allocation and failure to meet constitutional and international human rights standards as evidence of the government's responsibility for the oversights that led to the maternal deaths. However, the Court observed that no authorities were cited to support their contention and instead found that, although it had jurisdiction over the case, the claim that the state's failure to provide basic indispensable health items in government facilities for expectant mothers had led to preventable maternal deaths, and constituted a violation of constitutional provisions, would require reviewing and assessing all the policies of the entire health sector and the sub-sector of the maternal health care service, including the adequacy of allocation of resources, while the implementation of these policies was the sole responsibility of the executive and the legislature. It therefore agreed with the government that the claim 'deals generally with

all hospitals, health centres and the entire health sector, and broadly covers all expectant mothers'. As a result, it found that it had 'no power to determine or enforce its jurisdiction on matters that require analysis of the health sector government policies, make a review of some and let on, their implementation'.

The Court further observed that '[m]uch as it may be true that government has not allocated enough resources to the health sector and in particular the maternal health care services, this Court is, with guidance from the above discussions, reluctant to determine the questions raised in this petition'. It recommended seeking redress from the High Court which can provide remedies such as the prerogative order of *mandamus*, requiring a public officer to carry out public duties that relate to his or her scope and course of employment in a public office, or the other prerogative remedies of prohibition, *certiorari* and injunctions. Alternatively, it recommended the seeking of remedies against the government, including compensation, for wrongful actions under contract or tort law, if the actions were perpetrated by public officials.

Under the political question doctrine, even where courts have jurisdiction to hear a case, they could choose to dismiss it without considering it on its merits on the basis that it raises questions about the conduct of public business which are political in nature and which, under the Constitution, are the sole responsibility of the executive or legislative branches of government. However, it is generally understood that in the interest of justice, the doctrine should be construed narrowly and scholars have repeatedly advanced the argument that courts should be particularly reluctant to rely on the doctrine in human rights cases.¹⁷² The Constitutional Court's broad construction of the doctrine resulted in a missed opportunity to provide an authoritative interpretation of the Ugandan Constitution's guarantee of the right to life and right to health in the context of preventable maternal deaths and injuries in Uganda. Despite the framing of the claim, which it noted included the entire health sector and covered all expectant mothers and as such would necessitate reviewing all health sector government policies, the Court would have been within the boundaries of its constitutional mandate if it had chosen to assess these policies: not to take over their implementation from the executive, but instead to determine whether enough had been done to make certain that the guarantee of the rights to health and life were adequately ensured to women seeking maternal health care services.

Furthermore, the Court could still have determined whether the particular issues surrounding the deaths of Sylvia Nabulowa and Jennifer

172 NS Williams 'Political question, doctrine or judicial query: An examination of the modern doctrine and its inapplicability to human rights mass tort litigation'(2001) 28 *Pepperdine Law Review* 849; B Stephens *et al* *International human rights litigation in US courts* (2008) ch 13.

Anguko led to the violation of their rights to health and life without reviewing all health sector policies. The alternative means of redress recommended by the Court would provide inadequate remedies, since they could only address the responsibility, and possibly result in the punishment, of specific medical staff and public officials, and would not allow for an interpretation of the Constitution which determines whether the government is appropriately complying with certain human rights obligations, and which could compel the systemic changes required to prevent future preventable deaths. The Court's ruling allowed the political question doctrine to be used as a vehicle for maintaining impunity and the lack of accountability for the human rights violations that result in preventable maternal deaths. Many more women in Uganda succumbed to preventable maternal deaths during the case and since it was dismissed.¹⁷³ The Constitutional Court's decision has been appealed and the case is now before the Supreme Court which is expected to determine whether preventable maternal deaths in Uganda constitute a violation of fundamental human rights.¹⁷⁴

Kenya Case

Due to delays in the legal system and accompanying challenges, MNN ultimately decided not to continue with the legal process and her efforts to secure justice.

173 M Omara 'Are Ugandan women being denied their 'rights' to maternal healthcare services?' 28 July 2012; D Mafabi 'Mbale doctors held over death of woman in labour' 20 September 2011; CEHURD 'Activists and advocates ask government: Why aren't dying mothers a priority in Uganda?' 22 May 2012.

174 R Kasasira 'Uganda: Government sued over maternal healthcare' 9 August 2012.

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PART II: HIV/AIDS focus

CHAPTER 6

ADOLESCENT GIRLS, HIV, AND STATE OBLIGATIONS UNDER THE AFRICAN WOMEN'S PROTOCOL

Karen Stefiszyn

Summary

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, which defines women to include girls, is the first legally-binding treaty to explicitly provide for rights to protect women from HIV infection. In the light of the high prevalence of HIV among adolescent girls in sub-Saharan Africa, the Women's Protocol is, therefore, an important tool to guide state action towards alleviating the devastating effect the virus is having on young women. However, the relevant provisions are not clear in terms of the specific obligations placed on states in this respect. The author proposes that the African Commission on Human and Peoples' Rights should develop interpretive guidance for states which would serve a similar purpose as the General Comments or General Recommendations by the United Nations treaty bodies which have successfully expanded the interpretation of the treaties. This chapter explores the possible contents of such guidance, drawing on existing international guidelines relating to sexuality education, HIV protection methods, and HIV testing and disclosure.

1 Introduction

At a recent United Nations (UN) High-Level Meeting on HIV/AIDS, UN member states expressed grave concern that 'young people between the ages of 15 and 24 years account for more than one-third of all new HIV infections, with some 3 000 young people becoming infected with HIV each day'.¹ They also reiterated that sub-Saharan Africa remained the worst-affected region.² Their concern reflects the most recent UNAIDS

1 UN General Assembly 'Political Declaration on HIV/AIDS: Intensifying our efforts to eliminate HIV/AIDS' UN Doc A/65/L.77 para 25.

2 UN General Assembly (n 1 above) para 9.

statistics which illustrate that, of the 5 million young people aged 15 to 24 living with HIV globally, 3,8 million are in sub-Saharan Africa.³ Of this figure, 2,7 million are young women.⁴

There are a myriad of factors that compound the susceptibility of young women to HIV infection. A recent study conducted in Botswana, Malawi and Mozambique reveals some of the underlying determinants of adolescent girls' vulnerability.⁵ Through collected personal narratives, the researchers found that the 'prototypical sexual relationship associated with adolescent girls and risk of HIV transmission was transactional, intergenerational, unprotected, and concurrent'.⁶ Not surprisingly, poverty or consumerism, or a combination of both, emerged as the driving force behind such relationships. Focus group discussions in some African countries revealed that impoverished adolescent girls exchange sex for small items such as soap, salt and bread. The study also revealed that in Mozambique, sex is exchanged for monetary amounts as low as 20 US cents.⁷ Young women also engage in transactional sex, not only to secure basic necessities, but for material goods such as cell phones and the latest fashion.⁸ It is the intergenerational nature of these interactions that increases the risk of HIV infection, whereby older partners are most likely more sexually experienced and may be infected with HIV depending on the risks to which they have previously exposed themselves. Young women in Zimbabwe with sexual partners five or more years older than themselves were about seven times as likely to be HIV positive as women with same-age partners.⁹

Adolescent girls who are married or cohabiting are also more likely to be infected with HIV than unmarried girls.¹⁰ Despite an accepted prohibition of marriage for children under the age of 18 as a principle of international human rights law, and the widespread domestication of this principle in legislation throughout Africa, the practice of girls marrying before the age of 18 is not uncommon.¹¹ Twenty-three percent of girls between the age of 15 and 19 in sub-Saharan Africa are married or in a

3 UNAIDS 'Securing the future today: Synthesis of strategic information on HIV and young people 2011' 17.

4 As above.

5 C Underwood *et al* 'Structural determinants of adolescent girls' vulnerability to HIV: Views from community members in Botswana, Malawi and Mozambique' (2011) 73 *Social Science and Medicine* 343-350.

6 Underwood (n 5 above) 345.

7 Underwood (n 5 above) 346.

8 As above.

9 Q Abdool Karim *et al* 'Interventions with youth in high prevalence areas' in K Mayer & H Pizer (eds) *HIV prevention: A comprehensive approach* (2009) 413.

10 There are several studies to support this. See, eg, L Gavin *et al* 'Factors associated with HIV infection in adolescent females in Zimbabwe' (2006) 39 *Journal of Adolescent Health* 596; R Kelly *et al* 'Age differences in sexual partners and risk of HIV-1 infection in rural Uganda' (2003) 32 *Journal of Acquired Immune Deficiency Syndrome* 450; S Clark *et al* 'Protecting young women from HIV/AIDS: The case against child and adolescent marriage' (2006) 32 *International Family Planning Perspectives* 79.

11 Clark *et al* (n 10 above) 80.

union.¹² There are several reasons accounting for the greater risk of infection for girls or young married women compared to girls who are not married. For example, in most instances, there is a significant age gap in unions involving girls or young women where older male partners are generally more sexually experienced.¹³ Also, demographic and health surveys revealed that in all sub-Saharan African countries, where polygyny is practised, women who married before the age of 18 were likely to be in polygynous relationships.¹⁴ Furthermore, married adolescents are less likely to know how to prevent HIV, given that they are more likely to be out of school and, therefore, have less access to information.¹⁵ Higher levels of education are directly related to an increased awareness and knowledge of HIV, a greater knowledge of testing facilities, higher rates of condom use, and better communication between partners about HIV prevention.¹⁶ Finally, due to the inherent inequality of the relationship, girls and young women who are married early are unable to refrain from sex or negotiate the use of a condom.¹⁷

While this study does not aim to explore the factors that cause adolescent vulnerability to HIV exhaustively, there are some important underlying determinants that merit highlighting. One of the most pervasive manifestations of gender inequality is violence against girls and women of all ages and, in particular, sexual violence, which fuels the spread of HIV in Africa. Adolescents are vulnerable to violence in many situations, including at school by their peers and teachers.¹⁸ Poverty, gender and cultural norms concerning sexuality, masculinity and femininity, as well as inaccurate, limited, or no information about sex and HIV, also contribute to the high HIV infection rate among adolescent girls. Although none of these factors work in isolation, they are, however, all a result of gender inequality, which is addressed in the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol). A brief overview of the Women's Protocol is provided in the next section. The overview is followed by an exploration of possible state obligations arising from the Protocol's HIV-related provisions. The role of the African Commission on Human and Peoples' Rights (African Commission) in interpreting the African Women's Protocol and clarifying state obligations is taken into account.

12 UNICEF *The state of the world's children* (2011) 133.

13 Clark *et al* (n 10 above) 82.

14 As above.

15 Clark *et al* (n 10 above) 84.

16 UNAIDS *Facing the future together: Report of the Secretary-General's Task Force on Women, Girls and HIV/AIDS in Southern Africa* (2004) 10.

17 Clark (n 10 above) 84.

18 See, eg, Human Rights Watch *Scared at school: Violence against girls in South African schools* (2001); F Banda *Women, law and human rights in Africa: An African perspective* (2005) 176-177.

1.1 The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa

The African Women's Protocol, which defines women as 'persons of the female gender including girls', is an important regional instrument to guide state action towards protecting young women in Africa from HIV infection. The Women's Protocol was adopted by the African Union (AU) in 2003 and entered into force in 2005 after the required 15 states had ratified it. The number of ratifications has since doubled.¹⁹ The impetus for the Women's Protocol, arising ten years prior to its adoption, was from women's rights organisations based on their concern for the non-enforcement of protections for women's human rights in existing international and regional instruments, and the subsequent ongoing violations of women's human rights.²⁰ In this regard, the view was that the African Charter on Human and Peoples' Rights (African Charter), which is meant to equally protect the rights of men and women in Africa, fell short of offering substantive protection to women. In particular, providing for the elimination of discrimination against women in the same article (article 18), which also refers to the family as the 'custodian of morals and traditional values recognised by the community', and which includes protection for the aged and the disabled, was seen as reflecting a lack of insight by the drafters about the nature of discrimination against women in Africa and the need for special protection for women.²¹ Following a meeting in 1995 of the African Commission to focus on the situation of women in Africa, it was agreed that a draft Protocol to the African Charter on Human and Peoples' Rights be prepared. The initiative was led by the Special Rapporteur on the Rights of Women in Africa (SRRWA), in close collaboration with civil society.²²

Women's human rights in Africa are enumerated in the African Women's Protocol with measures to be taken by states to realise the human rights of women. The overarching goal of the Women's Protocol is to bring about gender equality in Africa, the converse of which is fuelling the spread of HIV on the continent. As with the UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the African Women's Protocol enshrines the principle of substantive equality and requires states to take specific measures to realise *de facto* equality, whereby women and men enjoy equality in practice. A notable distinction is made between discrimination in law and in fact, whereby

19 As of 1 May 2012, 32 countries had ratified the African Women's Protocol.

20 F Viljoen 'An introduction to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa' (2009) 16 *Washington and Lee Journal of Civil Rights and Social Justice* 17.

21 Art 18 African Charter on Human and Peoples' Rights. See, eg, C Packer *Using human rights to change tradition* (2002) for a summary of criticism regarding art 18 of the Charter.

22 Banda (n 18 above) 68.

corrective and positive action is required in each instance. State parties are required to go beyond the relatively simple act of enacting legislation that so often does not translate to real change in the lives of women.²³ The drafters adopted a holistic approach to the protection of women's rights, including measures that are innovative and idealistic. For example, states are required to include peace education in school curricula towards addressing violence against women, and to reduce military spending in favour of social spending to improve the lives of women.²⁴ Drawing from CEDAW, states must also employ public education, information, education and communication strategies to combat stereotypes and harmful practices.²⁵

The African Women's Protocol addresses various manifestations of gender inequality, many of which are the root causes of the disproportionate spread of HIV among young women in Africa, such as sexual violence and early marriage, as well as factors that exacerbate the effects of HIV infection on the enjoyment of human rights, including the denial of inheritance.²⁶ It has been hailed for its innovations beyond existing treaties, such as CEDAW. Whereas CEDAW was relied upon heavily in the drafting, given that it had already defined discrimination against women and what have come to be recognised as core women's human rights, the Women's Protocol advances women's human rights in many ways.²⁷ For example, it includes provisions such as the explicit prohibition of female genital mutilation and other harmful traditional practices, the protection of the right to peace and sustainable development for women, and the inclusion of provisions specific to the rights of widows, the elderly and the disabled.²⁸

The African Women's Protocol also addresses a striking gap in international human rights law as pertains to the protection of women. Whereas the drafters of CEDAW omitted to explicitly include violence against women in the Convention, an omission which was later rectified through the adoption of General Comment 19 by the CEDAW Committee, the drafters of the Women's Protocol included a comprehensive definition of violence against women and provided for measures to protect women from violence as well as preventing and punishing acts of violence.²⁹ All forms of violence against women are to be prohibited in laws that are to be enforced and applied to violence that takes place in the public or private sphere.³⁰ The implementation of the

23 Viljoen (n 20 above) 31.

24 Arts 4(2)(d) & 10(3) African Women's Protocol.

25 Art 2(2).

26 Arts 3, 6 & 21 respectively.

27 Banda (n 18 above) 66-83 for an overview of the history and drafting of the African Women's Protocol, including how it was influenced by CEDAW and goes beyond CEDAW.

28 Arts 5, 10, 19, 20, 22 & 23 respectively of the African Women's Protocol.

29 Arts 1, 3 & 4.

30 Art 4.

provisions relating to violence in the African Women's Protocol would go far in addressing the spread of HIV, in particular among young women, in Africa.

Beyond tackling the pandemic and its disproportionate effects on women through its broad goal of gender equality in all aspects of women's lives, the African Women's Protocol explicitly includes rights relating to HIV, representing another first in the development of normative standards for the protection of human rights. These are included in article 14 relating to women's health and reproductive rights, wherein the Protocol again proves its innovation. Article 14 goes further than any other legally-binding human rights treaty to protect the health and reproductive rights of women, including the legal right to abortion under specified circumstances.³¹ With respect to HIV, article 14 provides:

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

.....

(d) the right to self-protection and to be protected against sexually-transmitted infections, including HIV/AIDS;

(e) the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually-transmitted infections, including HIV/AIDS, in accordance with internationally-recognised standards and best practices.

These provisions, by virtue of being grounded in the African Women's Protocol, reiterate at least two important points: that HIV is a human rights issue; and that it has a disproportionate impact on African women and girls. Not least by its recognition of the right to non-discrimination, life, dignity, education, economic empowerment and equality in marriage, it addresses all of the factors noted above that render young women vulnerable to HIV infection. Furthermore, it provides for health and reproductive rights, including explicit reference to HIV. Given that the Women's Protocol defines women to include girls, all the obligations incumbent on states upon ratification of the Protocol apply to adolescents and young women, including those relating to sexual health and HIV.³² It is on this basis that it has been persuasively argued that the provisions of

31 Art 14(2)(c).

32 While many of the observations and arguments put forth will be necessarily general, relevant to all women throughout the life cycle, the focus is on young women between the ages of 15 and 24, representing the demographic group most infected with HIV in sub-Saharan Africa. Unique challenges faced by adolescent girls, aged 10-19, in exercising their rights under arts 14(1)(d) and (e), are given particular attention. WHO defines adolescents as 10-19 years old and recognises an overlapping stage of youth between 15 and 24 years. Under international law, children are persons under 18 years of age. The terms 'young women', 'adolescent girls' and 'girls' will be used throughout, and at times interchangeably, depending on the context.

the Women's Protocol are the strongest of any human rights instrument with respect to protecting the sexual health needs of adolescent girls.³³

However, despite the good intentions of the drafters, the HIV-specific provisions could have articulated the nature of state obligations more precisely in order to render them more useful in protecting women from being infected with, and affected by, the HIV virus. Instead, the provisions are ambiguous and are left to interpretation by states that are unlikely to read their obligations progressively or exhaustively. In this context, this chapter aims to elucidate some of the possible obligations of states under articles 14(1)(d) and (e) with respect to HIV. Other sexually-transmitted infections (STIs), while referenced in the Women's Protocol, are not included in this discussion. Broad possible interpretations will be proposed in order to promote a progressive reading of the Protocol which offers the widest possible scope of protection for women, including girls. Relevant international standards are identified throughout.

2 The right to self-protection and to be protected against HIV: Possible state obligations

Assuming that the drafters' differentiation of the right to self-protection and the right to be protected against HIV was deliberate, the distinct state obligations that are subsequently implied in each instance are not obvious. The provisions on the right to self-protection and the right to be protected against HIV are ripe for interpretation by the African Commission with the assistance of relevant special treaty mechanisms and academic opinion such as the opinion advanced in this chapter. This section will highlight two issues by means of stimulating debate on the scope and meaning of article 14(d) of the African Women's Protocol and shedding light on possible obligations drawn from the author's own interpretation, namely, to provide comprehensive sexuality education, and to ensure availability and access to prevention methods, including male and female condoms, and post-exposure prophylaxis.

2.1 Sexuality education

In sub-Saharan Africa, less than a quarter of adolescents between the ages of 15 and 29 have comprehensive knowledge of HIV.³⁴ Under article 14 of

33 E Durojaye 'Realising access to sexual health information and services for adolescents through the Protocol to the African Charter on the Rights of Women' (2009) 16 *Washington and Lee Journal of Civil Rights and Social Justice* 166.

34 According to UNICEF, 24% is the actual number: UNICEF (n 12 above) 133. The report defines comprehensive knowledge of HIV as the ability to identify two ways of preventing the sexual transmission of HIV: rejecting the two most common local misconceptions about HIV transmission, and understanding that a healthy person can be HIV-infected.

the African Women's Protocol, reference to protection from HIV must be interpreted to include an obligation on the state to provide information relating to sexuality and HIV prevention. While adolescents have the right to information broadly through a variety of mediums, particularly for purposes of protecting themselves from HIV, this section raises the issue of sexuality education in schools. Sexuality education is a human right and, while not explicitly included in an international human rights treaty, there is sufficient guidance from UN treaty bodies and international consensus documents which leave no question that it is a human right and an imperative element of HIV prevention. For example, according to the International Guidelines on HIV/AIDS and Human Rights (International Guidelines):³⁵

States should ensure the access of children and adolescents to adequate health information and education, including information related to HIV prevention and care, inside and outside school, which is tailored appropriately to age level and capacity and enables them to deal positively and responsibly with their sexuality.

Even more persuasive, due to its legally-binding nature, the Convention on the Rights of the Child (CRC) has been elaborated by its respective monitoring body (CRC Committee) as follows:³⁶

Effective HIV prevention requires States to refrain from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, and that, consistent with their obligations to ensure the right to life, survival and development of the child (art 6), States Parties must ensure that children have the ability to acquire the knowledge and skills to protect themselves and others as they begin to express their sexuality.

Also, the relevant treaty-monitoring bodies have recommended in their Concluding Observations that states provide sexuality education.³⁷

The African regional human rights system does not explicitly address the rights and obligations pertaining to sexuality education. However, the African Charter does provide for the right to information and the right to the highest attainable standard of health. The African Charter on the Rights and Welfare of the Child (African Children's Charter) as well as the African Women's Protocol also provide for the right to health. In line with article 60 of the African Charter and the Preamble to the Women's

35 UNAIDS & UNHCR *International guidelines on HIV/AIDS and human rights* (2002) para 60.

36 UN CRC Committee General Comment 3 para 16.

37 See, eg, CEDAW Committee Concluding Observations Burundi UN Doc A/56/38 (2001) para 62; CEDAW Committee Concluding Observations DRC UN Doc A/55/38 (2000) para 228; CRC Committee Concluding Observations Comoros UN Doc CRC/C/15/Add.145 (2001) para 36; CRC Committee Concluding Observations Egypt UN Doc CRC/C/15/Add. 145 (2001) para 44; ESCR Committee Concluding Observations Senegal UN Doc E/C.12/1/Add.62 (2001) para 47.

Protocol, which recognise international human rights instruments as points of reference, it is appropriate to take into account the view of the UN Committee on Economic, Social and Cultural Rights (ESCR Committee), which holds that the highest attainable standard of health includes the underlying determinants of health.³⁸ Access to health-related education and information, including on sexual and reproductive health, is one such determinant.³⁹

The state must not only provide sexuality education, but it must do so effectively. According to recommendations from UN treaty bodies, information must be accurate and objective, which means that it must be evidence-based and not biased, ideologically motivated, or censored.⁴⁰ Evidence-informed technical guidance on sexuality education indicates that it should include relationships, values, human rights, human development, sexual behaviour and sexual and reproductive health.⁴¹ The World Health Organisation (WHO) recommends that sexuality education be taught as a separate subject rather than be incorporated into other subjects.⁴²

2.2 Male condoms

Another reading of state obligations with respect to protection from HIV, and perhaps more obvious than sexuality education, is the obligation of states to ensure the availability and access to proven methods of preventing HIV infection. Universal access to HIV-prevention technologies requires that they are not only available, acceptable and of good quality, but that they are within physical reach and affordable for all.⁴³ Male condoms are the most effective available tool to reduce sexual transmission of HIV⁴⁴ According to UN guidance, 'they must be readily available universally, either free or at low cost, and promoted in ways that help overcome social and personal obstacles to their use'.⁴⁵ However, it has been reported that on average, less than half of young men and just over a third of young women used condoms during their last high-risk sexual activity in sub-Saharan African countries.⁴⁶

Legal barriers to accessing condoms may exist for adolescents. Most countries have a statutory age of consent to medical treatment whereby

38 ESCR Committee General Comment 14 para 11.

39 As above.

40 Centre for Reproductive Rights *An international human right: Sexuality education for adolescents in schools* (2010) http://reproductiverights.org/sites/crr.civicactions.net/files/documents/WEB_pub_fac_sexed_10.10.pdf (accessed 15 September 2011).

41 UNESCO *International technical guidance on sexuality education* (2010) vol 2 7.

42 Centre for Reproductive Rights (n 40 above) 3.

43 UNAIDS & UNHCR (n 35 above) para 26.

44 UNAIDS, WHO & UNFPA *Position statement condoms and HIV prevention* (2009).

45 As above.

46 *The Millennium Goals development report* (2012) 39.

parental consent is required for those below the prescribed age. The age of consent generally ranges between 12 (such as in South Africa) to 18 (such as in Mozambique, Zambia, Namibia and Zimbabwe). In most instances, the term 'medical treatment' applies to accessing contraceptives which, depending on the facility, could include condoms.

In instances where the age of sexual consent is legislated, there may be unintended consequences with respect to access to condoms by adolescents. In Zimbabwe, for example, where the legal age for consensual sex is 16, healthcare workers fear criminal complicity should they provide adolescents under 16 with services and information regarding contraception and STI prevention.⁴⁷ South African law suffers a similar contradiction, whereby the legal age of access to condoms is 12, yet sex below the age of 16 is illegal.⁴⁸ As Cook and Dickens note, laws designed to protect adolescents, such as those that deny a means of contraception or criminalise consensual sexual behaviour, 'not only fail in their protective purpose, but may violate the Children's Convention and others'.⁴⁹ The principle of 'evolving capacities' that is provided for in CRC, which recognises that children develop the ability to make decisions and understand the consequences of their choices, is at stake. CRC recognises their right to exercise decision-making power as their capacity to do so evolves.⁵⁰

2.3 Female condoms

Ensuring the availability and access to male condoms will not, on its own, satisfy compliance with the right to self-protection and to be protected from HIV under the African Women's Protocol, especially with respect to adolescent girls. Article 14(1)(d) must be read with the relevant provisions of the Women's Protocol which guarantee gender equality and women's empowerment, including through the enshrined right to education and social, economic and welfare rights. Moreover, if girls are to protect themselves from HIV infection, they need to be in control of the methods of prevention.

Current prevention methods, namely, male condoms, are irrelevant to millions of women in Africa who are unable to implement them.⁵¹ A

47 Sexual Offences Act 8 of 2001 sec 3(2). Part 1, sec 2(1) defines 'young person' as a boy or girl under the age of 16 years.

48 Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 sec 15; Children's Act 38 of 2005 sec 134.

49 R Cook & BM Dickens 'Recognising adolescents' "evolving capacities" to exercise choice in reproductive health care' (2000) 70 *International Journal of Gynaecology and Obstetrics* 18.

50 Cook & Dickens (n 49 above) 15.

51 E Durojaye & A Muchiri 'Addressing the link between gender inequality and access to microbicides in HIV/AIDS response in Africa' (2008) 16 *African Journal of International and Comparative Law* 198.

condom is not an effective means of protection for many young women in Africa who are not always able to insist on condom use. Adolescent brides, young women who are victims of sexual abuse, or even those engaging in consensual sex, yet who have not been empowered to negotiate condom use, will not be protected from HIV regardless of the extent to which condoms are available. As Kehler and Radebe note:⁵²

In the context of commitments to address especially women's risks and vulnerabilities to HIV, the distribution of male condoms, while at the same time recognising women's 'lack of power' to negotiate condom use, seems a rather insignificant effort to address women's HIV risks and vulnerabilities; as women continue to be more 'passive recipients' of men's prevention choices, as compared to become 'active agents' in HIV prevention choices for women.

Although the only available female prevention method is the female condom, only one is distributed for every 700 male condoms.⁵³ Concerns about affordability have been cited by policy makers to justify the relative low distribution of female condoms.⁵⁴ While more research is required, a study in rural South Africa among commercial sex workers that was based on potential savings to the healthcare sector as a result of averted cases of HIV infection and other STIs, suggests that female condom programmes are likely to be highly cost-effective.⁵⁵

Arguments about the high cost of female condoms are coupled with concerns about acceptability, namely that cultural barriers pose a significant challenge to the appeal of the female condom among women.⁵⁶ A review of literature published from 2005 to 2009 found that an initial lack of interest, negative rumours and fears can be overcome, while, at the same time, awareness of the possibility of pleasurable sex while being protected can be raised with effective programming.⁵⁷ This would include accurate, non-judgmental information from healthcare workers and the media, and training for women and couples with respect to the use of the female condom.⁵⁸ The researchers argue, however, that the evidence to this effect is not being taken seriously by relevant stakeholders.⁵⁹

52 J Kehler & B Radebe 'Moving beyond the commitments and rhetoric: HIV prevention interventions for women' (2010) *ALQ/Mujeres Adelente* 26.

53 UNAIDS *Report on the global AIDS epidemic* (2009) 11.

54 A Peters *et al* 'The female condom: The international denial of a strong potential' (2010) 18 *Reproductive Health Matters* 125.

55 Referenced in PATH and UNFPA 'Female condom: A powerful tool for protection' 2006. <http://www.path.org/publications/pub.php?id=1267> (accessed 4 September 2011).

56 Peters *et al* (n 54 above) 122.

57 Peters *et al* (n 54 above) 121.

58 As above.

59 As above.

Ensuring availability, affordability, acceptability and accessibility to female condoms would accord with international standards on the right to health.⁶⁰ The ESCR Committee has recommended that states integrate a gender perspective in their health-related policies, planning, programmes and research in order to promote better health for both women and men. According to the Committee, a gender-based approach recognises that biological and socio-cultural factors play a significant role in influencing the health of men and women.⁶¹ The lack of political will by states to make female condoms widely available and to promote their use with equal vigour as the male condom arguably violates article 14(d) of the African Women's Protocol. It also violates article 2 under which states are to eliminate discrimination against women. Whereas the objective of the current *status quo* for condom programming, which emphasises the male condom as the most effective means of preventing HIV, may not have the objective of compromising or destroying the recognition, the enjoyment or exercise by women of their human rights, it does have such an effect.

2.4 Post-exposure prophylaxis

Anti-retroviral medicines also prevent HIV infection. They are administered to prevent mother-to-child-transmission as post-exposure prophylaxis (PEP), and trials are ongoing to determine the efficacy of pre-exposure prophylaxis (PrEP). In the context of article 14(1)(d), concerning the right to self-protection and to be protected from HIV, the state would arguably be obligated to ensure availability, affordability and access to any available and effective drug that would prevent HIV and consequently save lives. This chapter limits the discussion of state obligations to the provision of PEP, which reduces the risk of HIV infection in an individual following possible exposure to the virus. The provision of PEP is an important component of compliance with protection obligations deriving from national and international human rights laws.⁶² States are strongly urged to provide PEP services as part of their national HIV-prevention policies.⁶³ International guidelines on the administration of PEP in the context of HIV focus on occupational exposure to the virus and sexual assault and, accordingly, policy at the national level tends to limit the administration of PEP to those circumstances.⁶⁴

However, African states should ensure access to PEP in alignment with the evidence, namely, that women, especially young women, are vulnerable to exposure to the virus as a result of several scenarios based on unequal relations with men, including, but not limited to, sexual assault.

60 ESCR Committee (n 38 above) para 12.

61 ESCR Committee (n 38 above) para 20.

62 WHO/ILO *Guidelines on post-exposure prophylaxis to prevent HIV infection* (2007) 2.

63 WHO/ILO (n 62 above) 5.

64 See, eg, South African Sexual Offences Act (n 48 above); Malawi National AIDS Policy sec 3.2.2.9.

While, indeed, certain occupations carry the risk of infection, and high levels of sexual assault are resulting in high infection rates among young women in Africa, the denial of PEP to those who do not meet certain criteria relating to the circumstances under which they were exposed to risk of transmission is flawed. Pieterse convincingly argues that, '[by] signalling to everyone who is exposed to HIV other than in the course of a sexual offence that they are undeserving of publicly-funded treatment and should bear the costs of their behaviour themselves, the policy framework exacerbates HIV-related stigma'.⁶⁵

The Southern African guidelines on post-exposure prophylaxis are a set of guidelines by the Southern African HIV Clinicians Society to guide internal practice. These guidelines demonstrate cognisance of the reality of the risk of exposure, and the need to save lives through the provision of the following:⁶⁶

Post-sexual exposure prophylaxis is indicated for those who present within 72 hours of unprotected risky sexual activity ... including but not limited to rape survivors. As a public health intervention equal access to treatment of persons who might otherwise not have been considered to have been raped, but who have definitely sustained a high-risk exposure, is essential to equality of therapy and minimisation of HIV transmission.

As the president of the Society noted, the Guidelines 'are very different from international guidelines, are definitely controversial, and have caused external reviewers to pause'.⁶⁷ One of the reasons for his statement is the recommendation of PEP for all exposures.⁶⁸ While these particular guidelines are not initiated by any state and are therefore not the policy of any state, they are nonetheless illustrative of alternative thinking with respect to PEP administration by a respected membership of HIV clinicians. A non-exhaustive review of policies in Africa for purposes of ascertaining a trend, which included the provision of PEP, did not reveal a similar recommendation to that of the Southern African HIV Clinicians Society, but rather prescribed PEP for occupational exposure and after sexual assault only.⁶⁹ It is unclear why there is no stronger voice within a human rights-based approach, advocating for public policies that encompass a wider variety of circumstances under which PEP is provided.

65 M Pieterse 'Impeding access? Stigma, individual responsibility and access to post-HIV exposure prophylaxis (PEP) in South Africa' (2011) 30 *Medicine and the Law* 291.

66 Southern African HIV Clinicians Society 'Guidelines: Post-exposure prophylaxis' (2008) *The Southern African Journal of HIV Medicine* 40.

67 Southern African HIV Clinicians Society (n 66 above) 36.

68 As above.

69 This is the case at least in Botswana, Côte d'Ivoire, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Swaziland, Tanzania, Uganda and Zambia, as gleaned, in part, from USAID *Gender-related barriers to HIV prevention methods: A review of post-exposure prophylaxis (PEP) policies for sexual assault* (2009).

There are instances of high-risk exposure to HIV beyond the narrow scenarios of occupational exposure or sexual assault. Limiting the administration of PEP in public health settings is a violation of the right to health and, arguably, subject to interpretation by the African Commission, of the right to be protected from HIV. States should, therefore, review laws and policies governing the administration of PEP and base eligibility on an assessment of the risk of the exposure. Healthcare providers should also be trained in assessing eligibility for PEP without discrimination.

3 Right to be informed of one's status and the status of one's partner

Article 14(1)(e) provides for the right to be informed of one's health status and of the health status of one's partner, particularly if infected with STIs, including HIV, in accordance with internationally recognised standards and best practices. For the purposes of this chapter, this particular provision will be explored in relation to HIV only. The two distinct components of this provision leave much open to interpretation.

3.1 Right to be informed of one's HIV status: Voluntary counselling and testing

An obvious interpretation of the right to be informed of one's status is that one has the right to know if one is HIV positive. However, a more subtle interpretation is that to be informed of one's status would require the provision of information on the implications of one's HIV status, namely, through pre- and post-test counselling. The positive duty of the state should therefore be interpreted as not only to ensure access to HIV testing, but to also provide information about the results of the test, and the means of preventing the transmission of HIV, depending on the results of the test. As explicitly stated in the text, this right must be guaranteed in accordance with internationally-accepted standards and best practices, meaning that testing should be undertaken only after informed voluntary consent has been given and pre- and post-test counselling has been provided.⁷⁰ Furthermore, the confidentiality of seeking a test and the test results should be respected.⁷¹

With respect to adolescent girls and testing, there are additional considerations for states. Many adolescents living with HIV do not access treatment because they have never been tested.⁷² Among the significant obstacles to testing for adolescents are laws and policies in many countries that require consent from parents or guardians for medical treatment. This

70 UNAIDS & UNHCR (n 35 above) para 20(b)(c).

71 UNAIDS & UNHCR (n 35 above) para 20(e).

72 UNICEF *Children and AIDS: 5th stocktaking report* (2010) 15.

is the trend in the laws and policies of several African countries. HIV laws in Angola, Kenya, Madagascar and Mauritius, to cite only some examples, require permission from parents or legal guardians for HIV tests on minors.⁷³ These laws contain certain variations which allow for flexibility in implementation. For example, in Kenya, a child who is pregnant, married, a parent, or is engaged in behaviour which puts him or her at risk of contracting HIV, may, in writing, directly consent to an HIV test.⁷⁴ In Madagascar, the absence of consent is not an obstacle to testing and counselling, and in Mauritius, the test may be administered where a minor makes a written request and the person undertaking the test is satisfied that the minor understands the nature of the request.⁷⁵ Tanzanian law provides for parental consent for minors with the 'inability to comprehend the result', which begs questions regarding the process of determining the ability to comprehend the test results of those minors who present themselves for testing.⁷⁶ How these laws, with their minor variations, are implemented in practice by healthcare practitioners, warrants study. If not implemented in the best interests of the child, they can have the effect of preventing adolescents, should they be younger than the legislated age, from HIV testing and, consequently, from accessing life-saving treatment should they be living with the virus.

South Africa provides a more progressive legislative model, reflective of the stark reality of the high HIV infection rates among young people. In the South African Children's Act, HIV testing has been distinguished from medical treatment.⁷⁷ Any child over the age 12 may consent to testing, and children below the age of 12 may consent independently to HIV testing if they are 'sufficiently mature'.⁷⁸ This provision implicitly recognises the effect that the HIV pandemic has had on many children in expediting their maturity. For example, many children have become heads of households as a result of HIV, and it would certainly be incongruent to undermine their capacity to consent to an HIV test, should they at the same time be the primary decision maker and caregiver for themselves and younger siblings.

Other barriers to testing for adolescent girls include social, cultural and moral norms that prescribe appropriate social behaviour for girls.⁷⁹ These

73 Angola Law 8/04 on HIV and AIDS (2004) sec 22(d); Kenya HIV and AIDS Prevention and Control Act 14 of 2006 sec 14(1)(b); Madagascar Law 2005-040 on the Fight against HIV/AIDS and the Protection of Rights of People Living with HIV (2005) art 5; Mauritius HIV and AIDS Act 31 of 2006 sec 7(2)(b). A systematic review of HIV law and policy throughout Africa to determine parental consent requirements is beyond the scope of this chapter.

74 Sec 14(1)(b).

75 Art 5 and sec 7(5) respectively.

76 Tanzania HIV and AIDS (Prevention and Control) Act (2008) sec 15(2).

77 Sec 130.

78 Secs 130(2)(a)(i) & (b).

79 UNAIDS Issue Paper 'HIV testing of specific populations: Children and adolescents' (2004).

are perpetuated within the family and community, but also by healthcare providers whose individual stereotypes and perceptions of girls and sexuality manifest in judgmental attitudes towards young women seeking services related to their sexual health or HIV prevention.⁸⁰ Voluntary counselling and testing services should be youth-friendly. In other words, it is not sufficient for a state to facilitate access to testing for adolescents without recognising the barriers that may inherently discriminate against them and, consequently, deter them from seeking HIV testing. According to the ESCR Committee, 'the realisation of the right to health of adolescents is dependent on the development of youth-friendly health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services'.⁸¹ Services should be available, accessible and equitable, meaning that all young people can use them.⁸² They should be acceptable, and serviced by trained staff who respect dignity and privacy.⁸³ Furthermore, youth-friendly means that the services are appropriate and effective in that the necessary skills, equipment and supplies are available to provide quality services for HIV prevention, treatment, care and support for young people.⁸⁴ Detailed guidance on providing youth-friendly services should be available and inform policies and capacity-building initiatives in order for testing adolescents to align with international standards and best practices as required by the African Women's Protocol.⁸⁵

3.2 Right to be informed of the HIV status of one's partner

Presumably, the underlying intention behind providing for the right to be informed of the HIV status of one's partner is to protect women and girls from HIV infection from partners who either are unaware of their HIV status or are deliberately withholding their positive status. This provision is, however, ambiguous and problematic in a number of respects and raises complex ethical and legal issues dealing, not least, with privacy and confidentiality.

The very same realities which put African women and girls at risk of HIV infection, namely, unequal power relations between men and women, are also significant barriers to asserting their right to know the status of their partners. Given that women are, in many instances, unable to demand to know the status of their partners, there is a risk that policy makers could interpret the right of women to be informed to justify compulsory testing of partners and the disclosure of test results. Neither

80 Durojaye (n 33 above) 150.

81 ESCR Committee (n 38 above) para 23.

82 Inter-Agency Task Team on HIV and Young People *Guidance brief: HIV interventions in the health sector for young people* (2008) 2.

83 As above.

84 As above.

85 See eg WHO *Adolescent friendly health services: An agenda for change* (2002).

practice accords with internationally-accepted standards and best practices to which the African Women's Protocol refers but does not specify. Legislators and policy makers are entrusted with identifying the relevant standards and practices, and applying them. Given that many legislators and policy makers in Africa are not well versed in international and regional human rights standards and guidelines, particularly those focusing on women's human rights or human rights in the context of the HIV pandemic, this provision may in fact weaken the protection of human rights. It may also serve as a deterrent to voluntary testing should one fear that the results would not be confidential based on a partner's right to be informed.

Interpretation of this provision should direct states, at a minimum, to the UN International Covenant on Civil and Political Rights (ICCPR), the Human Rights Committee's General Comment on privacy, and the International Guidelines on HIV and Human Rights (International Guidelines). The circumstances under which one is informed of the HIV status of one's partner must be in line with article 17 of ICCPR, which guarantees every individual the right to privacy. However, it must be understood in the light of the Human Rights Committee's General Comment elaborating state obligations under article 17, which clarifies that 'as all persons live in society, the protection of privacy is necessarily relative', and acknowledges that there may be circumstances that necessitate lawful interference with one's private life.⁸⁶ In relation to one's HIV status, the International Guidelines on Human Rights and HIV would be most pertinent, whereby strict circumstances under which an HIV-positive patient's status should be divulged to the patient's sexual partners are listed.⁸⁷ The SADC Model Law on HIV in Southern Africa also provides guidance for states on legislating third-party disclosure in line with human rights principles.⁸⁸

There are differing approaches to the disclosure of one's HIV status in law and policy. One approach is exemplified by the Burkina Faso Reproductive Health Act, wherein disclosure is compulsory, and healthcare professionals are granted a right to disclose should the person living with HIV not do so.⁸⁹ Tanzanian HIV law imposes an obligation to disclose to one's partner and also provides for third party disclosure to a

86 Human Rights Committee General Comment 16 para 7.

87 UNAIDS and UNHCR (n 35 above) para 20(g). The conditions are (i) the HIV-positive person in question has been thoroughly counselled; (ii) counselling of the HIV-positive person has failed to achieve the appropriate behavioural changes; (iii) the HIV-positive person has refused to notify, or consent to the notification of his/her partner(s); (iv) a risk of HIV transmission to the partner(s) exists; (v) the HIV-positive person is given reasonable advance notice; (vi) the identity of the HIV-positive person is concealed from the partner(s), if this is possible in practice; (vii) follow-up is provided to ensure support to those involved as necessary.

88 SADC Model Law on HIV in Southern Africa sec 15(4).

89 Arts 7 & 8 Law on Reproductive Health (Loi No 049-2005/AN).

spouse or sexual partner.⁹⁰ This approach, while appearing to comply with the African Women's Protocol in that the right to be informed on the HIV status of one's partner is being protected, is not aligned with international standards promoting voluntary disclosure.⁹¹ The law in Madagascar provides a better example in this respect, whereby anyone who is aware of his or her HIV status is encouraged to inform his or her partner.⁹² The Malawi National AIDS Policy also serves as a model as it promotes voluntary partner notification.⁹³ Aside from being in accordance with internationally-accepted best practices and human rights compliance, there are also valid justifications for the latter approach. As the judge in *Van Vuuren and Another NNO v Kruger* noted:⁹⁴

The serious personal and social consequences of the virus for the infected person justifies the protection of confidentiality. Such circumstances include isolation and rejection which may lead to increased anxiety, depression and psychological conditions that tend to hasten the onset of so-called full-blown AIDS.

The African Women's Protocol, while aiming to protect women by providing for the right to know the status of one's partner, may in fact contribute to an environment where their vulnerability to other rights violations is increased. In the light of the principle of non-discrimination, should a woman have the right to know the status of her partner, the converse must apply. In other words, a state could not provide, in law or policy, the right for only women to know the status of their male partners, as women would be exposed to compulsory testing and violations of their privacy rights should their status be disclosed involuntarily. For women, disclosing positive test results can be met with negative consequences, including violence. Women in Zambia, for example, reported that they were beaten, slapped, shouted at, verbally abused and raped after disclosing their HIV status to their husbands.⁹⁵ A review of 17 studies, which included 15 from sub-Saharan Africa, found that women's fear of abandonment, rejection, discrimination, violence, upsetting family members, accusations of infidelity, and loss of economic support from partners were obstacles to disclosure of their HIV-positive status.⁹⁶ While studies confirming similar fears and outcomes for adolescent girls specifically could not be found, one could hypothesise similarities in light

90 Tanzania HIV ACT (n 76 above) secs 21(1)(a) & 16(1).

91 See, eg, UNAIDS & UNHCR (n 35 above) and UNAIDS *Opening up the AIDS epidemic: Guidance on encouraging beneficial disclosure, ethical partner counselling & appropriate use of HIV case-reporting* (2000).

92 Madagascar Law (n 73 above) art 10.

93 Malawi National HIV/AIDS Policy sec 3.2.2.5.2.

94 1993 (4) SA 842 (SAA) para 10.

95 Human Rights Watch *Hidden in the mealie meal* (2007) 21.

96 A Medley *et al* 'Rates, barriers and outcomes of HIV sero-status disclosure among women in developing countries: Implications for prevention of mother-to-child transmission programmes' (2004) 82 *Bulletin of the World Health Organisation* 300.

of the common underlying determinant of gender inequality which contributes to an environment where disclosure is feared.

In order to elaborate state obligations under this particular component of the African Women's Protocol, international standards and best practices must, as a first step, be identified and articulated in order that the right to be informed of the HIV status of one's partner can be guaranteed in line with these standards and practices, as the provision explicitly states. The current lack of consensus among legislators in Africa regarding issues of compulsory and voluntary disclosure, which are closely related to one's right to know another's status, indicates that some states are either unaware of internationally-recognised standards and best practices, or are willing to disregard them.

4 Role of the African Commission on Human and Peoples' Rights

In line with their interpretive mandate, it is incumbent on the African Commission to explore further the nature of state obligations in relation to HIV as included in the African Women's Protocol.⁹⁷ This could be subsequently adopted as a Commission resolution, serving a similar purpose to the UN treaty bodies' practice of adopting General Recommendations, or General Comments, depending on the treaty body. The African Commission has previously adopted resolutions to elaborate on the content and scope of human rights principles.⁹⁸ The guidance should include a broad interpretation of the Women's Protocol elaborating the link between gender inequality, the rights enshrined in the Protocol and HIV. The focus should be on articles 14(1)(d) and (e) whereby state obligations and corresponding international standards should be enumerated. Special attention, where relevant, must be accorded to adolescent girls, and specific measures, where relevant, should be identified to protect them from HIV infection.

Two special mechanisms of the African Commission, namely, the SRRWA and the Committee on the Protection of the Rights of People Living with HIV and Those at Risk, Vulnerable to, and Affected by HIV (HIV Committee), are well placed to undertake the interpretation of states' roles and responsibilities with respect to HIV under the Women's Protocol. It would be directly in line with the particular component of the mandate of the SRRWA to assist African governments in the development and implementation of their policies of promotion and protection of the

⁹⁷ Art 45 African Charter.

⁹⁸ See eg Dakar Declaration and Recommendations on the Right to Fair Trial (1999); Declaration of Principles on Freedom of Expression in Africa (2002); Robben Island Guidelines (2002); Principles and Guidelines on the Right to a Fair Trial and Legal Assistance in Africa (2003).

rights of women in Africa, particularly in line with the domestication of the African Women's Protocol.⁹⁹ The HIV Committee's mandate includes engaging state parties and non-state actors on their responsibilities to respect the rights of people living with HIV and those that are vulnerable, and to recommend concrete and effective strategies to better protect the rights of people living with HIV and those at risk.¹⁰⁰ In so doing, they are to integrate a gender perspective.¹⁰¹ While the SRRWA was instrumental in realising the adoption of the Women's Protocol and in encouraging ratification of the treaty by states, the past mandate holders have yet to use their position and voice within the African Commission to impact on the women's rights jurisprudence of the Commission.¹⁰² A collaborative effort with the HIV Committee on one of the most urgent women's rights issues on the continent, that of adolescent vulnerability to HIV infection specifically, and women's reproductive health, broadly, is an excellent area upon which to break ground.

The SRRWA is also mandated to undertake fact-finding missions and comparative studies on the situation of women's rights in Africa.¹⁰³ Accordingly, this should be done with a focus on HIV and adolescent girls. The SRRWA should then recommend to state parties to the African Women's Protocol to report on measures taken to reduce the rate of HIV infection among adolescent girls, paying attention to articles 14(1)(d) and (e). The study should include a review of laws and policies in Africa which conflict with international standards and best practices concerning, in particular, comprehensive sexuality education, age of consent to medical treatment, voluntary counselling and testing, and confidentiality. The HIV Committee is mandated to include a gender perspective in their work, and can assist the SRRWA with information gathering, in particular from civil society networks of women living with HIV, including adolescent girls.

State reporting is an important entry point for the African Commission for interpreting the African Women's Protocol through engaging in dialogue with states and issuing concluding observations. It is unfortunate that its potential to advance the Women's Protocol remains unfulfilled. According to the Protocol, state parties are to include in their reports to the African Commission measures undertaken to implement the provisions of the Protocol, including those relating to HIV.¹⁰⁴ Not one state party to the Protocol has complied. The African Commission should promote reporting on the Women's Protocol by encouraging state parties to follow

99 African Charter Res 38 (XXV) 99.

100 African Charter Res 163 (XLVII) 2010.

101 As above.

102 For similar commentary, see CG Ngwena 'Inscribing abortion as a human right: Significance of the Protocol on the Rights of Women in Africa' (2010) 32 *Human Rights Quarterly* 860, noting that the office of the SRRWA has yet to become visible in discrete areas of women's rights, including reproductive rights and abortion in particular.

103 African Charter.

104 Art 26 African Women's Protocol.

the Guidelines for State Reporting. It should also remind states during the examination of reports submitted under the African Charter about their reporting obligations. In the meantime, and due to the absence of state reports under the Protocol, the Commission can question states under article 16 of the African Charter, which guarantees the right to the highest attainable standard of health, on measures they are taking to protect women, in particular young women, from HIV infection.

5 Conclusion

Articles 14(1)(d) and (e) guarantee the right to protection from HIV and the right to be informed of one's status, and the status of one's partner. However, the drafters of the African Women's Protocol fell short of enumerating specific measures to be taken by states in order to protect, respect, and fulfil these rights, and the African Commission has not provided any interpretive guidance. Additional obligations may be required to ensure that adolescent girls, protected under the Women's Protocol, also enjoy these enshrined rights. The African Charter and the African Women's Protocol provide that the African Commission may draw on relevant international instruments for interpretive guidance.¹⁰⁵ In particular, UN treaties, especially CEDAW, ICCPR, the International Covenant on Economic, Social and Cultural Rights (ICESCR) and CRC, and the very developed jurisprudence of their respective treaty-monitoring bodies, authoritatively define the standards to which the implementation of articles 14(1)(d) and (e) should accord. Within the confines of this chapter, specific obligations have been gleaned from a review of these instruments and related documents, along with guidance which has emerged from various UN agencies.

In summary, to ensure that women and girls enjoy the right to self-protection and to be protected from HIV, states must provide comprehensive sexuality education as well as to ensure availability, accessibility, acceptability and affordability of a means of HIV prevention, including male and female condoms. They must also provide PEP beyond current limitations to instances of occupational exposure or sexual assault. For adolescent girls, health services that provide information and tools for prevention must be youth-friendly.

With respect to the right to be informed of one's status and the status of one's partner, states must provide access to HIV testing and ensure that it is undertaken after informed consent has been given, that counselling is provided before and after the test, and that the confidentiality of the test and test results is respected. The privacy rights of one's partner must be

105 Art 60 and the Preamble respectively.

respected in accordance with international standards recognising that third party disclosure is permitted only under adherence to strict conditions.

Mindful that adolescent girls are the demographic group most infected with and vulnerable to HIV, states must remove barriers arising from law, policy and practice that prevent adolescents from accessing health services without parental consent, as this has the effect of preventing them from acquiring the means to prevent HIV and to access HIV testing and, ultimately, life-saving treatment. Also, efforts to protect the human rights of adolescent girls and eliminate gender inequality must be strengthened, guided by the African Women's Protocol, in order that the enabling conditions to reverse and halt the spread of HIV are in place.

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Rebecca Amollo

Summary

The unrelenting negative impact of HIV and AIDS in sub-Saharan Africa is well documented. There is evidence about the implications of the epidemic for women's health and well-being. A recent UNAIDS report reveals that sub-Saharan Africa still bears an excessive share of the global HIV burden. The UNAIDS report also revealed that sub-Saharan Africa has more women than men living with HIV. Women's vulnerability to HIV and AIDS is maintained by a lack of economic power, a lack of social power, a lack of political power and a lack of a voice to effectively influence policy-makers. Over the years, there have been established normative standards on realising women's rights to health within the context of HIV and AIDS. Against this background, this chapter proposes the imperative to address HIV and AIDS by tackling gendered-inequalities in relation to women's rights to access health services. In doing so, the chapter will also address the underlying determinants of health, such as food (and nutrition) and housing (including sanitation and land). The chapter relies on a combination of human rights standards and the feminist capabilities approach theory to make the argument for the realisation of the above rights.

1 Introduction

In 2010, UNAIDS¹ reported that sub-Saharan Africa still bore a high burden of HIV globally.² UNAIDS further reported that sub-Saharan Africa had more women than men living with HIV.³ The largest epidemics

1 UNAIDS is an innovative United Nations partnership that leads and inspires the world in achieving universal access to HIV prevention, treatment and care.

2 In 2009, that number reached 22,5 million or 68% of the global total. See UNAIDS *Global Report 2010* 25.

3 As above.

in sub-Saharan Africa exist in South Africa, Ethiopia, Nigeria, Zambia and Zimbabwe.⁴ However, in these countries, the epidemic has stabilised.⁵

UNAIDS noted that slightly more than half of all people living with HIV are women and girls.⁶ In sub-Saharan Africa, more women than men are living with HIV, and young women aged 15 to 24 years are as much as eight times more likely than men to be HIV positive.⁷ UNAIDS has also recently stated that protecting women and girls from HIV means protecting women against gender-based violence and promoting economic independence from older men.⁸

Within the above context, a woman remains at the lowest end of the pandemic. The underlying social and economic factors which contribute to women's vulnerability to HIV infection are vast. They include the lack of economic power to access treatment or preventive measures such as condoms;⁹ the lack of social power to make responsible sexual decisions, or opt for early diagnosis and a healthy and open approach to living with HIV;¹⁰ the lack of political power to change oppressive myths, cultural values and practices that perpetuate and exacerbate the powerlessness in the face of the pandemic;¹¹ and the lack of a voice to effectively influence decision makers and policy makers.¹² Furthermore, the issue of HIV raises profound ethical questions about human sexuality and relationships between women and men.¹³ Within the context of this chapter, the relationship between women's socio-economic rights and HIV is examined.

2 HIV/AIDS, women and socio-economic rights: An overview

The role of poverty in increasing women's vulnerability to HIV is immense. Poverty forces both women and men into precarious economic and social lifestyles that shape their vulnerability to HIV and AIDS. Poverty, therefore, constrains the choices that women and men are able to make in relation to their lives, including their sexual lives. Women's

4 As above.

5 The estimated 1,3 million people who died of HIV-related illnesses in sub-Saharan Africa in 2009 comprised 72% of the global total of the estimated 1,8 million deaths attributable to the epidemic. See n 2 above, 25.

6 n 2 above, 10.

7 As above.

8 As above.

9 GR Gupta 'Gender, sexuality, and HIV/AIDS: The what, the why, and the how in global perspectives on gender, sexual health, and HIV/AIDS' (2001) 29 *SIECUS* Report 5.

10 As above.

11 As above.

12 As above.

13 As above.

particular vulnerability, therefore, emerges from their greater economic vulnerability. In this milieu, improving women's economic conditions is of the essence. It is within this broader context that the argument for the realisation of women's rights to the highest attainable health, food and adequate housing is made.

Social and economic rights, gender equality and women's human rights have evolved within the international discourse of human rights and HIV and AIDS. Albertyn fittingly argues that these rights provide new weapons in the fight against the pandemic at the same time as they raise new conceptual and practical challenges.¹⁴ In addition, sexual inequality cannot be understood in isolation from socio-economic equality. HIV highlights the indivisibility and interdependence of rights such as dignity, privacy and autonomy in relation to one's body and sexual life, and the economic and social needs that constrain choices. Also, for example, the gendered nature of social and economic relations within and outside the household means that women experience discrimination and inequality in virtually every aspect of housing.

Against this backdrop, this chapter argues for an approach that focuses on women's capabilities. The chapter makes the above proposal using the philosophical stance of the feminist capabilities approach and the international and regional human rights standards. It is, therefore, a synergistic approach. In particular, this chapter proposes the imperative to address HIV and AIDS by tackling gendered-inequalities in relation to access to health services and other underlying determinants of health, such as the right to food (and nutrition) and the right to adequate housing (including sanitation and land). At this point, it is imperative to elaborate on what the capabilities approach is.

3 The capabilities approach: A philosophical basis

The preceding parts of this chapter reveal that gender inequality is the underlying factor of women's vulnerability within the context of HIV and AIDS. It is, therefore, imperative to remove the structural barriers hindering women from enjoying a state of well-being in the context of HIV. It is suggested that this necessitates the consideration of the capabilities approach as a constructive framework to address women's vulnerability to HIV. The choice to use the feminist capabilities approach presents a more realistic, albeit, not the only, tool in tackling the impact of HIV on women. The chapter will, therefore, rely on the capabilities

14 C Albertyn 'Prevention, treatment and care in the context of human rights' Windhoek: Presentation at the Expert Group Meeting on the HIV/AIDS Pandemic and its Gender Implications (2000) <http://www.un.org/womenwatch/daw/csw/hivaids/albertyn.html>. (accessed 23 August 2012).

approach theory as conceived by Sen¹⁵ and later developed in relation to women's development and philosophy by Nussbaum.¹⁶ As opposed to focusing on economic growth to measure the quality of life, Sen and Nussbaum suggest that human capabilities and functions provide a better index.

Simply put, the conceptual foundations of the capabilities approach can be found in Sen's critique of traditional welfare economics, which typically conflate well-being with either opulence (income, commodity command) or utility (happiness, desire, fulfilment).¹⁷

Sen developed the concept of substantial freedoms or capabilities as a way of addressing questions of social justice and human development.¹⁸ He advances the argument that all individuals are endowed with a certain set of capabilities, and that realising these capabilities will allow a person to escape from poverty and their state of 'unfreedom'.¹⁹ Sen questions the *status quo* of development economics and argues that income poverty should not be the single most important factor in determining development. He argues that, in spite of a world of sheer abundance, there simultaneously exist populations living in a state of 'unfreedom', unable to realise their capabilities.²⁰ Furthermore, Sen notes that constraints on freedom include not just political oppression or interference, but also socio-economic and personal circumstances. Hence, what people can achieve is influenced by economic opportunities, political liberties, social powers and the enabling conditions of good health, basic education, and the encouragement and cultivation of initiatives.²¹

Sen endeavours to expand the basic interpretations of freedom by examining five elemental forms of instrumental freedoms: political freedoms, economic facilities, social opportunities, transparency guarantees, and protective security. Each form of freedom is complementary to the other, remaining interrelated and inextricable. These freedoms constitute not only the means, but also the ends in development. Sen asserts that poverty should be seen 'as a deprivation of basic capabilities, rather than merely as low income'.²² He, therefore, challenges the general belief amongst economists who view income as the sole determinant of development. Sen's core argument, therefore, is that developmental progress and freedom are intertwined.

15 See, generally, A Sen *Development as freedom* (1999).

16 MC Nussbaum *Women and human development: The capabilities approach* (2000).

17 A Sen 'Development: Which way now?' (1983) 93 *Economic Journal* 745-762.

18 Sen (n 15 above).

19 As above.

20 As above.

21 Sen (n 15 above) 5.

22 As above.

The capabilities approach was later developed in relation to women's development and philosophy by Nussbaum, who derives the capabilities approach philosophically from Aristotle and feminism. For Nussbaum, the feminist capabilities approach means that 'international political and economic thought should be feminist, attentive to the special problems women face because of sex in more or less every nation in the world'.²³ She further argues that the capabilities approach is superior to the preference-based approaches.²⁴ The gender differences between men and women are reflected in patterns of health and illnesses. It can be contended that the scenario is worse within the context of HIV and AIDS. Poorly-managed HIV leads to an acute failure in women's central human capabilities. Nussbaum's argument, therefore, provides the philosophical understanding for an account of basic constitutional principles that should be respected and implemented by the governments of all nations, as a bare minimum of what respect for human dignity requires.²⁵ She then argues that the best approach to this idea of basic social minimum is provided by an approach that focuses on human capabilities. She persuasively argues that the capabilities in question should be pursued for each and every person, treating each as an end and none as a mere tool of the ends of others.²⁶ Nussbaum further asserts that women have all too often been treated as the supporters of the ends of others, rather than as ends in their own rights. She emphasises that the principle has particular critical force for women.²⁷ The feminist capabilities approach, therefore, highlights that gender discrimination affects women's human capabilities.

In essence, the capabilities approach asks not just about the total or average achievements of a nation, but about the opportunities available to each person. It is focused on choice or freedom holding that the crucial thing societies should be promoting for their people is a set of opportunities, or substantial freedoms, which people may or may not exercise in action as the choice is theirs.²⁸ The capabilities approach holds that the capability achievements that are central for people are different in quality, not just in quantity, that they cannot without distortion be reduced to a single numerical scale, and that a crucial part of understanding and producing them is an understanding of the specific nature of each. It, therefore, assigns an urgent task to government and public policy, namely, the improvement of quality of life for all people, as defined by their capabilities.²⁹

23 Nussbaum (n 16 above) 4.

24 As above.

25 As above.

26 Nussbaum (n 16 above) 5-6.

27 As above.

28 R Dixon & M Nussbaum 'Abortion, dignity and a capabilities approach' Public Law and Legal Theory Working Paper 345, March 2011 3-4 http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1799190 (accessed 19 April 2011).

29 Dixon & Nussbaum (n 28 above) 4.

Moreover, the capabilities approach provides a framework for the implementation of law and policy in a manner that seeks to eradicate deep-rooted gender inequalities with the goal of realising women's capabilities. A further argument is that a just society is one that secures to all citizens a threshold of a list of key entitlements, on the grounds that such entitlements are requisite of a life worth of human dignity. Hence, this approach also allows for an analysis in relation to state obligation to realise women's socio-economic rights in the context of HIV.³⁰

On the strength of the above argument, the nucleus of the argument in this chapter is that the state should undertake to realise the rights of women affected by HIV in the areas of health, food and housing (including sanitation and land). This obligation is grounded on the argument that women affected by HIV form a specific group whose nature must be understood contextually. In agreement with Dixon and Nussbaum, the idea is that a minimally-just society is one that secures to all citizens a threshold of a list of key entitlements, on the grounds that such entitlements are requisite of a life worth of human dignity.³¹ It is defensible that this approach expands women's choices and opportunities in such a manner as to empower them to live dignified and productive lives. The approach considers women independently and does not lump individuals into families and ignore the relations and unequal distributions of power within families. In this way, the approach provides a useful framework because women's vulnerability in the context of HIV is a matter of 'who wields power', *inter alia*, in sexual relationships and decision making. The major constituents of the capabilities approach are 'functionings' and 'capabilities'.

3.1 Functionings and capabilities

Functionings are the 'beings and doings' of a person, whereas a person's capability is the various combinations of functionings that a person can achieve.³² Hence, in the context of women, HIV and AIDS, the capabilities approach means women's ability 'not to get infected' or 'to be able to live normally' amidst the epidemic. This can be achieved through women's access to both material and non-material needs, such as the appropriate health services, food security and adequate housing. These needs also relate to Nussbaum's list of elements for poor women. These are life, bodily health, bodily integrity, senses, imagination, thought, emotions, practical reason, affiliation, other species, play, and control over one's environment.³³

30 Nussbaum (n 16 above) 4.

31 Dixon & Nussbaum (n 28 above) 4.

32 A Sen *The standard of living: The Tanner lectures* (1987) 36.

33 Nussbaum (n 16 above) 78-80.

A necessary component of Nussbaum's capability approach is the list of the aspects of life to which capabilities relate. Nussbaum asks an Aristotelian question: What activities characteristically performed by human beings are so central that they seem definitive of a life that is truly human?³⁴ Two more questions are then formulated. First, which changes or transitions are compatible with the continued existence of a being as a member of the human kind and which are not?³⁵ Second, what kinds of activity must be there if we are going to acknowledge that a given life is human?³⁶ Similar questions are relevant in the context of women, HIV and AIDS. This is especially the case in relation to state responsibility to realise women's rights to health, food and housing. Therefore, this leads to an examination of the relationship between capabilities and human rights.

3.2 Capabilities and human rights

The relationship between the capabilities approach and human rights merits discussion. Human rights entitlements have operated as rivals to the capabilities approach and have formed the basis of the attack on Sen and Nussbaum's arguments. In response, Sen has generally shown that each approach has something to offer, but only the capabilities approach can address all relevant concerns.³⁷ His argument that the capabilities approach comes in to augment legislative and human rights approaches is valid. Sen has appositely argued that this approach transcends legislation.³⁸ He trounces the idea that democracy and human rights are some sort of 'luxury' that a poor nation cannot afford, that may conflict with economic necessities.³⁹ Furthermore, the idea of human rights may be interpreted as implying the moral principle that capabilities of human beings should not be permitted to fall below a certain level, so far as nation-states and the international community are able to produce that minimum threshold for everyone. This argument resonates with the minimum core concept of the Committee on Economic, Social and Cultural Rights (ESCR Committee). What women are actually capable of doing is primarily a matter of combined capabilities, which depends in turn upon internal capabilities and basic capabilities. However, internal capabilities and combined capabilities depend in different ways upon external conditions, and it is these conditions that political and public action can modify or improve. Hence, badly-chosen government action can undermine these conditions and thus undermine combined capabilities.

34 Nussbaum (n 16 above) 39.

35 As above.

36 As above.

37 A Sen 'Human rights and capabilities' (2005) 6 *Journal of Human Development* 151-66.

38 A Sen 'Elements of a theory of human rights' (2004) 32 *Philosophy and Public Affairs* 319-320.

39 Sen (n 15 above).

Accordingly, producing capabilities requires material and institutional support, and the approach thus takes issue with the simplistic distinction of rights as ‘first generation’ (political and civil) and ‘second-generation’ (economic and social).⁴⁰ All rights, understood as entitlements to capabilities, have material and social preconditions, and all require government action. Within this argument, the capability approach has pushed forward the analysis of women’s human rights. It is clear that it is the socio-economic realities of women that influence their existence within the milieu of HIV and AIDS.

On the relationship between the capabilities approach and human rights, Fredman convincingly asserts that capabilities refer to those valued goals which are feasible for an individual to pursue.⁴¹ It is not enough to have the formal opportunity to pursue one’s chosen goals; ‘capability’ crucially denotes feasible options.⁴² The capabilities approach is also sensitive to the fact that the same input might have very different results, depending on each individual’s circumstances.⁴³ Fredman argues that, in this case, it reflects many of the insights of substantive equality. Using the right to water as an example, she elucidates that the right to water is not fulfilled solely by providing a fixed volume of water. In order for the right to genuinely increase women’s capabilities, or their ability to achieve valued goals, it is necessary in addition to require other factors, for example, that water be accessible, and that women be free from violence in the process of collecting water. According to Fredman, therefore, combining the capabilities approach with substantive equality gives us the means to engender socio-economic rights. She compellingly argues that to achieve genuine change, socio-economic rights and equality need to work synergistically. Fredman further suggests that in formulating the content of a right, attention must be paid to the extent to which the right genuinely enhances the range of feasible options available to women.

To further establish the advantage of combining the capabilities approach and human rights, McCowan has fittingly argued that viewing rights as rights to capabilities protects against the dangers of assuming that the holding of formal entitlements is sufficient for them to be exercised in practice.⁴⁴ Using the right to education, McCowan asserts that there are three areas in which capabilities can make a significant contribution in the field of education. Firstly, it can provide a fuller conception of the realisation of the right to education. Secondly, it can direct attention towards the heterogeneity of learners and, thirdly, it can guard against an approach which overly focuses on the state as the only party with human

40 Nussbaum (n 16 above) 97.

41 S Fredman ‘Engendering social and economic rights’ in B Goldblatt & K McLean (eds) *Women’s social and economic rights: Developments in South Africa* (2010) 16.

42 As above.

43 Fredman (n 41 above) 17.

44 T McCowan ‘Human rights, capabilities and the normative basis of Education for All’ (2011) 9 *Theory and Research in Education* 283.

rights obligations to discharge.⁴⁵ According to the author, these points relate to different aspects of the right to education and thereby they provide insight beyond the rights-based approach: whether the right has been upheld; whether the constraints on individuals and groups exercising the right are met; and whether the responsibility for the upholding of the right is taken.⁴⁶ Similarly, this article argues that as one of the means to realise women's rights to health within the HIV context, rights could be viewed as rights to capabilities.

Additionally, the relationship between the capabilities approach and human rights could be viewed in the light of court decisions. To this end, two South African cases are relied upon. In *Government of the Republic of South Africa v Grootboom (Grootboom)*,⁴⁷ the South African Constitutional Court censured the government's housing programme for failing to cater for groups in urgent need, as is apparent in the following enunciation:⁴⁸

To be reasonable, measures cannot leave out of account the degree and extent of the denial of the right they endeavour to realise. Those whose needs are most urgent and whose ability to enjoy all rights therefore is most in peril, must not be ignored by the measures aimed at achieving the realisation of the right. It may not be sufficient to meet the test of reasonableness to show that the measures are capable of achieving a statistical advance in the realisation of the right. Furthermore, the Constitution requires that everyone must be treated with care and concern. If the measures, though statistically successful, fail to respond to the needs of those most desperate, they may pass the test.

Also, the decision in *Minister of Health and Others v Treatment Action Campaign and Others (TAC)*⁴⁹ is enlightening. This case presented a constitutional challenge to restrictions on the provision of anti-retroviral drugs to HIV-positive pregnant women, resulting in tens of thousands of unnecessary infections and deaths. The case alleged a violation of the right to healthcare services in sections 27(1) and 28(1)(c) of the South African Constitution.⁵⁰ The state's policy towards the prevention of mother-to-child-transmission was confusing and uncertain. The policy established 18 'research sites' – two in each province – where Nevirapine would be provided to HIV-positive pregnant mothers at childbirth.⁵¹ Further, the policy placed a ban on healthcare professionals in state healthcare facilities other than the 18 pilot sites from administering Nevirapine to HIV-positive pregnant mothers.⁵² This essentially meant that mothers and their babies who could not afford private health care and did not have access to one of

45 McCowan (n 44 above) 293.

46 As above.

47 2000 (1) SA 46 (CC).

48 *Grootboom* (n 47 above) para 44.

49 2002 (5) SA 721 (CC).

50 Constitution of the Republic of South Africa Act 108 of 1996.

51 *TAC* (n 49 above) paras 10-11.

52 As above.

the pilot sites could not access anti-retroviral treatment.⁵³ The Constitutional Court found government policy on the provision of mother-to-child-transmission unreasonable and unconstitutional because it excluded a significant segment of society.⁵⁴ The programme had failed to address the needs of mothers.⁵⁵ To this extent, the Court's approach can be described as one that considered the role of anti-retrovirals in enhancing women's capabilities in the midst of HIV and AIDS.

The capabilities approach, however, is not impeccable. Fredman, for instance, has criticised the capabilities approach and argues that it operates at a level of *minima* and that it tends to give too much emphasis to personal choice.⁵⁶ She is of the opinion that Nussbaum's capabilities approach is a basic minimum, and is not concerned with the distribution above the minimum. Fredman is concerned that the capabilities approach employs the notion of a threshold, and does not comment on what justice requires us to do about inequalities over the threshold.⁵⁷ She further critiques Nussbaum's position that inequalities which track traditional sources of discrimination, such as race or sex, will be impermissible because they affect the equal dignity of citizens. Fredman further suggests that socio-economic rights require progressive realisation and that it is not sufficient to provide only the minimum. According to the author, tracking traditional sources of discrimination in the context of gender will necessarily implicate inequalities in power and resources.⁵⁸ Nevertheless, it can be contended that the capabilities approach provides one of the obligatory avenues for the realisation of women's socio-economic rights. The next section explores the normative standards on the right to health (and housing as its underlying determinant).

4 Normative standards on right to health and its underlying determinants

The Declaration of Alma-Ata proclaims that the attainment of the highest possible level of health is a 'most important worldwide social goal'.⁵⁹ The Constitution of the World Health Organisation (WHO) provides for the right to health in its Preamble.⁶⁰ The Universal Declaration of Human

53 TAC (n 49 above) para 17.

54 Para 68.

55 Para 67.

56 Fredman (n 41 above) 17.

57 As above.

58 As above.

59 Para I. The Declaration was adopted at the International Conference on Primary Health Care, held in Alma-Ata, USSR (6-12 September 1978).

60 Preamble to the Constitution of WHO. The WHO Constitution was adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 states (Off Rec World Health Organisation, 2, 100), and entered into force on 7 April 1948.

Rights (Universal Declaration) also proclaims the right to health.⁶¹ The Convention on the Rights of the Child (CRC) contains a comprehensive provision on health.⁶² The International Covenant on Economic, Social and Cultural Rights (ICESCR) provides for the right to health.⁶³ The ICESCR provision on health deserves particular mention as the most important provision for the realisation of the right to health.⁶⁴ The list in this provision is considered to be illustrative, and non-exhaustive, of parties' obligations.⁶⁵ The ESCR Committee has elucidated on the right to health.⁶⁶ The ESCR Committee emphasised that the enjoyment of the right to health must satisfy the essential elements of availability, accessibility, acceptability and quality.⁶⁷ Furthermore, the Committee recommended that states integrate a gender perspective in their health-related policies, planning, programmes and research in order to promote better health for both women and men. According to the ESCR Committee, a gender-based approach recognises that biological and socio-cultural factors play a significant role in influencing the health of men and women. It explains further that the disaggregation of health and socio-economic data according to sex is essential for identifying and remedying inequalities in health.⁶⁸

In addition, the ESCR Committee recommended that, in order to eliminate discrimination against women, there is a need to develop and implement a comprehensive national strategy for promoting women's rights to health throughout their life span. Such a strategy should include interventions aimed at the prevention and treatment of diseases affecting women, as well as policies to provide access to a full range of high-quality and affordable healthcare, including sexual and reproductive services.⁶⁹ The ESCR Committee highlighted:⁷⁰

The realisation of women's rights to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health. It is also important to undertake preventive, promotive and remedial action to shield women from

61 Art 25 Universal Declaration of Human Rights, proclaimed on 10 December 1948 General Assembly Resolution 217 A (III).

62 Convention on the Rights of the Child, GA Res 44/25, annex, 44 UN GAOR Supp (No 49) 167, UN Doc A/44/49 (1989), entered into force 2 September 1990.

63 Art 12 International Covenant on Economics, Social and Cultural Rights, adopted 16 December 1966, GA Res 2200 (XXI), UN.Doc A/6316(1966)993 UNTS 3, entered into force 3 January 1976. It has a treaty-monitoring body, the Committee on Economic and Social Cultural Rights (ESCR Committee).

64 R Chapman 'Core obligations related to the right to health and their relevance for South Africa' in D Brand & S Russell (eds) *Exploring the core content of socio-economic rights: South Africa and international perspectives* (2002) 40.

65 Art 12(2).

66 ESCR Committee General Comment 14: The Right to the Highest Attainable Standard of Health (art 12 of the Covenant), 11 August 2000, E/C.12/2000/4 (2000).

67 General Comment 14 (n 66 above) paras 12 (a-d).

68 General Comment 14 (n 66 above) para 20.

69 General Comment 14 (n 66 above) para 21.

70 As above.

the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights.

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) also provides for the right to health.⁷¹ It has a narrower focus than the health rights in ICESCR, as it only refers to healthcare services and not underlying determinants of health.⁷² However, the manner in which the CEDAW Committee has interpreted CEDAW cannot be said to have excluded the underlying determinants of health. CEDAW also provides for the particular problems faced by rural women.⁷³ This provision is critical for most women in sub-Saharan Africa. The CEDAW Committee has also emphasised the importance of women's health in realising women's rights.⁷⁴ It categorically stated:⁷⁵

While biological differences between women and men may lead to differences in health status, there are societal factors which are determinative of the health status of women and men and which can vary among women themselves ... For that reason, special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups, such as migrant women, refugee and internally-displaced women, the girl child and older women, women in prostitution, indigenous women and women with physical or mental disabilities.

The CEDAW Committee also aptly stated:⁷⁶

The Committee notes that the full realisation of women's right to health can be achieved only when States parties fulfil their obligation to respect, protect and promote women's fundamental human right to nutritional well-being throughout their life span by means of a food supply that is safe, nutritious and adapted to local conditions. Towards this end, States parties should take steps to facilitate physical and economic access to productive resources especially for rural women, and to otherwise ensure that the special nutritional needs of all women within their jurisdiction are met.

The African Charter on Human and Peoples' Rights (African Charter) espouses the right to health.⁷⁷ There is, however, no jurisprudence on women and HIV from the African Commission on Human and Peoples' Rights (African Commission). In the absence of any jurisprudence on the

71 Art 12 of the Convention on the Elimination of All Forms of Discrimination Against Women, GA Res 34/180, adopted 18 December 1979, entered into force 3 September 1981. CEDAW has a monitoring body called the Committee on the Elimination of Discrimination Against Women (CEDAW Committee).

72 B Toebes 'Towards an improved understanding of the international human right to health' (1999) 21 *Human Rights Quarterly* 55.

73 Art 14 CEDAW.

74 CEDAW Committee General Recommendation 24: Article of the Convention (Women and Health) A54/38/Rev 1, ch 1 (1999).

75 CEDAW Committee (n 74 above) para 6.

76 Para 7.

77 African Charter on Human and Peoples' Rights, OAU Doc CAB/LEG/67/3/Rev 5, adopted by the Organisation of African Unity 27 June 1981, entered into force 21 October 1986, art 16.

subject, there is no direct point of reference in terms of interpretation by the African Commission on state obligations to women in this context. However, the Commission had developed body of normative standards that is applicable. For instance, the African Commission has found that states have an obligation to ensure that healthcare facilities and commodities, including medicines, are made available to citizens in the case of *Purohit & Another v The Gambia (Purohit)*.⁷⁸ It stated that the enjoyment of the right to health is crucial to the realisation of other fundamental rights and freedoms and includes the right of all to health facilities, as well as access to goods and services, without discrimination of any kind.⁷⁹ The *Purohit* decision provides a basis for the promotion of women's right to health in the context of HIV and AIDS in Africa. Moreover, the African Commission was also emphatic about the obligation on the state to provide for analysis, diagnosis, treatment and rehabilitation.

Exercising its promotional mandate,⁸⁰ in 2002, the African Commission issued a resolution calling on African governments to adopt a human rights-based approach to addressing the impact of HIV in the region. According to the Commission, it is imperative that all efforts adopted by African governments towards curbing the spread of HIV must be respectful of individual human rights.⁸¹ Further, the Commission has called for the allocation of resources to curb the spread of HIV, and to ensure affordable and comprehensive health services.⁸² It also issued a resolution on access to medicines.⁸³ In this regard, Balogun and Durojaye have validly argued that the African Commission is in a pivotal position to advance sexual and reproductive rights in the region.⁸⁴ Further, the authors have argued that, while the African Commission is not averse to advancing sexual and reproductive rights, it could do better.⁸⁵

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol)⁸⁶ became the first document to provide for binding obligations on the right to sexual and

78 (2003) AHRLR 96 (ACHPR 2003). See also *Social and Economic Rights Action Centre (SERAC) & Another v Nigeria* (2001) AHRLR 60 (ACHPR 2001) (*SERAC* case).

79 Para 80 *Purohit*.

80 Art 45 African Charter.

81 Resolution on the HIV/AIDS Pandemic – Threat against Human Rights and Humanity, adopted at the 29th ordinary session of the African Commission held in Tripoli, Libya, ACHPR Res 53/(XXIX)01.

82 African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, Abuja, Nigeria, 24-27 April 2001, OAU/SPS/ABUJA/3.

83 ACHPR/Res 141 (XXXIII) 08: Resolution on Access to Health and Needed Medicines in Africa.

84 V Balogun & E Durojaye 'The African Commission on Human and Peoples' Rights and the promotion and protection of sexual and reproductive rights' (2011) 11 *African Human Rights Law Journal* 394.

85 As above.

86 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, AHG/Res. 240 (XXXI), adopted 11 July 2003, entered into force 25 November 2005.

reproductive health.⁸⁷ Hailed as the beacon of hope for African women, the Women's Protocol explicitly addresses HIV and AIDS.⁸⁸ Moreover, the African Women's Protocol provides an extensive array of rights relating to sexual and reproductive rights.⁸⁹ This array of rights has the potential to improve women's capabilities to live with dignity in the midst of HIV and AIDS. The African Charter on the Rights and Welfare of the Child (African Children's Charter) also provides for the right to health.⁹⁰ It should be noted that the African Women's Protocol has defined women to include girls.⁹¹ To this extent, therefore, its provisions protect the girl child.

Other important normative standards on health, HIV and AIDS can be found in the International Guidelines on HIV/AIDS and human rights.⁹² In 2002, the Office of the High Commissioner on Human Rights (OHCHR) and UNAIDS updated the Guidelines. Among many things, the revision was meant to take into account the obligation of countries to provide anti-retroviral treatment (ARVs) as part of the right to health as interpreted by the ESCR Committee.⁹³ This resulted in the Revised Guideline 6 (Revision) which specifically refers to HIV/AIDS treatment and recommends that countries enact legislation to provide for HIV-related goods, safe services and information to ensure, among other things, safe and effective medication.⁹⁴ Other key processes on HIV and AIDS include the 1994 International Conference on Population and Development (ICPD),⁹⁵ the Fourth World Conference on Women in

87 Art 14 African Women's Protocol.

88 See, generally, E Durojaye 'Advancing gender equity in access to HIV treatment through the Protocol on the Rights of Women in Africa' (2006) 6 *African Human Rights Law Journal* 187. See also F Banda 'Blazing a trail: The African Women's Protocol comes into force' (2006) 50 *Journal of African Law* 72.

89 Art 14 provides, *inter alia*: (1) States Parties shall ensure that the right to health of women, including sexual and reproductive health, is respected and promoted. This includes (a) the right to control their fertility; (b) the right to decide whether to have children, the number of children and the spacing of children; (c) the right to choose any method of contraception; (d) the right to self-protection and to be protected against sexually-transmitted infections, including HIV/AIDS; (e) the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually-transmitted infections, including HIV/AIDS, in accordance with internationally-recognised standards and best practices; (f) the right to have family planning education. (2) States Parties shall take all appropriate measures to (a) provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas; (b) establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding.

90 African Charter on the Rights and Welfare of the Child, 11 July 1990, entry into force 29 November 1990, CAB/LEG/24.9/49 (1990).

91 Art (1)(k) African Women's Protocol.

92 Office of the United Nations High Commissioner for Human Rights, International Guidelines on HIV/AIDS and Human Rights, UNCHR Res 1997/33, UN Doc E/CN.4/1997/150 (1997).

93 ESCR Committee General Comment 14 (n 66 above).

94 Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS, International Guidelines on HIV/AIDS Revised Guideline 6 (2002).

Beijing,⁹⁶ the Millennium Development Goals (MDGs)⁹⁷ and the Declaration of Commitment on HIV/AIDS.⁹⁸

On housing, the ESCR Committee has elucidated that the right to housing should not be interpreted in a narrow or restrictive sense which equates it with, for example, the shelter provided by merely having a roof over one's head or views shelter exclusively as a commodity.⁹⁹ The ESCR Committee further highlighted that the right to adequate housing should be seen as the right to live somewhere in security, peace and dignity.¹⁰⁰ There is an inextricable linkage of this right with other human rights such as right to health,¹⁰¹ land rights,¹⁰² the right not to be arbitrarily deprived of property,¹⁰³ the right to non-discrimination¹⁰⁴ and the right to gender equality.¹⁰⁵ The right to adequate housing is provided for in several instruments, including the Universal Declaration,¹⁰⁶ ICESCR,¹⁰⁷ the International Covenant on Civil and Political Rights (ICCPR),¹⁰⁸ CEDAW,¹⁰⁹ and CRC.¹¹⁰ At the regional level, the right to housing is also protected in the African Charter,¹¹¹ the African Women's Protocol,¹¹² and the African Children's Charter.¹¹³ Furthermore, the United Nations (UN) organised two world conferences, in 1976¹¹⁴ and in 1996,¹¹⁵ during which declarations and action plans were adopted with the purpose of solving the

95 Held in Cairo, Egypt, 5-13 September 1994. See Programme of Action of the International Conference on Population and Development A/CONF.171/13 (18 October 1994).

96 Held in Beijing, China, 15 September 1995. See Beijing Declaration and Platform of Action A/Conf.177/20 and A/Conf.177/20/Add.1 (15 September 1995), endorsed by the UN General Assembly on 8 December 1995 (A/RES/50/42).

97 See MDGs 3 & 6.

98 Declaration of Commitment on HIV/AIDS, UNGA Res S-62/2, 27 June 2001.

99 ESCR Committee General Comment 4: Right to adequate housing (1991) para 7.

100 Para 7.

101 Para 8(b).

102 Para 8(a).

103 As above.

104 Para 9.

105 Para 6.

106 Art 25(1) Universal Declaration.

107 Art 11(1) ICESCR.

108 International Covenant on Civil and Political Rights, GA Res 2200, UN GAOR, Supp 16 52, UN Doc A/6316 (1966), 999 UNTS. 171 174, entered into force on 23 March 1976. See art 17.

109 Art 14(2)(h) CEDAW.

110 Art 16(1) CRC.

111 The African Charter does not explicitly recognise the right to adequate housing, but several other recognised rights, such as the right to health (art 16) and the right of peoples to a general satisfactory environment favourable to their development (art 24), can be interpreted as protecting the right to adequate housing. The African Charter also provides that African states should realise the right to adequate housing that they have recognised at the international level, including by accepting ICESCR (art 60). The African Commission has interpreted the right to housing to cover shelter in the *SERAC* case (n 78 above).

112 Art 16 African Women's Protocol.

113 Art 20 African Children's Charter.

114 UN Conference on Human Settlements, 31 May-11 June 1976, Vancouver, Canada (Habitat I).

115 UN Conference on Human Settlements, 3-14 June 1996, Istanbul, Turkey (Habitat II).

problems of access to adequate housing in the world. Many other international declarations have also denounced the practice of forced evictions.¹¹⁶

There have been recent developments showing progress in addressing women's access to adequate housing. At the international level, the newly-created UN Entity for Gender Equality and the Empowerment of Women has incorporated a specific goal on increasing women's access to economic empowerment and opportunities.¹¹⁷ These developments seek to promote the adoption and implementation of laws and policies that expand women's economic assets and security, including laws and policies to guarantee equal access to land and property.¹¹⁸ Furthermore, the recently-created Working Group on the issue of discrimination against women in law and practice has been tasked by the Human Rights Council with promoting and exchanging views on best practices related to the elimination of laws that discriminate against women or are discriminatory to women in terms of implementation or impact.¹¹⁹ In the African region, the Framework and Guidelines for Land Policy in Africa also represents a positive new development from the standpoint of women's equal rights to access and control land, with specific sections on strengthening the land rights of women.¹²⁰

Quintessentially, for a state to be said to be responding to women's needs in the context of HIV and AIDS, the state must pay attention to the principle of substantive equality in the sense that all women's functionings and capabilities must be nurtured. For the state to eliminate discrimination in both fact and law, the feminist capabilities approach is useful. The state should enable access to 'free' health services, including sexual and reproductive health services, and create access to confidential testing and counselling. Furthermore, the state must facilitate access to essential medicines. In this regard, treatments like ARVs have to be provided by the state, not only as a core obligation,¹²¹ but as an imperative to control the marketing of medicines which are critical to the treatment and prevention of HIV and AIDS among vulnerable groups like women. Access to ARVs, therefore, has the potential to enhance women's capabilities and functionings in the context of HIV and AIDS.

116 Eg, ch 7, 6 & 9(b) of Agenda 21, adopted at the 1992 United Nations Conference on Environment and Development.

117 Report of the Special Rapporteur on adequate housing as a component of the right to an adequate standard of living, and on the right to non-discrimination in this context. A/HRC/19/53, 7 (2011).

118 UNW/2011/9, para. 40.

119 UN Conference on Human Settlements (n 114 above) 7.

120 African Union Commission (AUC), United Nations Economic Commission for Africa (ECA) and African Development Bank (AfDB) Consortium, Framework and Guidelines on Land Policy in Africa: Land Policy in Africa: A Framework to Strengthen Land Rights, Enhance Productivity and Secure Livelihoods, Addis Ababa, Ethiopia (September 2010).

121 ESCR Committee (n 99 above) para 43.

The state should also ensure the training of healthcare personnel to deliver a congenial environment with respect to the ethos of confidentiality, privacy and dignity. This includes respect for adolescent girls. In addition, the state must strive to realise women's access to adequate housing (including land). The state must also ensure the availability of skilled personnel and should guarantee the availability of adequate food and nutrition. The main proposition in this chapter is that the realisation of these obligations has the potential to enhance women's capabilities to live with dignity amidst the epidemic.

The UN Special Rapporteur on the Right to Adequate Housing has provided guidance on gender-sensitive housing. The Special Rapporteur indicated that it is clear that the legal and policy barriers to women's enjoyment of their rights to adequate housing must be removed, and replaced by laws, policies and programming which take a focused and proactive approach.¹²² The report further stressed that legislative and policy measures must be put in place at national and regional levels, explicitly prioritising women's rights to adequate housing.¹²³ The Special Rapporteur's guidance relates to security of tenure,¹²⁴ the availability of services, materials, facilities and infrastructure,¹²⁵ location,¹²⁶ affordability,¹²⁷ habitability,¹²⁸ accessibility¹²⁹ and cultural adequacy.¹³⁰ These guidelines have the potential to enhance women's capabilities and functioning in the context of HIV and AIDS. The sum total of the above international and regional standards is the realisation of women's rights to health from a substantive equality point of view. These standards strongly resonate with the capabilities approach. The next section explores the connections between women's rights to health and HIV and AIDS.

5 Women's rights to health and its underlying determinants

5.1 Access to health services

Women generally experience structural difficulties in accessing healthcare services, more so in the area of sexual and reproductive health. The World Health Organisation (WHO) has noted that 'women's health is linked to status in society. It benefits from equality and suffers from discrimination.'¹³¹ Moreover, women also bear the global burden of

122 Report of the Special Rapporteur (n 117 above) 11.

123 As above.

124 Report of the Special Rapporteur (n 117 above) 12.

125 As above.

126 Report of the Special Rapporteur (n 117 above) 13.

127 Report of the Special Rapporteur (n 117 above) 14.

128 As above.

129 Report of the Special Rapporteur (n 117 above) 15.

130 Report of the Special Rapporteur (n 117 above) 16.

disease, particularly HIV and AIDS.¹³² Furthermore, because women are still being denied equal status in many societies, their health suffers and, in turn, that of their families and communities. Also, access to services like ARV rollout programmes are inhibited by gender inequities.¹³³

The importance of sexual and reproductive rights within the context of women and HIV needs no further emphasis. However, women still face stigma and discrimination in health services. This is linked to inequities in access to health services that are aggravated by poverty.¹³⁴ Respect, dignity, privacy and confidentiality are crucial to the clinical management of women and HIV/AIDS. Applied together, these are supposed to provide a congenial environment in which women are supported in decision making regarding treatment, thereby improving the quality of care.¹³⁵ Women living with HIV face problems in accessing appropriate services that meet their specific health needs, which needs are rarely understood or addressed by health service providers. In addition, in the midst of HIV and AIDS, women are beset with issues relating to disclosure, privacy, confidentiality and involuntary abortions.

It is acknowledged that anti-retroviral therapy significantly reduces morbidity and mortality among people living with HIV. In relation to disclosure, testing for HIV is an important element of an effective state response to HIV and AIDS. Hence, enabling women to know their status means that they can access treatment, care and support if they test positive, or take further steps to protect themselves against infection, if negative.¹³⁶ It also means that those living with HIV can protect sexual partners from HIV infection and themselves from re-infection with another strain of the virus. For pregnant women, there is an additional benefit from testing for HIV. Where there is a prevention of mother-to-child-transmission programme available, a woman can dramatically reduce the chances of passing HIV to her baby.¹³⁷

There must be a careful balancing between health-related goals and the protection of the rights of those being tested. In this light, the right to privacy and confidentiality are pivotal.¹³⁸ Pregnant women can benefit

131 WHO *The world health report* (1998) 6.

132 JL Murray & AD Lopez 'The global burden of disease: A comprehensive assessment of mortality and disability from diseases, injuries and risk factors in 1990 and projected to 2020' (1996).

133 N Nattrass 'Gender and access to anti-retroviral treatment in South Africa' (2008) 14 *Feminist Economics* 19-36.

134 See ME Greene & T Merrick *Poverty reduction: Does reproductive health matter? HNP discussion paper* (2005).

135 HM Coovadia & J Hadingham 'HIV/AIDS: Global trends, global funds and delivery bottlenecks' (2005) 1 *Globalization and Health* 1-13.

136 R Jurgens *Increasing access to HIV testing and counselling while respecting human rights*' Background paper (2007).

137 As above.

138 G Seidel 'Confidentiality and HIV status in KwaZulu-Natal, South Africa: Implications, resistances and challenges' (1996) 11 *Health Policy Planning* 418-427.

from testing in order to address their own future health and that of the growing foetus. It should, however, be noted that testing should be carried out with particular attention to counselling and confidentiality. There is a need for a confidential environment and facilities that allow for calm and informed discussion, including how a woman will deal with telling a spouse or partner about a negative outcome of testing (in this case an HIV-positive result). This would be interfered with by, for example, overcrowding in health facilities and a lack of trained personnel. Research has shown that where people think that the benefits of knowing their HIV status outweigh the risks, and where levels of stigma and discrimination are low, people are more likely to take an HIV test.¹³⁹

Women are also usually confronted with judgmental attitudes by health workers, who may pressure them to undergo abortions, sterilisations, or to use contraception, in the belief that people living with HIV should not have children due to the possibility of vertical transmission. This violates women's rights to the choice and autonomy to have children.¹⁴⁰ In this regard, one of the key areas of debate relates to pre- and post-abortion rights and care. One of the criticisms levelled against the scaling up of HIV and AIDS treatment and care relates to the disconnect in policies on reproductive health rights and AIDS. It has been found that a comprehensive approach to HIV and AIDS should deal with both aspects.¹⁴¹ Another aspect affecting women's health in the context of HIV and AIDS is food and nutrition.

5.2 The necessity for food and nutrition

The right to food is an underlying determinant of health and is particularly important for women living with HIV. Given African women's roles as mothers and farmers, the household food security and family survival of millions of Africans are under serious threat with the HIV pandemic.¹⁴² Hence, nutrition is the pivotal interface between food security and health security.¹⁴³ An individual's capacity to fight any disease depends on the strength of their immune system which, among other factors, is affected by nutrition.¹⁴⁴ Malnutrition, particularly involving vitamin A deficiency, is associated with the increased risk of genital ulcers and cervical herpes

139 SC Kalichman & LC Simbayi 'HIV testing attitudes, AIDS stigma and voluntary counselling and testing in a black township in Cape Town' (2003) 79 *Journal for Sexually Transmitted Infections* 442–447.

140 C Bailey & M O'Sullivan 'Reproductive rights' in S Woolman *et al* (eds) *Constitutional law of South Africa* (2002) 16–18.

141 M de Bruyn *HIV/AIDS and reproductive health: Sensitive and neglected issues* (2005).

142 S Page 'Promoting the survival of rural mothers with HIV/AIDS: A development strategy for Southern Africa' (2001) 44 *Development* 40–46.

143 See, generally, IE Engh *Developing capacity to realise socio-economic rights. The example of the right to food in the context of HIV/AIDS in South Africa and Uganda* (2008).

144 E Stillwagon 'The ecology of poverty, nutrition, parasites and vulnerability to HIV/AIDS' in S Gillespie (ed) *AIDS, poverty, and hunger: Challenges and responses* (International Food Policy Research Institute: Washington, DC 2006).

simplex virus (HSV) shedding, which in turn has been found to increase the risk of HIV transmission.¹⁴⁵

HIV and nutrition are interlinked in two ways. The first relates to nutritional consequences of HIV and the other to the growing realisation that food insecurity may increase HIV risk behaviours and susceptibility.¹⁴⁶ In respect of the first aspect, access to adequate food is essential for coping with the side effects of anti-retroviral medication on a daily basis. The energy requirements of HIV-infected individuals increase by about 20 to 30 per cent when chronic opportunistic infections or HIV-specific conditions begin to be felt. Consequently, WHO recommends that infected individuals should be assured of at least one recommended daily allowance of most vitamins. Rollins rightly argues that '[i]n the absence of an adequate diet, this often means that HIV care and treatment programmes must apply multiple micronutrient preparations'.¹⁴⁷ In addition, there are further considerations for an HIV-infected person who has progressed to the stage where he or she needs to be placed on an anti-retroviral treatment programme. Anti-retroviral medication, which has strong effects on the user and may in some cases be serious, needs to be taken at regular intervals - mostly twice a day - for the rest of that person's life.¹⁴⁸

The second aspect of high-risk behaviour, particularly as it relates to HIV/AIDS and nutrition, is that women exchange sex for food.¹⁴⁹ For example, a study in Botswana and Swaziland revealed that 32 per cent of the women and 22 per cent of the men who participated in the study had experienced food insecurity in the previous 12 months.¹⁵⁰ Risk behaviour in the above countries was found to include inconsistent condom use, sex in exchange for food, increased intergenerational sex and a lack of control over sexual relationships. This is exacerbated by the women's additional burden of caring for children, the elderly and ill family members.¹⁵¹ It is, therefore, clear that, in relation to women and access to food, an interaction exists that re-emphasises the link between HIV and nutrition from both biological and socio-economic perspectives.

145 SB Mostadet *et al* 'Cervical shedding of herpes simplex virus in human immunodeficiency virus-infected women: Effects of hormonal contraception, pregnancy, and vitamin A deficiency' (2003) 181 *Journal of Acquired Immune Deficiency Syndrome* 58-63.

146 SD Weiser *et al* 'Food insufficiency is associated with high-risk sexual behaviours among women in Botswana and Swaziland' (2007) 4 *PLoS Medicine* 260.

147 N Rollins 'Food insecurity: A risk factor for HIV infection (2007) 4 *PLoS Medicine* 1576, citing WHO standards.

148 Amnesty International 'South Africa: I am at the lowest end of all: Rural women living with HIV face human rights abuses in South Africa' <http://www.amnesty.org/en/news-and-updates/report/rural-women-hit-south-africas-hiv-response-20080318> (accessed 17 August 2012).

149 Weiser *et al* (n 146 above) 260.

150 As above.

151 D Rajaraman *et al* 'HIV/AIDS, income loss and economic survival in Botswana' (2006) 18 *AIDS Care* 656-662.

In times of distress and conflict, women also resort to transactional sex as a coping mechanism. A survey conducted in Uganda has shown that women living in camps set up for internally-displaced people in the war-affected towns of Gulu and Katakwi exchanged sex for money in order to buy food.¹⁵² This was done with the clear knowledge that they were at risk of HIV. The above survey also revealed that sexual violence, especially against women and girls, was exacerbated by food insecurity. The research showed that there was a relationship between persons perceived to be vulnerable to forced sex and those perceived to have sex in exchange for food.¹⁵³ This is further exacerbated by the care burden borne by women in situations of conflict. This fatal link should not be ignored in HIV interventions and programmes intended to enhance women's capacity to live amidst the epidemic. Similarly, women's lack of access to adequate housing affects their wellbeing in the context of HIV and AIDS.

5.3 Access to adequate housing

In Africa, urbanisation, climate change, low levels of financial literacy amongst women, and the rising number of female-headed households all emerged as key issues affecting the status of women's rights to adequate housing on the African continent today.¹⁵⁴ Without adequate housing, women are incapable of enjoying all other rights, both in the public and private domain.¹⁵⁵ Access to housing is closely linked with the right to health.¹⁵⁶ Moreover, there is increasing research showing that poorly-housed and homeless women are more prone to HIV.¹⁵⁷ For example, inadequate space can limit women's capacity to undertake income-generating activities from home, and has been shown as a contributing variable to increased levels of sexual violence.¹⁵⁸ Women also face rejection, which usually ends in homelessness, upon disclosure of their HIV status. Furthermore, women and child-headed households is a phenomenon arising from HIV and AIDS-related deaths of family members. Within the context of HIV and AIDS, housing, therefore, presents a situation of special needs for women.

152 See, generally, P Bukuluki 'Gender dimensions, food security, and HIV and AIDS in internally-displaced people's (IDPs) camps in Uganda: Implications for HIV-responsive policy and programming'. Department of Social Work and Social Administration, Makerere University 2008. The report is available at <http://programs.ifpri.org/renewal/renewalpub.asp>. (accessed 21 January 2012).

153 Interviews conducted by Bukuluki *et al* 2008, 29.

154 Report of the Special Rapporteur (n 117 above).

155 See, generally, L Farha 'Women and housing' in AD Askin & DM Koenig (eds) *Women and international law* (1999) 483. See also C Moser 'Women, human settlements, and housing: A conceptual framework for analysis and policy making' in C Moser & L Peake (eds) *Women, human settlements, and housing* (1987) 12.

156 ESCR Committee General Comment 14 paras 3, 8 & 11 (n 66 above).

157 S Liebenberg & K Pillay 'Poverty and human rights report of the national 'Speak Out on Poverty'.hHearings, March to June 1998, convened by SANGOCO, the CGE and the SAHRC, SANGOCO, Johannesburg, 15.

158 Farha (n 155 above).

Moser persuasively argues that women's housing needs are distinct from those of men in terms of 'practical' and 'strategic' needs.¹⁵⁹ In her view, practical needs are those that arise from the concrete conditions of women's positioning, by virtue of their gender, within the sexual division of labour.¹⁶⁰ Hence, within these positions, women formulate their needs in response to their living conditions. This argument, as applied to the situation of women living with HIV and AIDS, means that their practical needs relate to, for example, the reality of domestic violence. This is supported by a report of the UN Special Rapporteur on Adequate Housing which revealed that women living in situations of domestic violence inherently lived in inadequate housing.¹⁶¹ The Special Rapporteur pointed out that there were different groups of women who were particularly vulnerable to discrimination and, due to a combination of factors, faced additional obstacles in accessing adequate housing.¹⁶²

Furthermore, as part of the right to housing, access to affordable, accessible and reliable water and sanitation is crucial for people living with HIV, and for providing home-based care. Research shows that women are responsible for making water available in most homes in sub-Saharan Africa.¹⁶³ Women and children walk long distances to find water in both rural and urban areas. Research shows that a water reform policy may in fact increase social and gender differentiation, inequality and ill-health.¹⁶⁴ Water is needed for taking anti-retroviral medication, bathing patients, washing soiled clothing and linen; and for essential hygiene, which reduces exposure to infection.¹⁶⁵ Toilets should also be accessible for weak patients. Within this context, access to water and sanitation, therefore, defines the context of care women have to work in.

Women render most of the home-based care, which involves fetching water, bathing patients, washing laundry, digging pits for solid waste disposal, cleaning households and yards, assisting with access to social, health and other services, and providing counselling, information and support. In this regard, Clacherty and Potter rightly argue that controlled water supply, as is the case in most urban and peri-urban areas, makes it difficult for home-based caregivers to carry out their activities, and compromises the impact of health and hygiene education and promotion carried out by community health workers.¹⁶⁶ Challenges surrounding the water and HIV matrix are sharpened by the fact that affected communities

159 Moser (n 155 above) 29.

160 As above.

161 UN Special Rapporteur on Adequate Housing 'Women and adequate housing'. UN Doc E/CN.4/2006/118 (2006).

162 As above.

163 As above.

164 C Desmond *et al* 'The hidden battle: HIV/AIDS in the household and community' (2000) 7 *South African Journal of International Affairs* 39–58.

165 A Clacherty & A Potter *Water services and HIV/AIDS: Integrating health and hygiene education in the water and sanitation sector in the context of HIV/AIDS* (2007).

166 As above.

and donors working in the developing world do not make an immediate connection between water availability and slowing down infections, especially in urban and peri-urban areas.¹⁶⁷ This is despite the fact that water supply is problematic in most of the sub-continent. A large part of urban populations live in informal and unplanned areas with inadequate water supplies and sanitation services.

A point can therefore be made that, in order to confront HIV and AIDS amongst women in sub-Saharan Africa, efforts must be strengthened to improve women's access to health and its underlying determinants. On the above basis, this chapter argues that the feminist capabilities framework provides one of the most important analytical approaches for addressing women, HIV and AIDS. A poor woman's health and well-being depends not only on their economic income and access to medical services, but on many other elements, as shown above. Thus, the capabilities approach in this work is viewed in light of substantive equality as it seeks to eliminate deep-seated barriers as orchestrated and sustained by historical, cultural and socio-economic factors. Hence, the uniqueness of the capabilities approach is that it looks at what is needed to enable poor women (especially those affected by HIV and AIDS) to function fully within society and family.

Consequently, the capabilities approach covers a wide array of women's rights – rights that are useful in the context of HIV and AIDS. This means that the state should put in place financial resources, economic production, political practices, such as the effective guaranteeing and protection of equality, freedom from gender-based violence, political participation, or social structures, social institutions, public goods, social norms, traditions or habits that enable women to exist amidst the HIV epidemic. This approach is also of particular significance in the context of poor countries, such as those in sub-Saharan Africa.

6 Conclusion

This chapter demonstrates the indivisibility and interrelatedness of rights affecting women in the context of HIV and AIDS. This is particularly so in light of the underlying determinants of the right to health, namely, the right to food and nutrition, and the right to adequate housing. It is undoubted that the relationship between the capabilities approach and human rights is symbiotic. In this chapter, they are applied synergistically. This closeness presents a framework that can be utilised to demand from the state certain types of actions in relation to women, HIV and AIDS. This approach provides a platform to demand for resources, and also provides a basis for accountability. Combining the capabilities approach with

167 A Ferguson 'Water reform, gender, and HIV/AIDS: Perspectives from Malawi' paper delivered at the Society for Applied Anthropology Meetings, Portland (2003).

human rights principles provides the means to engender women's socio-economic rights in the context of HIV and AIDS. The emphasis of the capabilities approach on the imperative to improve women's material conditions resonates even more with the state's duty to ensure the progressive realisation of women's socio-economic rights within its available resources.

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THE RIGHT TO HEALTH AND AIDS
MEDICINES IN SUB-SAHARAN AFRICA:
ASSESSING THE OUTCOMES OF
A HUMAN RIGHTS-BASED
APPROACH TO MEDICINES

*Lisa Forman**

Summary

This chapter explores the outcomes of rights-based social action throughout the 2000s, focused on increasing access to AIDS medicines in sub-Saharan Africa, and how these actions have influenced related domestic and global policy and law. After outlining current levels of anti-retroviral (ARV) access throughout sub-Saharan Africa, the chapter explores global trade-related intellectual property rights and international human rights related to medicines. It turns to explore the path towards current increases, focusing on illustrative case studies from Brazil, Thailand and South Africa. Finally, it explores the emergence of a right to medicines in international law and the corresponding institutional and policy changes in ARV access globally. The chapter suggests that rights-based social action has been central to these legal and policy changes, and may offer important strategies for addressing other health inequities within the sub-Saharan African region.

1 Introduction

HIV and AIDS continue to pose major health, human rights and development challenges throughout sub-Saharan Africa. While the pandemic is stabilising and declining in countries throughout the region, associated health and human rights needs remain inadequately addressed, including prevention, treatment and protection against pervasive stigma and discrimination. Yet, in the past decade, the accessibility of anti-retroviral therapies (ARVs) has dramatically increased, from well under 1 per cent in 2000 to current levels of almost 40 per cent. While multiple factors have contributed, this chapter suggests that rights-based social movements framed around the human rights to life and health have been a primary factor instigating and sustaining these increases. This chapter

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explores the growth in access to ARVs through the lens of human rights-based social action, and how these strategies have influenced not only domestic and regional access, but also related global practice, policy and law in sub-Saharan Africa, including trade-related intellectual property rights in international trade law and the emergent right to medicines within international human rights law.

After looking at current levels of ARV access throughout sub-Saharan Africa, the chapter explores global trade laws that have significantly influenced access to affordable medicines. It then explores international human rights law related to health and the emergence of rights-based treatment activism, focusing on case studies from Thailand, South Africa and Brazil. Finally, the chapter explores emerging definitions of a right to medicines in international human rights law and its analogues in regional and domestic jurisprudence, as well as global institutional and policy changes in relation to ARV access in sub-Saharan Africa.

2 Access to AIDS medicines in sub-Saharan Africa

The HIV pandemic continues to pose serious challenges to public health and human rights within the sub-Saharan African region. In 2010, of the 33.4 million people globally living with HIV,¹ 22.5 million were located in the sub-Saharan African region.² HIV and AIDS remains the leading killer of women of reproductive age and one of the leading causes of adult and child deaths in low and middle-income countries.³ In 2008 alone, 2.7 million people were newly infected,⁴ 1.8 million of whom were in sub-Saharan Africa.⁵ In light of this scale of infection and illness, effective HIV treatment and prevention remain essential to public health and human rights needs within sub-Saharan Africa. Globally, two-thirds of people in need of ARVs lack access to these treatments,⁶ the median percentage of people living with HIV who know their HIV status in sub-Saharan Africa is below 40 per cent⁷ and, in many countries, HIV-related stigma, discrimination and social marginalisation continue to mark the daily lives of people with HIV, including within vulnerable populations who already experience persistent human rights violations, such as sex workers, injecting drug users, men who have sex with men, transgender people, prisoners and migrants.⁸

1 WHO *et al* *Towards universal access: Scaling up priority HIV/AIDS interventions in the health sector – Progress report 2010* (2010) 5.

2 UNAIDS *Report on the global AIDS epidemic 2010* (2010) 20.

3 WHO 'World health statistics' (2010); F Girard *et al* 'Universal access in the fight against HIV/AIDS' (2010) 329 *Science* 147-149.

4 WHO *et al* (n 1 above) 5.

5 UNAIDS (n 2 above) 20.

6 WHO *et al* (n 1 above) 3.

7 WHO *et al* (n 1 above) 5.

8 WHO *et al* (n 1 above) 3.

While the pandemic's order of magnitude remains immense and access to key HIV-related health interventions remains inadequate, recent years have seen a major shift in the pandemic's trajectory: For the first time in its almost 30-year history, significant progress has been made, with UNAIDS arguing in 2010 that 'the world has turned the corner – it has halted and begun to reverse the spread of HIV'.⁹ Between 2001 and 2009, the HIV incidence is estimated to have fallen by more than 25 per cent in 33 countries, with the largest epidemics in sub-Saharan Africa (in Ethiopia, Nigeria, South Africa, Zambia and Zimbabwe) either stabilising or showing signs of decline.¹⁰ While this progress is at least in part due to the maturation of regional pandemics, certainly a contributing factor is the major increase in access to AIDS treatment throughout the region.

In 2009, 5,25 million people (36 per cent of those in need) were accessing ARVs in low and middle-income countries, 3,91 million of whom are located in sub-Saharan Africa,¹¹ with ARV coverage in sub-Saharan Africa reaching 37 per cent in 2009.¹² While these figures *prima facie* point to the inadequacies of current access levels, they nonetheless reflect an immense sea change. Only ten years ago, access to ARVs in low and middle-income countries was around 5 per cent, and in sub-Saharan Africa, access was considerably under 1 per cent, with a few thousand people accessing these drugs through non-governmental organisations (NGOs) and philanthropic programmes. As the dramatic shift in access between 2001 and 2009 may suggest, the rate of increase has been rapid. Based on the World Health Organisation (WHO)'s 2010 guidelines for the initiation of ARVs,¹³ there has been a thirteen-fold increase since 2003, when 400 000 people were accessing ARVs, with a 33 per cent increase seen between 2008 and 2009 alone (from 2,95 million to 3,91 million people).¹⁴ By December 2009, eight low and middle-income countries (Botswana, Cambodia, Croatia, Cuba, Guyana, Oman, Romania and Rwanda) had achieved universal access to ARVs, defined as coverage of at least 80 per cent of people in need.¹⁵ Another 21 countries had coverage

9 UNAIDS (n 2 above) 7.

10 UNAIDS (n 2 above) 8.

11 WHO *et al* (n 1 above) 6.

12 WHO *et al* (n 1 above) 55.

13 In considering these increases, it is important to note that in 2010, WHO revised the initiation point for ARV to an earlier stage of the disease, requiring that people with HIV infection start ARVs at a CD4 count of 350 cells/mm³ or below, instead of the previous initiation point of CD4 count of 200 cells/mm. WHO's shift from its 2006 guidelines considerably increased the number of people estimated to be in need of ARVs from 10,1 million people to 14,6 million at the end of 2009. This change is significant in terms of contextualising the rates of increase in ARV access, since under the WHO's 2006 guidelines, global access to ARVs would have been 52% (rather than 36%). Certainly, it is important to note that all access figures before 2009 reflect this earlier initiation point. See WHO *et al* (n 1 above) 55.

14 WHO *et al* (n 1 above) 6.

15 WHO *et al* (n 1 above) 56-57. Under the 2006 guidelines, nine other countries would have reached universal access in 2009, including Argentina, Chile, Costa Rica, Georgia, Lao People's Democratic Republic, Namibia, Swaziland, Turkey and Zambia.

rates higher than 50 per cent.¹⁶ Within sub-Saharan Africa, access is highest in Eastern and Southern Africa where, in 2009, 41 per cent of those in need received ARVs. In contrast, in West and Central Africa, only 25 per cent of people had access (at least in part because of low coverage in Nigeria, which accounts for 50 per cent of treatment needs in the sub-region). Eighty-nine per cent of countries in the region have had ARV programmes in place for at least five years, including some of the countries with the highest prevalence rates, such as Nigeria (2002), Ethiopia (2003), Zambia (2003), Kenya (2004) and South Africa (2004).¹⁷ More people are receiving ARVs in all regions of the world than at any previous time.¹⁸ Given the gendered dimensions of HIV, it is notable that the overall access to ARVs throughout the region was higher among women than men (40 per cent versus 32 per cent).¹⁹ Moreover, there have been significant increases in access to ARVs to reduce the risk of maternal transmission, with approximately 54 per cent of pregnant women living with HIV in sub-Saharan Africa receiving it.²⁰

The impact of access to ARVs across the sub-Saharan African region is evident in the declining overall death rates since 2005, coinciding with these increases.²¹ In 2006 and 2007, AIDS mortality decreased for the first time, partly due to the scaling-up of treatment services.²² Broader access is estimated to have contributed to a 19 per cent decline in AIDS-related deaths among people living with HIV between 2004 and 2009.²³ It is also understood to have had preventive impacts on transmission, with a 17 per cent decrease in new HIV infections seen worldwide from 2001 to the end of 2008.²⁴

What caused these dramatic increases in access to ARVs? In exploring these changes, it is helpful to consider WHO's identification of four primary factors that influence the accessibility of medicines in any given country, namely, whether there are national health policies on medicines (and whether these promote the 'rational' use of medicines), reliable health systems, affordable drugs and sustainable financing.²⁵ In this light, current rates of increase in ARVs can be linked to two primary interventions in this causal chain of access, namely, in relation to drug financing and pricing. Two financing programmes are responsible for a significant proportion of ARV financing: As of December 2009, the Global Fund to Fight HIV/

16 WHO *et al* (n 1 above) 51.

17 WHO *et al* (n 1 above) 55–59.

18 UNAIDS (n 2 above) 12.

19 WHO *et al* (n 1 above) 57.

20 WHO *et al* (n 1 above) 7. Children's access remains lower than adult rates. However, 26% of children under 15 years of age who needed ARVs received them in 2009, approximately 356 400 children.

21 WHO *et al* (n 1 above) 61.

22 UNAIDS & WHO *AIDS epidemic update: December 2007* (2007) 5–6.

23 UNAIDS (n 2 above) 8.

24 WHO *et al* (n 1 above) 26.

25 WHO *WHO medicines strategy: Countries at the core 2004–2007* (2004) 24.

AIDS, Tuberculosis and Malaria (GFATM) had supported AIDS treatment for 2,5 million people, while the United States (US) government's Presidential Emergency Plan for AIDS Relief programme (PEPFAR) was supporting anti-retroviral therapy for 2,4 million people.²⁶ These funding mechanisms play a central role in sustaining access, funding access for approximately 70 per cent of all people receiving ARVs,²⁷ a somewhat troubling dependency, given northern funding cuts discussed below.

The second major determinant of access has been the significant reductions in ARV pricing. In 2009, the median price of the most commonly-used first-line regimens was US \$137 per person per year in low-income countries, US \$141 per person per year in lower-middle-income countries, and US \$202 in upper-middle-income countries.²⁸ These price decreases reflect an over hundred-fold decrease from their 2002 pricing of US \$15 000. Prices are considerably higher for the most commonly-used second-line regimens, at US \$853, US \$1378 and US \$3678 respectively, making these drugs less accessible throughout sub-Saharan Africa and other low and middle-income regions.²⁹ While the majority of patients in low and middle-income countries receive first-line regimens, increasing resistance over time will make access to second-line regimens increasingly important.

These price decreases are attributable to a range of factors which, according to UNAIDS, WHO and UNICEF include:

sustained scaling up treatment programmes, the growing transaction volumes and predictability of demand, the competition between a growing number of products prequalified by WHO and the favourable pricing policies of pharmaceutical companies.³⁰

Certainly, this analysis pinpoints many of the moving parts of the engine driving towards universal access. What it occludes, however, are the driving forces of this engine. It is suggested that rights-based social movements that challenged the pricing of ARVs and its legal codification in international trade law have played this centrifugal role.

26 WHO *et al* (n 1 above) 54.

27 Since approximately 1,3 million people were receiving ARVs through programmes that receive joint financing from GFATM and PEPFAR, the total amount of people supported by these programmes was 3,7 million people at the end of 2009.

28 WHO *et al* (n 1 above) 51.

29 As above.

30 WHO *et al* (n 1 above) 71.

3 Global trade law and policy regarding AIDS medicines

While several factors determine drug pricing (including manufacturer's prices, transport and storage costs, import tariffs and taxes, procurement practices, and dispensing fees),³¹ patents are broadly recognised as the most significant determinant of drug prices.³² This is because patents give market exclusivity for particular periods, during which time medicine prices are not subject to the downward pressures of market competition. Pharmaceutical product prices fall sharply when generic entry occurs following the expiration of patents.³³ Patents are protected internationally under the World Trade Organisation's (WTO) Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). TRIPS requires 20-year patents for pharmaceuticals, which give exclusive rights to holders to prevent non-consensual use, and which are subject to extensive domestic and international enforcement, including the WTO's formal mechanism for settling disputes related to the WTO agreement.³⁴ This legal requirement was unprecedented in many countries that had not patented drugs or had far less stringent patent rules for medicines. For example, before TRIPS, over 40 countries did not patent drugs; many (like India) only patented processes and not products, and many others had patents for less than 20 years.³⁵ Today, all WTO members, except least-developed countries (which are not obliged to implement TRIPS until 1 January 2016), are bound by TRIPS. By 2016, this agreement will apply to all WTO members, including the poorest nations. TRIPS does permit limits to patents in order to enable governments to meet public health needs, including - but not limited to - parallel imports (where countries import cheaper patented medicines) and compulsory licensing (where countries manufacture or import generics under strict conditions).³⁶ Initially, TRIPS prohibited the export of medicines produced under compulsory licensing, creating a double bind for some low-income countries, since this effectively meant that countries that lacked the

31 D Henry & J Lexchin 'The pharmaceutical industry as a medicines provider' (2002) 360 *Lancet* 1590-1595.

32 RE Caves *et al* 'Patent expiration, entry, and competition in the US pharmaceutical industry' (1991) 1991 *Brookings Papers on Economic Activity Special Issue* 1-62; FM Abbott *WTO TRIPS Agreement and its implications for access to medicines in developing countries* (2002); C Correa 'Public health and intellectual property rights' (2002) 2 *Global Public Policy* 261-278.

33 FM Scherer 'The pharmaceutical industry' in AJ Culyer & JP Newhouse (eds) *Handbook of health economics* (2000) 1322-1324.

34 Agreement on Trade-Related Aspects of Intellectual Property Rights, Annexure 1C to the Marrakesh Agreement Establishing the World Trade Organisation, 1869 UNTS 299, 33 *ILM* 1197 arts 28.1.a & b (15 April 1994)(TRIPS).

35 WHO 'Globalization, TRIPS, and access to pharmaceuticals' (2001) 3 *Policy Perspectives on Medicines Series* 3; S Bartelt 'Compulsory licenses pursuant to TRIPS Article 31 in the light of the Doha Declaration on the TRIPS Agreement and public health' (2003) 6 *Journal of World Intellectual Property* 285.

36 TRIPS (n 34 above), arts 6 & 31.

capacity to manufacture their own drugs also could not import generic versions of patented medicines. This section was later amended to permit, under strict conditions, least-developed and other developing countries to import generics made under compulsory licensing.³⁷ It is notable that this provision has been used only once.³⁸ Several factors account for this limited usage, including persistent corporate and governmental threats of legal or economic sanctions and the complexity, cost, and limited duration and scope of the rules themselves.³⁹

It is notable too that the use of the legal provisions within TRIPS (the so-called 'flexibilities') has been highly contested and constrained by corporate and government pressures, such as litigation and unilateral trade sanctions. Foreign and corporate contestation of the use of TRIPS flexibilities motivated developing countries at the Doha round of WTO trade negotiations in November 2001 to advocate for a Ministerial Declaration to clarify the TRIPS legality of using measures like compulsory licensing and parallel import. The Doha Declaration explicitly endorses the right of WTO members to protect public health and promote access to medicines for all, and to use TRIPS' flexibilities to the full, including compulsory licences.⁴⁰ While there have been growing issuances of compulsory licences for AIDS medicines, including by Malaysia, Indonesia, Zambia, Zimbabwe, Mozambique, Brazil and Thailand,⁴¹ pressures against countries using compulsory licences persist post-Doha. For example, Thailand's 2007 and 2008 compulsory licences attracted broad condemnation from companies, their host governments and corporate allies.⁴² The limited ability of countries to freely exercise legal flexibilities within TRIPS is similarly underscored by persistent seizures by

37 This is known colloquially as the '30 August decision': See World Trade Organisation General Council, Implementation of Paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health: Decision of the General Council of 30 August 2003.

38 While Canada implemented legislation in 2004 to enable exports under licence, this provision remained unutilised until 2007, when Rwanda gave notification of its intent to import medicines from Canada.

39 L Forman 'Trading health for profit: Bilateral and regional free trade agreements affecting domestic property rules on intellectual property rules on pharmaceuticals' in JC Cohen *et al* (eds) *The power of pills: Social, ethical, and legal issues in drug development, marketing, and pricing* (2006) 341.

40 World Trade Organisation Ministerial Conference 'Declaration on the TRIPS Agreement and Public Health' 14 November 2001 para 4.

41 J Love *Recent examples of the movements on the use of compulsory licences around the world* (2007), quoted in the Thai Ministry of Public Health and the National Health Security Office Thailand 'Facts and evidences on the 10 burning issues related to the government use of patents on three patented essential drugs in Thailand' (February 2007) <http://www.moph.go.th/hot/White%20Paper%20CL-EN.pdf> (accessed 19 November 2012).

42 The 2007 United States Trade Representative (USTR) Special 301 Report elevated Thailand to the priority watch list, a move which precedes formal trade sanctions, arguing that this status related to the government's issuing of compulsory licenses, which the USTR argued was an indication of 'a weakening of respect for patents'. Abbott Laboratories, the patent holder in question, withdrew all of its new products from Thailand, including drugs for HIV, rheumatoid arthritis, kidney disease, heart disease and high blood pressure and respiratory infections. It also threatened not to

European port authorities of 'counterfeit' Indian generic medicines bound for other countries, irrespective of the patent status of those drugs in either exporting or importing countries.⁴³

The primary impact of TRIPS has been to drive up drug prices in countries introducing drug patents, since patents give their holders the exclusive right to sell these medicines for particular periods, thereby excluding the price-reducing impact of generic competition.⁴⁴ However, TRIPS is also restricting global access to generic alternatives by phasing out generic manufacture unless authorised under TRIPS. These restrictions will particularly affect countries dependent on generic exports, as are many sub-Saharan African countries. These impacts are exacerbated by the proliferation of 'TRIPS-plus' intellectual property rules in bilateral and regional free-trade agreements (FTA) that make it more difficult for generic medicines to enter the market.⁴⁵ The expansion of 'TRIPS-plus' trade-related intellectual property rights poses serious threats to the continued availability of affordable ARVs. For example, Indian generic manufacturers currently account for more than 80 per cent of the donor-funded ARV market in low and middle-income countries, comprising 87 per cent of ARV purchase volumes in 2008.⁴⁶ India is currently negotiating a free trade agreement with the European Union (EU) that include 'TRIPS-plus' measures that would extend patent terms beyond 20 years, introduce data exclusivity requirements (that delay registration of generic medicines) and enable border enforcement measures that could restrict international trade in generic medicines if suspected of infringing patents in countries through which they transit.⁴⁷ These rules threaten the production of existing and new drugs, placing into jeopardy India's role as 'the pharmacy of the developing world' and, therefore, of sub-Saharan Africa. This potential impact may amplify in the light of WHO's treatment guidelines which not only recommend earlier initiation of treatment, but also suggest using newer and more expensive first-line treatment regimes,

register any of its new medicines in Thailand in the future because 'Thailand has chosen to break patents on numerous medicines, ignoring the patent system'. See Office of the United States Trade Representative *2007 Special 301 Report* (2007) 27; S Tantivess *et al* *Introducing government use of patents on essential medicines in Thailand, 2006-2007: Policy analysis with key lessons learned and recommendations* (2008) 103, citing the Thai Food and Drug Administration; 'Thailand takes on drug industry, and may be winning' *New York Times* 11 April 2007, citing Jennifer Smoter, an Abbott spokesperson.

43 K Mara 'India may be nearing dispute settlement with EU over generic drug seizures' *Intellectual Property Watch* 29 August 2009.

44 FM Abbott *Study paper for the British Commission on intellectual property rights on the WTO TRIPS Agreement and its implications for access to medicines in developing countries* (2002) 5; Correa (n 32 above) 262; MG Bloche 'WTO deference to national health policy: Toward an interpretive principle' (2002) 5 *Journal of International Economic Law* 838.

45 Forman (n 39 above) 190.

46 B Waning *et al* 'A lifeline to treatment: The role of Indian generic manufacturers in supplying anti-retroviral medicines to developing countries' (2010) 13 *Journal of the International AIDS Society* 35.

47 Waning *et al* (n 46 above) 2.

some of which contain drugs that are widely patented.⁴⁸ These drugs are estimated to be three to four times more expensive than older regimes, and Indian manufacturers are not yet manufacturing lower cost versions.⁴⁹

These threats to the availability of affordable medicines are exacerbated by recession-related cut-backs and stagnation in global health funding and concomitant reductions in domestic health funding. For example, in May 2011, Tanzania cited the recession as responsible for a 25 per cent cut to its health budget.⁵⁰ Moreover, inadequate budgeting and management has seen numerous African countries experience ARV stock-outs, including Zimbabwe, Uganda, the Democratic Republic of the Congo, Malawi, Guinea and South Africa.⁵¹ Uganda's persistent stock-outs are reported to have resulted in at least 17 HIV-positive people dying in June 2011.⁵² In late 2011, the GFATM was forced to cancel its 2012 funding round in light of recession-related funding cuts by northern donors.⁵³ The continued expansion of access to ARVs therefore remains inextricably tied to the ability of countries to access continuing global funding and low-cost generic medicines. Global trade-related intellectual property rights are threatening the supply of the latter, thereby restricting the volume of medicines that can be purchased with diminishing global health funding.

4 Human rights and medicines: Global rights and domestic activism

The inaccessibility of medicines threatens the realisation of a range of human rights, including the right to health, in particular. This latter right has been protected in international law since 1948 when the Universal Declaration of Human Rights (Universal Declaration) recognised everyone's right to a standard of living adequate for health and well-being, including food, clothing, housing, medical care and necessary social services.⁵⁴ In the International Covenant on Economic, Social and Cultural Rights (ICESCR), state parties recognise everyone's right to the enjoyment of the highest attainable standard of physical and mental

48 WHO *Rapid advice: Anti-retroviral therapy for HIV infection in adults and adolescents* (2009); B Waning *et al* 'Intervening in global markets to improve access to HIV/AIDS treatment: An analysis of international policies and the dynamics of global antiretroviral medicines markets' (2010) 6 *Globalization and Health* 2.

49 Waning *et al* (n 46 above) 35.

50 'Financial crisis scapegoat for ARV stockouts?' *Inter Press Service: Health Africa* 23 September 2011.

51 P Chatterjee 'Stretching the AIDS dollar' (2009) 374 *Lancet* 678.

52 n 50 above; L Muhamadi *et al* 'Inadequate pre-anti-retroviral care, stock-out of anti-retroviral drugs and stigma: Policy challenges/bottlenecks to the new WHO recommendations for earlier initiation of anti-retroviral therapy (CD<350 cells) in Eastern Uganda' (2010) 97 *Health Policy* 187-194.

53 Economic crisis hits health aid that has helped millions as donors cut back' *Globe and Mail* 23 November 2011.

54 Art 25 Universal Declaration.

health, and agree to take steps to achieve this goal, including preventing, treating and controlling disease and creating conditions to assure to all medical services and attention in sickness.⁵⁵ Numerous other international instruments protect the right to health, including the Convention on the Rights of the Child (CRC), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and, most recently, the Convention on the Rights of Persons with Disabilities.⁵⁶ The regional analogue of these rights appears in article 16 of the African Charter on Human and Peoples' Rights (African Charter), which provides for every individual's right to enjoy the 'best attainable state of physical and mental health' and requires states to take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.⁵⁷

In 2000, the UN Committee on Economic, Social and Cultural Rights (ESCR Committee) interpreted the right to the highest attainable standard of health to require states to ensure both adequate levels of health care as well as the underlying determinants of health.⁵⁸ The Committee suggested that the state duty to provide adequate health care requires as an essential element and minimum core duty that states provide universal access to essential medicines.⁵⁹ Moreover, it indicated that states have a duty to ensure access to affordable, available and safe drugs more generally.

Despite these international and regional codifications and interpretations, until about 2001, international and regional human rights law offered only vague normative support for viewing access to medicines, either as a specific component of the right to health, or as a human rights entitlement which could supersede intellectual property protections. There appeared little hope that governments in sub-Saharan Africa could realise access to affordable ARVs under existing human rights obligations and in apparent conflict with their WTO duties. At that time, ARV pricing was US \$15 000 a year. WHO's and UNAIDS's official position was that, given high drug costs and the need for effective prevention, treatment was not a wise use of resources in poorer countries.⁶⁰ There was no international funding for low and middle-income countries to purchase drugs, and companies gave extremely limited price concessions. Access in

55 Art 12 ICESCR.

56 Art 24(1) International Convention on the Rights of the Child; art (5)(e)(iv) International Convention on the Elimination of Racial Discrimination; arts 11(1)(f) & 12 Convention on the Elimination of All Forms of Discrimination against Women; Convention on the Rights of Persons with Disabilities.

57 African Charter on Human and Peoples' Rights of 1981, OAU Doc CAB/LEG/67/3 rev 5, 21 *ILM* 58 (entered into force 21 October 1986).

58 United Nations Committee on Economic, Social and Cultural Rights, General Comment 14 (2000): The Right to the Highest Attainable Standard of Health (art 12 of the International Covenant on Economic, Social, and Cultural Rights) (11 August 2000) para 4.

59 As above.

60 WHO & UNAIDS *Guidance modules on anti-retroviral treatments: Module 9: Ethical and societal issues relating to antiretroviral treatments* (1998) 13.

low and middle-income countries was around 5 per cent of HIV-positive persons and, in sub-Saharan Africa, access was considerably under 1 per cent.

Civil society and people with HIV did not accept this *status quo*, and global treatment advocacy focused on AIDS medicines emerged.⁶¹ Given the virtually unchecked growth of HIV in sub-Saharan Africa, and its corresponding scale of deaths, activists were able to force the question of affordable AIDS medicines into the global spotlight as a grave human rights concern, rather than simply a question of intellectual property protections under TRIPS.⁶² While the human rights dimensions of the problem were to some extent evident in the scale of HIV/AIDS-related deaths in sub-Saharan Africa, activists were also able to point to the legal protection that international human rights law gives to the right to health and its implied right to access essential medicines.⁶³ Dramatic battles for AIDS medicines, aimed at both domestic policy and global processes, ensued. These social actions coalesced around moral arguments and human rights claims for medicines and mass actions by social networks of health and human rights activists. This battle challenged drug pricing, legal interpretations of TRIPS, and corporate contestation of TRIPS flexibilities. Major turning points in this battle came through rights-based social actions focused both on global law and policy events and on actions within key countries such as South Africa, Brazil and Thailand.

The following section focuses on the role of the rights-based social movement in each of these countries in relation to national ARV programmes and national law and policy on trade-related intellectual property rights, before proceeding to explore global legal and institutional changes.

4.1 Social movements, human rights and access to ARVs in South Africa

South Africa is home to the greatest number of people living with HIV, and currently provides ARVs to 18 per cent of all patients treated globally.⁶⁴ In 2009, South Africa was treating 920 000 people, 38 per cent of those in

61 E t'Hoen 'TRIPS, pharmaceutical patents, and access to essential medicines: A long way from Seattle to Doha' (2002) 3 *Chicago Journal of International Law* 27-46; L Highleyman 'The global epidemic: Affordable drug access for developing countries' (2000) *Bulletin of Experimental Treatments for AIDS* <http://www.thebody.com/content/policy/art2611.html>.

62 L Forman 'Global health governance from below: Access to AIDS medicines, international human rights law and social movements' in AW Cooper *et al* (eds) *Innovation in global health governance: Critical cases* (2009).

63 As above.

64 WHO *et al* (n 1 above) 54.

need within the country.⁶⁵ This outcome is in large part due to the efforts of national treatment activists who, in addition to sustained public mobilisation, brought successful human rights-based legal challenges against government and pharmaceutical companies in three important cases.

In the *Pharmaceutical Manufacturer's Association* case that took place between 1997 and 2001, 40 pharmaceutical companies sued the South African government to prevent it from passing the Medicines and Related Substances Control Amendment Act (Medicines Act), which was intended to ensure broader access to medicines in line with the post-apartheid government's intentions of transforming the health sector.⁶⁶ The Medicines Act aimed to achieve these goals by promoting generic substitution, establishing a drug-pricing committee, and providing for policy makers to generally limit patent rights to assure the supply of more affordable medicines.⁶⁷ These provisions served to expand the legal capacity entrenched in the Patents Act of 1978, which already authorised compulsory licences for dependent patents and where patent rights are being abused.⁶⁸

In 2000, the US withdrew its trade pressures after Al Gore was embarrassed by AIDS advocates during his presidential campaign.⁶⁹ However, the pharmaceutical companies went to court in South Africa, claiming that South Africa's legislation (and the parallel importation it authorised) breached the TRIPS agreement and South Africa's constitutional property protection,⁷⁰ and threatened the industry's incentive to innovate new medicines.⁷¹ In April 2001, South African treatment advocates joined the government's case, bringing human rights arguments from international and domestic law, and arguing that the South African Constitution's right to access healthcare services provided constitutional authority for the legislation itself, and a legal interest that should be prioritised over corporate property rights. At the same time, the Treatment Action Campaign (TAC) and other South African human rights groups worked with activists around the world. They organised an extraordinary level of public action, including international protests and

65 G Mooney & L Gilson 'The economic situation in South Africa and health inequities' (2009) 374 *Lancet* 858–859.

66 *Pharmaceutical Manufacturer's Association & Others v The President of the Republic of South Africa* Case 4183/98, Trans Prov Div (17 April 2001).

67 The Medicines and Related Substances Control Amendment Act 90 of 1997, secs 22(g) & 15(c).

68 Patents Act 57 of 1978, as revised.

69 See P Bond 'Globalization, pharmaceutical pricing and South African health policy: Managing confrontation with US firms and politicians' (1999) 29 *International Journal of Health Services* 788–798; 'A conflict of health and profits: Gore at centre of trade policy reversal on AIDS drugs to S Africa' *Washington Post* 21 May 2000.

70 *Pharmaceutical Manufacturer's Association* (n 66 above); Notice in terms of Rule 16A, establishing the constitutional issues raised in the applicant's notice of motion and supporting affidavits, para 1(b).

71 *Pharmaceutical Manufacturer's Association* (n 66 above) Founding Affidavit, paras 5 & 8.

national and international petitions, and motivating the EU, Dutch government and WHO to pass resolutions calling for the case to be dropped.⁷² In the days before the hearing, Nelson Mandela, the former South African President, criticised the pharmaceutical companies for charging exorbitant prices on AIDS drugs, attracting considerable media attention.⁷³ As a result, in April 2001, the pharmaceutical companies withdrew their case.⁷⁴ The author has previously argued that this case provoked a major tipping point globally around the issue of access to AIDS treatment as a human right and as a legitimate global policy objective.⁷⁵ The litigation and surrounding media furore precipitated a discernible shift in how the appropriateness of TRIPS and patents in poor countries came to be seen, and immediately preceded many of the international declarations and institutions which emerged from 2002 onwards in support of universal access to ARVs, and which are discussed in the following section.

In another instance of socially-driven human rights litigation, in the 2002 *Hazel Tau* case, social groups approached the Competition Commission of South Africa, arguing that four ARVs sold by GlaxoSmithKline and Boeringer Ingelheim were excessively priced and violated constitutional and international rights to health and life.⁷⁶ The corporations settled the case out of court before a final decision could be made by the competition tribunal, and agreed to issue voluntary licences at significantly-reduced prices.⁷⁷

While the withdrawal of the *Pharmaceutical Manufacturer's Association* case and the outcomes of the *Hazel Tau* case ostensibly opened the door for President Mbeki to ensure broader access to affordable AIDS drugs, there was little chance that he would do so, given his support for 'AIDS denialism', a dissident body of thought that disputes that HIV causes AIDS and views anti-retroviral drugs as toxic agents that are themselves the real

72 'WHO backs South Africa in anti-AIDS drug case' *Agence France-Presse* 6 March 2001; 'Worldwide protest mark first day of drug trial' *WOZA Interne* 6 March 2001; 'Shamed and humiliated - The drug firms back down' *The Guardian* 19 April 2001; M Heywood 'Debunking 'Conglomo-talk': A case study of the *amicus curiae* as an instrument for advocacy, investigation and mobilisation' paper presented at 'Health law and human rights: Exploring the connections', an International Cross-Disciplinary Conference, 29 September-1 October 2001, Philadelphia 9.

73 C Denny 'Mandela hits out at AIDS drug firms' *The Guardian* 16 April 2001.

74 *Pharmaceutical Manufacturer's Association* (n 66 above); 'Joint statement of understanding between the Republic of South Africa and the applicants'.

75 See, eg, L Forman "'Rights" and wrongs: What utility for the right to health in reforming trade rules on medicines?' (2008) 10 *Health and Human Rights: An International Journal* 558.

76 *Hazel Tau & Others v GlaxoSmithKline SA (Pty) Ltd & Others*, Complaint before the Competition Commission of South Africa, Case 2002.

77 J Berger 'Litigating for social justice in post-apartheid South Africa' in V Gauri & DM Brinks (eds) *Courting social justice: Judicial enforcement of social and economic rights in the developing world* (2008) 57-58.

cause of AIDS-related death.⁷⁸ Social contestation over government's resolute refusal to provide AIDS treatment coalesced around its delays and active obstruction of public sector use of Nevirapine, an anti-retroviral drug with growing efficacy in preventing mother-to-child-transmission (MTCT) of AIDS.⁷⁹ In August 2001, a group of NGOs and public sector doctors, led by TAC, instituted successful legal action in the High Court against the Minister of Health and provincial health departments, arguing that the state's delays and refusal to make Nevirapine available in the public sector breached the Constitution's right to access health services and children's rights to basic health services.⁸⁰ The government appealed the case to the Constitutional Court, defending the reasonableness of its approach from the perspective of cost and efficacy. The Constitutional Court found state policy to be unreasonable, and held that excluding the drug in question in public healthcare facilities pending study results unreasonably denied a potentially-lifesaving drug to children born to mostly indigent mothers dependent on the state for their health care.⁸¹ The Court not only declared that it is government's responsibility to devise and implement a comprehensive MTCT programme within available resources, but also ordered government, without delay, to remove restrictions on the drug and to make it available in the public sector, to provide for training of counsellors and to take reasonable measures to extend testing and counselling facilities throughout the public health sector.

The Constitutional Court's order in *TAC* motivated the government to establish a national MTCT programme and, by 2009, MTCT interventions were available in 95 per cent of public facilities.⁸² The programme is believed to have contributed to declines in child mortality (which had increased from 50 per 1 000 live births in 1994 to 60 per 1 000 in 2005).⁸³ The *TAC* decision and its outcomes also laid the groundwork for a national AIDS treatment programme, which was announced in 2003.⁸⁴ The

78 See M Harvey 'How can a virus cause a syndrome? Asks Mbeki' *iClinic* 21 September 2000 <http://www.aegis.com/news/woza/2000/IC000906.html>; 'Mbeki questions HIV testing' *The Associated Press* 24 April 2001; E Cameron 'AIDS denial and holocaust denial - AIDS, justice and the courts in South Africa' (2003) 120:3 *South African Law Journal* 525.

79 D Moodley 'The Saint trial: Nevirapine (NVP) versus Zidovudine (ZDV) + Lamivudine (3TC) in prevention of peripartum transmission' XIII International AIDS Conference, Durban, South Africa, 9-14 July 2000, Abstract LbOr2; LA Guay *et al* 'Intrapartum and neonatal single-dose Nevirapine compared with Zidovudine for prevention of mother-to-child transmission of HIV-1 in Kampala, Uganda: HIVNET 012 randomised trial' (1999) 354 *Lancet* 795-802.

80 Constitution of the Republic of South Africa, 1996 secs 27 & 28.

81 *Minister of Health & Another v Treatment Action Campaign & Others* 2002 (5) SA 721 (CC) para 79.

82 Statistics South Africa *Mid-year population estimates 2010* (2010) 5.

83 D Harrison *An overview of health and health care in South Africa 1994-2010: Priorities, progress and prospects for new gains* (2009) 6.

84 South African Department of Health 'Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa 19 November 2003 (Care Plan)' (2003)

national anti-retroviral programme has increased its coverage from 133 000 people in 2005 (7 per cent of people in need) to 920 000 people in 2009 (38 per cent of those in need).⁸⁵ The government plans to increase coverage to 1,4 million people by 2011-2012.⁸⁶ Most significantly, national increases in life expectancy at birth (from 43 years in 2007 to 53,3 years in 2010) are attributed to the rollout of anti-retrovirals.⁸⁷

4.2 Social movements, human rights and access to ARVs in Brazil

Brazil was the first middle-income country to begin offering free treatment to AIDS patients, initiating a public sector ARV programme in the early 1990s, and committing to the provision of free universal access to ARVs in 1996.⁸⁸ Since then, the government has made AIDS treatment available through the public sector to 194 984 people, approximately 50 to 89 per cent of those in need in the country.⁸⁹ The introduction of ARVs has seen significant population health outcomes: a 40 per cent reduction in mortality and 70 per cent reduction in morbidity between 1997 and 2004.⁹⁰ Brazil's large-scale HIV/AIDS treatment programme is considered a model for other low and middle-income countries, while the government is also considered influential in changing norms related to international human rights, health and trade policies governing essential medicines.⁹¹

Certainly, the country's ARV programme is largely attributable to successful advocacy by a domestic AIDS movement. During the late 1980s and early 1990s, the first AIDS NGOs initiated demands for government to improve access to HIV/AIDS-related prevention and treatment services as a function of its duties under the Brazilian Constitution, including in relation to health.⁹² Brazil's new AIDS civil society sector successfully pushed for prevention campaigns and initiatives to combat stigma and

85 Mooney & Gilson (n 65 above) 859.

86 South Africa Department of Health *Annual report 2008/09* (2009).

87 Statistics South Africa *Mid-year population estimates 2009* (2009) 6.

88 AS Nunn *et al* 'Evolution of anti-retroviral drugs costs in Brazil in the context of free and universal access to AIDS treatment' (2007) 4 *PLoS Medicine* 1804-1817; AS Nunn *et al* 'Changing global essential medicines norms to improve access to AIDS treatment: Lessons from Brazil' (2009) 4 *Global Public Health* 131-132.

89 WHO (n 1 above), 114. This figure is based on the 2010 WHO guidelines. Under the 2006 WHO guidelines, Brazil's ARV coverage would have reached between approximately 65% to 95%.

90 R Reis *et al* 'Access to medicines and intellectual property in Brazil: A civil society experience' in Brazilian Interdisciplinary AIDS Society *Intellectual property rights and access to ARV medicines: Civil society resistance in the Global South* (2009) 15

91 Nunn (n 88 above) 131.

92 Nunn (n 88 above) 133. Art 196 of the Federative Republic of Brazil Constitution of 1988 holds that '[h]ealth is a right of all and a duty of the state and shall be guaranteed by means of social and economic policies aimed at reducing the risk of illness and other hazards and at the universal and equal access to actions and services for its promotion, protection and recovery'.

discrimination.⁹³ In 1990, the Health Ministry responded to these demands by committing to provide AIDS treatment and, in 1993, initiated the production of generic ARV drugs.⁹⁴ Early court victories in the early 1990s saw the constitutional right to health interpreted to include access to AIDS medicines.⁹⁵ Yet, AIDS treatment was available only sporadically until the mid- to late-1990s because the National Congress and Health Ministry had not appropriated sufficient funds for treatment and had given a fragmentary health infrastructure.⁹⁶

In 1996, Brazil's Congress passed a law guaranteeing free and universal access to AIDS drugs for all people living with HIV in Brazil.⁹⁷ In 1997, the country passed its first laws recognising intellectual property rights for pharmaceutical products, in order to bring its laws into compliance with TRIPS.⁹⁸ Brazil used only two years of the ten-year transition period it was entitled to as a middle-income country before recognising patents in relation to medicines.⁹⁹ In the face of rapidly-rising treatment costs, the Brazilian health minister publicly discussed issuing a compulsory licence to produce several ARVs in Brazil's public drug-manufacturing facilities.¹⁰⁰

These efforts prompted the US in 2001 to lodge a complaint at the WTO against Brazil's intellectual property law on compulsory licences. As transnational AIDS groups mobilised against the South African Pharmaceutical Manufacturers Association (PMA) litigation, they joined action against the US WTO complaint. At the same time, the Brazilian government adopted a strategic approach at the UN and in global media to promote access to medicines as a fundamental human right, with the explicit intent of influencing international public opinion and thereby indirectly countering the US WTO challenge.¹⁰¹ Accordingly in May 2001, Brazil introduced a resolution at the UN Commission on Human Rights arguing that AIDS treatment should be recognised as a fundamental component of the right to the highest attainable standard of physical and mental health, and calling on nation states to make treatment available to individuals living with HIV/AIDS.¹⁰² The Commission overwhelmingly approved the resolution with 52 votes in favour and none

93 Reis *et al* (n 90 above) 18.

94 Nunn *et al* 'Changing global essential medicines norms to improve access to AIDS treatment' (n 88 above) 133.

95 As above.

96 As above 133-134; also citing Nunn *et al* (n 88 above) 1804-1817.

97 Nunn *et al* 'Changing global essential medicines norms to improve access to AIDS treatment' (n 88 above) 134.

98 As above.

99 Reis *et al* (n 90 above) 21.

100 Nunn *et al* 'Changing global essential medicines norms to improve access to AIDS treatment' (n 88 above) 134.

101 Nunn *et al* 'Changing global essential medicines norms to improve access to AIDS treatment' (n 88 above) 136.

102 United Nations Commission on Human Rights Resolution 2001/33 'Access to medication in the context of pandemics such as HIV/AIDS' (23 April 2001).

against, with only the US abstaining.¹⁰³ It is notable that, in the aftermath of global demonstrations and Brazil's effective strategic adoption of rights-based arguments, the US chose to directly settle its WTO complaint with Brazil.

The Brazilian government has also effectively used the threat of compulsory licences to negotiate with pharmaceutical companies over drug prices leading to corporate price reductions for several ARV medicines in Brazil, saving the government an estimated US \$1 billion in drug costs since 2001.¹⁰⁴ This strategy is illustrated in the government's approach to Kaletra, an ARV manufactured by Abbott Laboratories that consumed nearly 30 per cent of the National STD/AIDS Programme's budget.¹⁰⁵ In 2005, after government efforts to negotiate a lower price with Abbott failed, the Brazilian Minister of Health declared the drug to be of public interest, a first step towards issuing a compulsory licence.¹⁰⁶ As a result, Abbott agreed to lower the price in exchange for government not issuing a compulsory licence.¹⁰⁷ However, Brazil has issued only one compulsory licence in 2007, to enable it to import generic versions of Efavirenz from India and later for locally-manufactured generics.¹⁰⁸

4.3 Social movements, human rights and access to ARVs in Thailand

Thailand is another middle-income country that has played an important role in global treatment access. In 2009, 216 118 people were receiving ARVs in Thailand, reflecting coverage of 61 per cent of those in need.¹⁰⁹ This figure is in stark contrast to 2001 rates, when only 3 600 people were accessing ARVs throughout Thailand.¹¹⁰ This increase is due to numerous factors, including GFATM support, the introduction of public sector programmes, and the domestic production of key ARVs, including production through compulsory licensing. Civil society challenges against government and pharmaceutical companies have also played an influential role, as have government commitments to public sector provision of affordable medicines, including in relation to HIV.

Largely in compliance with US pressures, Thailand's intellectual property laws had been in compliance with TRIPS for several years before that agreement had even been drafted. By 1992, Thailand was providing

103 Nunn *et al* 'Changing global essential medicines norms to improve access to AIDS treatment' (n 88 above) 137.

104 As above, 132.

105 Reis *et al* (n 90 above) 33.

106 Reis *et al* (n 90 above) 34.

107 As above.

108 Reis *et al* (n 90 above) 27.

109 WHO (n 1 above) 118. This figure is based on the 2010 WHO guidelines.

110 C Lyttleton *et al* 'Expanding community through ARV provision in Thailand' (2007) 19 *AIDS Care* S1: 44-53.

20-year patent protection to drugs and pharmaceutical products and, in 1994, it extended this law to give pipeline protection to drugs patented in foreign countries. In 2002, a Trade Secret Act was passed that protected test data, reflecting similar 'TRIPS-plus' provisions in free-trade agreements (FTA).¹¹¹

While the Thai Public Health Ministry had been providing ARVs as far back as 1992, prior to 2000, treatment was only available through research facilities and private hospitals.¹¹² In 2000, Thailand began a national ARV treatment programme premised on the provision of free or reduced cost ARV drugs. In 2002, the Thai Government Pharmaceutical Organisation (GPO) began the production of a generic fixed-dose combination ARV named GPO-VIR. In 2004, under Prime Minister Shinawatra, the Access to Care programme was expanded into the '30 baht' programme premised on achieving universal treatment,¹¹³ which entitled eligible patients to hospital care for 30 baht (75 US cents) per visit regardless of the ailment.¹¹⁴ All public sector regional, provincial, and district hospitals and some private and university hospitals in Thailand now provide ARV treatment to eligible HIV-infected patients.¹¹⁵

A strong Thai civil society has played an important role in motivating these government initiatives, including, in particular, the Thai Network for People Living with HIV/AIDS.¹¹⁶ Civil society has brought legal challenges against ARV pricing and to enable compulsory licensing of patented ARVs using constitutional and international human rights to health and life to supplement challenges under national intellectual property laws.¹¹⁷ In a 2002 case, the Thai Intellectual Property and Trade Court dismissed a corporate challenge against individual and NGO standing to challenge their patent, holding that 'medicine is essential for human life' and that 'the treatment of life and health transcends the importance of any other property'.¹¹⁸ The Court partially invalidated a Bristol Myers-Squibb patent on didanosine to permit the domestic production and distribution of a generic version of this medicine.¹¹⁹ This verdict allowed the Ministry of Public Health to produce generic drugs without fear of breaking TRIPS rules, and allowed the government's treatment programme to expand rapidly.¹²⁰

111 Trade Secret Act (TSA) BE 2545 (2002).

112 Lyttleton *et al* (n 110 above); S Chasombat *et al* 'National expansion of anti-retroviral treatment in Thailand, 2000-2007: Programme scale-up and patient outcomes' (2009) 50 *Journal of Acquired Immune Deficiency Syndrome* 506-512.

113 Chasombat *et al* (n 112 above).

114 Lyttleton *et al* (n 110 above).

115 Chasombat *et al* (n 112 above).

116 Lyttleton *et al* (n 110 above).

117 *AIDS Access Foundation et al v Bristol Myers-Squibb Company and Department of Intellectual Property* 93/2545 THCIPITC 1, Black Case 34/2544, Red Case 93/2545 (2002).

118 As above.

119 As above.

120 Lyttleton *et al* (n 110 above).

The Thai government has also displayed a willingness to use TRIPS flexibilities to increase access to AIDS and other drugs, with a strong emphasis on human rights motivations. On 25 January 2007, Thailand's interim government issued compulsory licences on two anti-retroviral drugs and a heart disease drug. In 2008, the government issued compulsory licences on four anti-cancer drugs. A White Paper issued in 2007 by the Thai Ministry of Public Health and National Health Security Office argued that the rationale for the licences lay in government's mandate to achieve universal access to essential medicines for all, including ARVs, which the public health insurance schemes could not afford to fulfil despite significant increases to the health budget.¹²¹ The White Paper argued that the licences were 'clear evidence of the government's commitment to put the right to life above the trade interest'.¹²²

Given the problems of access to drugs in Thailand and other low and middle-income countries, the impact of the compulsory licences on drug pricing and availability is worth noting. By June 2008, the Thai government had imported generic versions of two AIDS drugs and a heart disease drug from three Indian manufacturers (Ranbaxy, Matrix and Cadila), with significant increases in the volume of these drugs being provided through the three major publicly-subsidised health benefit plans.¹²³ Access to these medicines increased significantly, with people taking Efavirenz growing from 5 000 to 20 000 by September 2008, and people taking Lopinavir-Ritonavir growing from under 300 to 3 000.¹²⁴ Moreover, the price of all three drugs reduced globally,¹²⁵ with each of the companies holding patents offering significant price reductions even before the compulsory licences were issued (although generic drugs for some versions remained cheaper than the patented product).¹²⁶

5 Global shifts in recognition of access to ARVs as a human right

Broad-based social activism around ARVs in the countries discussed above, as well as in other countries, were key drivers of domestic ARV programmes, producing significant additional policy changes. Yet, the changes wrought through global activism were not domestically constrained. In many of these cases, including the South African

121 Thai Ministry of Public Health and The National Health Security Office (n 41 above) 1-2.

122 Thai Ministry of Public Health and The National Health Security Office (n 41 above) 4.

123 Tantivess *et al* (n 42 above) 120-124.

124 MN Songkhla 'Health before profits? Learning from Thailand's experience' (2009) 373 *The Lancet* 441 442.

125 Tantivess *et al* (n 42 above) 125.

126 Tantivess *et al* (n 42 above) 119.

Pharmaceutical Manufacturer's Association case and US-Brazil WTO challenge, activists mobilised action through transnational networks which co-ordinated global actions such as protests and petitions, amassing widespread public and media attention. Activists also used the windows of opportunity offered by global legal and policy fora, including the WTO Ministerial Conference in Doha where activists worked in conjunction with key low and middle-income countries to motivate the passing of the Doha Declaration itself.¹²⁷

These actions also added momentum to significant normative shifts at the UN in defining ARV access in terms of human rights entitlements and duties. Before 2001, international human rights law offered little in the way of official recognition of a human right to medicines or to AIDS treatment in particular. From 2001 onwards (directly following the withdrawal of the *Pharmaceutical Manufacturer's Association* case in South Africa and the US withdrawal of its WTO complaint against Brazil), there was a sharp upsurge from UN institutions and actors in international statements on treatment as a human right and on state obligations to provide ARVs.¹²⁸ In 2006, the ESCR Committee issued a General Comment addressing authors' rights to protection of their moral interests, which differentiated between human rights, which are fundamental and inherent to being human, and intellectual property rights, which are state tools to provide incentives for inventions.¹²⁹ The Committee emphasised that this meant that intellectual property rights could be proportionally limited to ensure a balance with public needs, and that state parties should ensure that their protection of intellectual property rights should not impede their ability to comply with core duties under rights to food, health and education. The

127 For a thorough exploration of some of these actions through to 2002, see t'Hoen (n 61 above).

128 United Nations Commission on Human Rights Resolutions 2001/33, 23 April 2001, 2002/32, 6 March 2002, 2003/29, 22 April 2003, 2004/26, 16 April 2004; United Nations Commission on Human Rights 'Intellectual property rights and human rights: Report of the Secretary-General' UN Doc E/CN.4/Sub.2/2001/12 (2001); United Nations Commission on Human Rights 'The impact of the agreement on Trade-Related Aspects of Intellectual Property Rights on human rights: Report of the High Commissioner' UN Doc E/CN.4/Sub.2/2001/13 (2001); United Nations Committee on Economic, Social and Cultural Rights 'Human rights and intellectual property' UN Doc E/C.12/2001/15 (2001); United Nations Office of the High Commissioner for Human Rights and UNAIDS 'HIV/AIDS and human rights international guidelines, revised guideline 6: Access to prevention, treatment, care and support, Third International Consultation on HIV/AIDS and Human Rights' UNAIDS/02.49E, HR/PUB/2002/1 (2002); United Nations General Assembly 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health' UN Doc A/61/338 (2006); United Nations Human Rights Council 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Expert consultation on access to medicines as a fundamental component of the right to health' UN Doc A/HRC/17/43 (16 March 2011).

129 United Nations Committee on Economic, Social and Cultural Rights General Comment 17 (2006): The right of everyone to benefit from the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he or she is the author (art 15, para 1(c), of the Covenant) UN Doc E/C.12/GC/17, 12 January 2006, para 1.

ESCR Committee was explicit in specifying that this meant that state parties 'have a duty to prevent unreasonably high costs for access to essential medicines'.¹³⁰

State obligations to ensure access to AIDS medicines for all have also been explicitly extended to children. In 2003, the Committee on the Rights of the Child (CRC Committee), in a General Comment on HIV/AIDS and Children's Rights, urged states to provide ARVs to pregnant mothers for preventive purposes, arguing that state obligations under CRC extend to ensuring that children have sustained and equal access to comprehensive treatment and care, which includes ARVs and other drugs.¹³¹ Several treaty-monitoring committees at the UN have cautioned states about the potential adverse effects of trade agreements on access to affordable medicines (particularly generic medicines) and have called on countries to conduct assessments of the effect of international trade rules on the right to health.¹³²

The regional systems have similarly shifted towards the explicit recognition of ARV access in human rights terms. While the African Commission on Human and Peoples' Rights (African Commission) has heard several health-related cases,¹³³ it has not yet had cause to apply the African Charter's right to health to AIDS medicines. In 2008, the African Commission issued a resolution titled 'Access to Health and Needed Medicines in Africa', which recognised that 'access to needed medicines is a fundamental component of the right to health and that state parties to the African Charter have an obligation to provide where appropriate needed medicines, or facilitate access to them'.¹³⁴ While not explicitly identifying HIV/AIDS, 'needed medicines' would incorporate clearly the same in the

130 ESCR Committee (n 129 above) para 55.

131 Committee on the Rights of the Child 'General Comment 3 (2003): HIV/AIDS and the rights of the child' UN Doc CRC/GC/2003/3, 17 March 2003 paras 26 & 28.

132 ESCR Committee 'Concluding Observations of the Committee on Economic, Social and Cultural Rights: Ecuador, UN Doc E/C.12/1/Add.100, 7 June 2004 para 55; ESCR Committee 'Concluding Observations of the Committee on Economic, Social and Cultural Rights: Morocco' UN Doc E/C.12/MAR/CO/3, 4 September 2006 paras 29 & 56; ESCR Committee 'Concluding Observations for Costa Rica' UN Doc E/C.12/CRI/CO/4, 4 January 2008 paras 27 & 48; CRC Committee 'Consideration of Reports Submitted by States Parties under Article 44 of the Convention – Concluding Observations: El Salvador, UN Doc CRC/C/15/Add.232, 4 June 2004 paras 47 & 48.

133 See, eg, *Free Legal Assistance Group & Others v Zaire* (1995) AHRLR 74 (ACHPR 1995) (the failure of the [then Zaire] government to provide basic services such as safe drinking water and electricity and the shortage of medicine as alleged in the communication violated art 16); *Malawi African Association & Others v Mauritania* (2000) AHRLR 149 (ACHPR 2000) (poor living conditions for prisoners, including a lack of medical treatment constituted a violation of art 16(1)); Communication 155/96, *SERAC and CESR v Nigeria*, Fifteenth Annual Activity Report of ACHPR, annex V (a number of the Ogoni People's rights, including the right to health, had been violated by the government of Nigeria, acting through the national petroleum company, which was a majority shareholder in a consortium with Shell Petroleum).

134 African Commission on Human and Peoples' Rights 'Resolution on access to health and needed medicines in Africa' ACHPR/Res 141 (XXXXVIII) 08 24 November 2008.

context of sub-Saharan African pandemics. The resolution adopts the language of the ESCR Committee's General Comment 14, urging states to guarantee the full scope of access to needed medicines, including assuring the availability, accessibility, acceptability and quality of medicines. The resolution further called on states to 'fulfil their duties with respect to access to medicines', specifying a range of duties to respect, protect and fulfil this right, including:

- refraining from 'implementing intellectual property policies that do not take full advantage of all flexibilities in [TRIPS] that promote access to affordable medicines, including entering 'TRIPS-plus' free trade agreements;
- preventing unreasonably high prices for needed medicines in both the public and private sectors, through promotion of equity pricing in which the poor are not required to pay a disproportionate amount of their income for access; and
- immediately meeting the minimum core obligations of ensuring availability and affordability to all of essential medicines as defined by the country's essential medicines list and the WHO Action Programme on Essential Drugs.¹³⁵

The resolution mandates a working group on economic, social and cultural rights to 'further define state obligations related to access to medicines and to develop model monitoring and assessment guidelines'. It is notable that the resolution was the result of an intervention at the 44th session of the African Commission by South African and American civil society groups focused on human rights and AIDS.¹³⁶ Nonetheless, as the regional experiences below imply, the African Commission remains a significantly underutilised mechanism.

Of the regional systems, the Inter-American system has most extensively been used by people with HIV and AIDS, who in numerous cases have claimed treatment access on the basis of the rights to life and health in the American Convention on Human Rights and the Protocol of San Salvador.¹³⁷ In the 2001 case of *Jorge Odir Miranda Cortez et al v El Salvador*, people living with HIV/AIDS sought a precautionary measure from the Inter-American Commission of Human Rights to order the

¹³⁵ As above.

¹³⁶ See, eg, Centre for Human Rights (South Africa) and Programme on Information Justice and Intellectual Property (USA) 'Statement in support of a resolution on right to health and access to medicines' http://www.chr.up.ac.za/images/files/research/ahrru/news/ahrru_news_09_statement_achpr_access_medicines.pdf. (accessed 19 November 2012).

¹³⁷ American Convention on Human Rights, OAS Treaty Series 36, 1144 UNTS 123 (entered into force 18 July 1978), reprinted in Basic Documents Pertaining to Human Rights in the Inter-American System, OAS Doc OEA/SerLV/II82 Doc6 Rev1 (1992)25; and Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights 'Protocol of San Salvador', OAS Treaty Series 69 (entered into force 16 November 1999). Art 10 provides that '[e]veryone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being'.

government to provide ARVs on an interim basis while the merits of their claim was being assessed, alleging that the government of El Salvador had violated their rights to life and health by failing to provide them with ARVs.¹³⁸ The Commission granted an interim precautionary measure requesting government to provide ARVs to the petitioners pending the determination on the merits of the case, and also declared the complaint to be admissible, as a preliminary step to considering the merits. Shortly thereafter, the El Salvadoran Supreme Court ordered the Salvadoran Social Security Institute to provide Cortez with ARVs, thereby rendering the complaint before the Inter-American Commission moot. This decision appears to have been largely motivated by the pressure exerted through the Commission's decision.¹³⁹ Notably, government introduced legislation that same year which affirmed the right of every person living with HIV/AIDS to health care, medical, surgical and psychological treatment, and preventive measures.¹⁴⁰ It has been argued that this legislation was introduced largely because of the influence of the Commission's decision and subsequent Supreme Court decision.¹⁴¹ These legislative changes have been criticised by the Commission itself which, in a 2009 report, concluded that they lacked the simplicity and effectiveness necessary to protect fundamental rights and consequently that El Salvador had failed in its duty to make its domestic laws consistent with its international obligations in the area of human rights.¹⁴² While the Commission granted precautionary measures in another seven cases after the *Cortez* case, which ordered governments to provide specific litigants with ARVs, it is reported that these orders have largely been ignored.¹⁴³

138 *Jorge Odir Miranda Cortez et al v El Salvador* Inter-American Commission of Human Rights, IAmComm of HR (2000), OEA/Ser/L/V/III11 Doc 20 Rev 200.

139 UNAIDS & Canadian HIV/AIDS Legal Network *Courting rights: Case studies in litigating the human rights of people living with HIV* (2006) 71.

140 Law on the Prevention and Control of the Infection caused by the Human Immunodeficiency Virus (Decree 588, 24 October 2001) art 5(a), cited in UNAIDS and Canadian HIV/AIDS Legal Network (n 139 above) 71.

141 As above.

142 *Miranda Cortez* (n 138 above).

143 MA Torres 'Access to treatment in Latin America: Using the legal system to access anti-retroviral treatment' presentation at University of Toronto Faculty of Law, World AIDS Day Conference, 26 October 2004, on file with author. These countries were Honduras; Nicaragua, Guatemala, Dominican Republic, Peru, Bolivia and El Salvador. Torres indicates that only in Honduras were all 12 applicants provided with treatment. In all other countries, compliance with provisory measures has almost entirely been ignored - eg, in Nicaragua (16 applicants); Guatemala (12 applicants); Dominican Republic (128 applicants); Peru (15 applicants); and Bolivia (52 applicants); not a single claimant has received ARV and, in Ecuador, only 1 out of 153 claimants has. In El Salvador, it is not known how many of 36 claimants have received ARV.

In a 2008 case, the Commission found in favour of a woman with HIV/AIDS who was seeking protection from deportation from the US to Jamaica, where she would lack adequate access to treatment.¹⁴⁴ This outcome is in stark contrast to a line of decisions from the European Court of Human Rights, in which claimants with HIV/AIDS unsuccessfully tried to avoid deportation to various African countries on the basis that the inaccessibility of ARVs would endanger their rights to life and health.¹⁴⁵ However, this line of decisions is in contrast to the Court's own earlier decision in the 1997 case of *D v United Kingdom*, where it held that deporting someone with advanced AIDS back to St Kitts, where ARVs were not available, would violate the European Convention on Human Rights' prohibition against inhuman or degrading treatment.¹⁴⁶ Nonetheless, other aspects of the European Court of Human Rights jurisprudence support prisoners' rights to ARVs, with the Court finding in two recent decisions that denying prisoners with HIV/AIDS access to proper medical care, including ARVs, constituted a violation of the Convention prohibition against inhuman or degrading treatment.¹⁴⁷

144 See *Andrea Mortlock v United States* Inter-American Commission of Human Rights, IAmComm of HR, OEA/SerL/V/II134 Doc 5 Rev 1 (2008). In *Mortlock*, the applicant was a Jamaican national facing deportation from the US to Jamaica, which would deny her access to medication critical to her treatment for HIV/AIDS. The Commission found that '[k]nowingly sending Ms Mortlock to Jamaica with the knowledge of her current health care regime and the country's sub-standard access to similar health for those with HIV/AIDS would violate Ms Mortlock's rights, and would constitute a *de facto* sentence to protracted suffering and unnecessarily premature death'. In particular, the Commission concluded that issuing a deportation order to Mortlock would violate the protection of art XXVI of the American Declaration not to receive cruel, infamous or unusual punishment.

145 In *Karara v Finland* (Appln 40900/98, 29 May 1998), the Commission rejected a challenge against deportation to Uganda since the applicant's HIV infection was not as advanced as in the case of *D*. In *SCC v Sweden* (Appln 46553/99, 15 February 2000), the court rejected a similar challenge to deportation to Zambia because of the applicant's relatively early diagnosis and recent initiation into treatment, and since treatment was available in Zambia and her children and relatives lived there. In 2005, the UK House of Lords rejected a similar challenge against deportation back to Uganda as violating the European Convention. See *N (FC) v Secretary of State for the Home Department* [2005] UKLH 31. Following the dismissal of her case by the House of Lords, *N* brought her case to the European Court of Human Rights, which also rejected her claim for asylum. The Court found that the applicant's case did not disclose 'very exceptional circumstances' such that the decision to remove her to Uganda would not give rise to a violation of art 3 (prohibition of inhuman or degrading treatment) of the Convention. See *N v the United Kingdom* (Appln 26565/05, 27 May 2008).

146 *D v United Kingdom* (1997) 24 EHRR 423.

147 In *Logvinenko v Ukraine* (Appln 13448/07, 14 October 2010), the applicant, who suffered from tuberculosis and an advanced stage of HIV, was imprisoned under very poor conditions in a Ukrainian prison and was denied adequate medical care, including treatment for HIV. The Court concluded that Logvinenko had suffered inhuman and degrading treatment in violation of art 3 of the Convention. In *AB v Russia* (Appln 1439/06, 14 October 2010), the applicant, who was HIV positive, was serving his sentence in deplorable conditions in the solitary confinement wing of a Russian prison. Despite his worsening medical condition, *AB* received inadequate medical care and was denied anti-retroviral treatment, which the Court found constituted inhuman and degrading treatment in violation of art 3.

Similar shifts are apparent at domestic level, with the past decade seeing an upsurge in successful domestic claims by individuals and NGOs for state provision of ARVs under constitutional, regional and international rights to health and life, including in Colombia,¹⁴⁸ Costa Rica,¹⁴⁹ Venezuela,¹⁵⁰ Argentina,¹⁵¹ Bolivia¹⁵² and Ecuador.¹⁵³ This trend has expanded beyond HIV/AIDS medicines, and a 2006 study identified 71 cases from 12 countries where access to medicines was claimed as a human right, finding that 83 per cent of these cases were successful.¹⁵⁴ The study found that the consistent variables in successful

- 148 *Alonso Muñoz Ceballos v Instituto de Seguros Sociales*, Constitutional Court of Colombia, Judgment T-484-92 (11 August 1992) (constitutional right to access health care services and to freedom from discrimination required Social Security Institute to pay for applicant's medical treatment); *Diego Serna Gomez v Hospital Universitario del Valle*, Constitutional Court of Colombia, Judgment T-505 (28 August 1992) (in response to a challenge to hospitals' denial of free medical services by a person with HIV/AIDS, the court ruled that the constitutional right to health was fundamental when connected to the right to life and required the state to provide special protection when a lack of economic resources prevented a person from decreasing suffering from a terminal, transmissible or incurable disease); *X v Instituto de Seguros Sociales (ISS)* Constitutional Court of Colombia Judgment T-271 (23 June 1995) (in response to a claim for social security to fund ARV costs, the court held that the right to health was fundamental when connected to the right to life and required that ISS provide treatment to alleviate the condition of people with serious illness).
- 149 *Luis Guillermo Murillo Rodríguez et al v Caja Costarricense de Seguro Social*, Constitutional Chamber of the Supreme Court of Justice of Costa Rica, Decision 6096-97 (1997); *William García Álvarez v Caja Costarricense de Seguro Social*, Constitutional Chamber of the Supreme Court of Justice of Costa Rica, Decision 5934-97 (1997) (constitutional and international rights to life and health required the Social Security Fund to provide ARVs).
- 150 *JRB et al v Ministerio de la Defensa*, Supreme Court of Venezuela, Expediente 14000 (20 January 1998) (the right to health is related to the right to life, and required the Minister of Defence to solicit funds from National Congress to provide ARV through the military social security scheme); *NA, YF et al v Ministerio de Sandidad y Asistencia Social*, Supreme Court of Venezuela, Expediente 14625 (14 August 1998) (constitutional right to health and life obligated state to provide ARVs); *Cruz del Valle Bermudez et al v Ministry of Health and Social Action*, Supreme Court of Venezuela (Political-Administrative Chamber), Decision 916, Court File 15.789 (1999) (constitutional and international rights to life, health and the benefits of science and technology required the Ministry to provide medicines, develop treatment policies and programmes and reallocate the budget sufficient to carry out the court's decision); *Glenda Lopez et al v Instituto Venezolano de Seguros Sociales (IVSS)*, Supreme Court of Venezuela, Expediente 00-1343 (6 April 2001) (constitutional and international rights required IVSS to provide ARVs and testing).
- 151 *AV & CM v Ministerio de Salud de la Nación*, Argentine Federal Civil and Commercial Court 7 (26 April 2002) (the constitutional right to life, which included the right to health and international and regional rights to life and health, required the Ministry of Health to ensure a regular and uninterrupted supply of ARVs to people with HIV/AIDS through the public health system).
- 152 *NN v la Corporación del Seguro Social Militar (COSSMIL)* Bolivian Supreme Court, Expediente 2002-05354-10 (8 January 2003) (the constitutional right to health related to the right to life required COSSMIL to continue the provision of ARVs after it had been interrupted).
- 153 *Edgar Mauricio Carpio Castro et al v Programa Nacional del SIDA-VIH-ITS & Ministerio de Salud Pública*, Constitutional Tribunal of Ecuador (Third Chamber), Decision 0749-2003-RA (2004) (the constitutional rights to life and health required the Minister of Health and Director of National HIV/AIDS programme to take urgent measures to provide treatment and testing).
- 154 HV Hogerzeil et al 'Is access to essential medicines as part of the fulfilment of the right to health enforceable through the courts?' (2006) 368 *Lancet* 306.

cases were national ratification of the Social Rights Covenant and constitutional entrenchment of a right to health.¹⁵⁵ It is worth noting that social groups initiated all of these cases.

6 Global shift towards treatment access

These domestic and legal changes have catalysed the institutional and policy changes formative in advancing access to ARVs so rapidly through the sub-Saharan African region. The combination of pressure, price concessions and generic alternatives from India saw drug prices in many low-income countries drop from its US \$15 000 high to current levels. In the August 2001 UN Declaration of Commitment on HIV/AIDS,¹⁵⁶ 189 countries agreed at a UN General Assembly Special Session (UNGASS) on HIV/AIDS to undertake specific time-bound commitments on care, support and treatment using the right to health language, with states committing to make every effort in an urgent manner 'to provide progressively and in a sustainable manner, the highest attainable standard of treatment for HIV/AIDS', including the effective use of ARVs.¹⁵⁷ In July 2001, the Global Fund to Fight AIDS, Tuberculosis and Malaria was established, followed shortly by the US PEPFAR programme. In 2002, WHO adopted the goal of placing 3 million people on ARVs, which in late 2005 shifted upwards to the goal of achieving universal access to treatment by 2010, a goal similarly adopted by the UN General Assembly and by the G8 as part of a comprehensive plan of assistance for Africa.¹⁵⁸ In 2008, at the 61st World Health Assembly, WHO member states adopted a global strategy and plan of action on public health, innovation, and intellectual property explicitly based on recognising the right to health and promoting a country's right to use TRIPS flexibilities to the fullest.¹⁵⁹

A similar growing consensus on state duties to provide ARVs is reflected in regional African declarations, including the 2000 African Consensus and Plan of Action: Leadership to Overcome HIV/AIDS,¹⁶⁰ the 2001 Abuja Declaration on HIV/AIDS, Tuberculosis and Other

155 As above.

156 United Nations General Assembly, Declaration of Commitment on HIV/AIDS, UN Doc A/RES/S-26/2 (2 August 2001).

157 n 156 above, para 55.

158 United Nations General Assembly, 60th session, 2005 World Summit Outcome, UN Doc A/Res/60/1 (24 October 2005) para 57d; WHO (n 1 above); Group of Eight, Gleneagles Summit, Chair's Summary (8 July 2005).

159 Sixty-First World Health Assembly (Geneva, 19-24 May 2008) paras 16 and 35-36 respectively.

160 African Development Forum 2000 'The African Consensus and Plan of Action: Leadership to Overcome HIV/AIDS' paras 4.3 & 3.4 <http://www.uneca.org/adf2000/consensus.htm>. (accessed 19 November 2012).

Related Infectious Diseases,¹⁶¹ the African Union's 2003 African Women's Declaration on Malaria, HIV/AIDS, Tuberculosis and Other Related Infectious Diseases,¹⁶² and the 2003 Southern African Development Community (SADC) Maseru Declaration on HIV/AIDS.¹⁶³ In these commitments, states undertake specific strategies to provide the widest possible access to ARVs, including through legislation on essential drugs and regional co-operation. They reflect a consensus among African states on the necessity and, indeed, urgency of ensuring the broadest possible access to treatment, and reinforce the binding legal obligations that many of these states hold under international treaties and the African Charter.

7 Conclusion

Social movements have advanced rhetorical and institutional recognition and support for universal access to ARVs as a fundamental human right, in sharp contradistinction to previous positions. Health rights in conjunction with effective social action have played an important role in fomenting current wide-scale efforts to achieve universal access to ARVs in the sub-Saharan region and globally. Rights-based social movements have also played a key role in motivating both domestic and global recognition of ARV access as a human right and in producing limited, albeit important, changes to trade-related intellectual property rights at the WTO. Human rights-based approaches therefore have provided key strategies to improve access to ARVs throughout sub-Saharan Africa and, indeed, other low and middle-income regions. Key factors leading to the success of these strategies include transnational advocacy and strong public mobilisation. Yet, equally important, has been the entrenchment of health rights at various levels to support legal challenges, the existence of independent judiciaries willing to enforce health rights and to direct state health policy, and the existence of vibrant domestic human rights cultures. The sustained expansion of ARV access is likely to continue to rely on social action in conjunction with legal and political use of existing and new rights-based approaches, including litigation, advocacy and political interventions in key global policy arenas. These strategies will continue to be of importance in relation to ARVs if 'TRIPS-plus' intellectual property rights limit Indian generic manufacturing and exports. The African Commission remains a somewhat untapped institution in this regard, and its willingness to address state duties regarding medicines, as evidenced in

161 African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases 'Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases' OAU Doc OAU/SPS/ABUJA/3 (24-27 April 2001) paras 30 & 31.

162 African Union, 2nd ordinary session 'African Women's Declaration on Malaria, HIV/AIDS, Tuberculosis and Other Related Infectious Diseases' Assembly/Au/Decl.6 (10-12 July 2003).

163 Southern African Development Community Maseru Declaration on the Fight Against HIV/AIDS in the SADC Region 4 July 2003.

its 2008 resolution, certainly suggests that the institution may play an important role in defining human rights duties within the region in the future.

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**PART III: Sexual and reproductive
health and rights: Intersections with
adolescence, early marriage,
gender-based violence and poverty**

CHAPTER 9

SEXUAL HEALTH AND RIGHTS OF ADOLESCENTS: A DIALOGUE WITH SUB-SAHARAN AFRICA

Godfrey Kangaude and Tiffany Banda

Summary

Sub-Saharan Africa has a large population of young people who are transitioning from the pre-reproductive into the reproductive phase. Adolescence is a crucial time for sexuality development and adolescents need firm support to maintain good sexual and reproductive health as they evolve into adults. Societies control sexuality through social norms and practices based on value and belief systems. Adolescent sexual health is therefore determined by socio-cultural factors such as initiation rites, religion, attitudes and beliefs about sexuality. However, social norms do not always ensure positive outcomes for sexual health. In sub-Saharan Africa, adolescents continue to face challenges such as early and unwanted pregnancies, unsafe abortions, and sexually-transmitted infections. Governments party to the Convention on the Rights of the Child and to the African Charter on the Rights and Welfare of the Child are obligated to address such issues based on the underlying principles that these human rights instruments espouse: non-discrimination, the best interests of the child, life, survival and development, and participation of the child in matters affecting their own lives. In order to ensure that adolescents enjoy and maintain the highest attainable standard of sexual and reproductive health, governments need to apply these principles in the provision of sexual health services that are relevant to, and address lived realities of, adolescents. Adolescents need appropriate education and adequate information on sexuality to enable them to critically engage social norms that affect their sexual lives. Only through the realisation of sexual and reproductive rights of the adolescent will sub-Saharan Africa curb the negative trend of sexual health outcomes affecting adolescents.

1 Introduction

The Convention on the Rights of the Child (CRC) defines a child as ‘every human being below the age of 18 years unless under the law applicable to the child, majority is attained earlier’.¹ The African Charter on the Rights and Welfare of the Child (African Children’s Charter) defines a child as ‘every human being below the age of 18 years’,² with no further qualification. According to the World Health Organisation (WHO), ‘adolescents’ are persons in the 10-19 years age group.³ The term ‘young people’ is sometimes used to refer to the age range of 10-24 years.⁴ This chapter focuses on adolescents, though at times, the term is used interchangeably with children, young people and youth. Adolescence, the transitory period between childhood and adulthood, is a phase in human development with unique needs. At this time, sexual organs mature and sexual arousal and interests emerge. The person transits into a period where they attain the capacity to engage in reproductive sexual intercourse.

Adolescents in sub-Saharan Africa face many challenges in the area of sexual and reproductive health, such as unwanted pregnancies, sexually-transmitted infections (STIs) and sexual exploitation. This chapter discusses some of the socio-cultural determinants of adolescent sexual health. It discusses how sexual health challenges amongst adolescents could be addressed by implementing principles articulated by treaties on the rights of the child.

Three aspects make the discourse on adolescent sexual health important. The first is the sheer number of young people in the world. According to the WHO, ‘a quarter of today’s world populations are young people aged 10–24 years, numbering more than 1,8 billion. Most of them live in developing countries.’⁵ In Malawi, for instance, children constitute 52 per cent of the entire population.⁶ It is a similar scenario in other sub-Saharan countries. There is a large group in the pre-reproductive phase constantly transitioning into the reproductive group.

Secondly, the sexual health needs of adolescents tend to be neglected because sexuality is a contentious subject. Societies and cultures have

- 1 United Nations General Assembly, Convention on the Rights of the Child, 20 November 1989, United Nations Treaty Series Vol 1577 3, art 2.
- 2 Organisation of African Unity, African Charter on the Rights and Welfare of the Child, 11 July 1990, CAB/LEG/24.9/49 (1990) art 1.
- 3 WHO *The health of youth* Background Technical Document, Technical Discussions A42/Technical Discussions/2 (1989).
- 4 As above.
- 5 WHO *International youth day* Statement by Assistant Director-General (2011).
- 6 National Statistical Office of Malawi *Children and youth report* http://www.nso.malawi.net/images/stories/data_on_line/demography/census_2008/Main%20Report/ThematicReports/Children%20and%20youth%20report.pdf (accessed 20 July 2011).

deeply-held convictions, beliefs and attitudes around sexuality and sexual relationships. Sometimes there is a clash of norms and values, and a disjunction between normative ideals and lived realities. Adolescents may find this confusing. This has an impact on their sexual health.

Thirdly, adolescents are vulnerable because, even as they evolve into adults, parents and other parent-figures continue to exercise a sphere of control over the life of the adolescents. Sometimes adults intentionally or unintentionally neglect or fail to facilitate positive sexual health development. Other times, adults perpetrate actions that curtail healthy sexual development of the adolescent, for instance sexual abuse.

1.1 Concepts of sexual health and sexual rights

Two interrelated concepts are central to the discussion, and these are sexual health and sexual rights. As already alluded to, it must be appreciated from the outset that sexuality is a contested area. As Petchesky describes:

‘Sex is always political’, and its politicisation involves the continual attempt to draw boundaries between ‘good’ and ‘bad’ sex based on ‘hierarchies of sexual value’ in religion, medicine, public policies, and popular culture.⁷

Sexual health and sexual rights are political notions that continue to stir intense debate in various political arenas, global and local, public and private. On the international scene, one is taken back in time to the 1948 United Nations (UN) Universal Declaration of Human Rights (Universal Declaration), which was then followed by various human rights treaties. The UN has since been a site for a covert and overt struggle over sexuality through treaties that attempt to address issues of family, marriage, and equality between the sexes.⁸ The debate on sexual rights intensified in the 1990s, and especially at the International Conference on Population and Development (ICPD) of 1994⁹ and the 1995 Fourth World Conference on Women (FWCW).¹⁰ At these fora, various women groups made valiant efforts to argue for recognition of reproductive and sexual rights. However, at the ICPD, reproductive rights were articulated, but not sexual rights.

The debate raged again at the FWCW. The result was a negotiated ‘human rights of women’, which included sexuality:

7 R Petchesky ‘Sexual rights policies across countries and cultures: Conceptual frameworks and minefields’ in R Parker *et al* (eds) *Sex politics: Reports from the front lines* (2007) 9.

8 Girard ‘Negotiating sexual rights and sexual orientation at the UN’ in R Parker *et al* (n 7 above) 312.

9 Programme of Action of the International Conference on Population and Development, 5-13 September 1994, Doc ST/ESA/SER.A/149.

10 Platform for Action of the Fourth World Conference on Women, September 1995, para 96, UN Doc A/CONF.177/20 (17 October 1995).

The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences.¹¹

While at the international level, the UN documents developed the concepts this far, other stakeholders took them further. A Technical Consultation on Sexual Health convened by WHO, which brought together over 60 international and national experts on sexuality and sexual-health-related issues, defined sexual health as follows:

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.¹²

The Technical Consultation defined sexual rights as follows:

Sexual rights embrace human rights that are already recognised in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:

- the highest attainable standard of sexual health, including access to sexual and reproductive health care services;
- seek, receive and impart information related to sexuality;
- sexuality education;
- respect for bodily integrity;
- choose their partner;
- decide to be sexually active or not;
- consensual sexual relations;
- consensual marriage;
- decide whether or not, and when, to have children; and
- pursue a satisfying, safe and pleasurable sexual life.¹³

The consultation process was a rigorous scientific and ideological engagement with the concepts that took into account socio-cultural and geographical diversity. These concepts are, therefore, useful tools in the discussion of sexual health from various perspectives, such as public health and human rights. This chapter will therefore adopt these when discussing

11 n 10 above, para 96.

12 WHO *Defining sexual health: Report of a technical consultation on sexual health, 28–31 January 2002* (2006) 5.

13 As above.

sexual health and rights. It is, however, acknowledged that they are not universally accepted.

1.2 Socio-cultural determinants of adolescent sexual health

The challenges adolescents face when they become potentially or actually sexually active are not radically different despite the diversity of the social and cultural contexts. While adolescents are apt to come to terms with the physical changes and physiological transformation, the greater challenge is in adopting values and behaviours around sexuality that will culminate in positive sexual self-esteem and identity. This is complicated by the web of socio-cultural factors impinging on the adolescent's evolving autonomy. This determines the possibilities for achieving healthy sexual development.¹⁴

For instance, some cultures, such as the Yao and Chewa in Malawi and Zambia, practise initiation rites for adolescents. At these ceremonies, they are given information, education and treatment that prepare them for adult sexuality and reproduction. Sometimes this involves encouraging or forcing them into sexual intercourse when they are not physiologically or emotionally ready.

Patriarchal masculinity notions of gender encourage early sexual debut and non-consensual sex in other contexts apart from initiation ceremonies. Boys are socialised to associate masculinity with control and domination over girls, so that sexual intercourse is taken as an entitlement rather than a good to be negotiated. Girls, on the other hand, are encouraged to be submissive and sexually accessible to boys. This power differential influences the negotiation of contraceptive use amongst boys and girls.¹⁵

Hurried sexual experiences may result in adolescents engaging in sexual activity when they are not prepared to deal with the physical and emotional consequences. They may not have acquired the necessary skills, such as communication. As Moore and Rosenthal have stated:

We know that many adolescents report disturbingly low levels of confidence in their ability to discuss the use of condoms with their partners and many believe that they are unable to take the initiative in expressing their sexual needs. It is important, then, that adolescents be taught the skills which will

14 S Moore & D Rosenthal *Sexuality in adolescence: Current trends* (2006) 820-826.

15 R Ingham & P Aggleton *Promoting young people's sexual health: International perspectives* (2009) 62-63.

enable them to communicate confidently and accurately in a climate of mutual acceptance.¹⁶

In contrast to social norms that hurry or encourage sex, in the same sub-Saharan Africa, most religions are very influential and promote the idea that the adolescent should delay sex until marriage. Countries like Lesotho, Kenya, Uganda and Malawi have a faith-based programme in schools called 'WHY WAIT'. The emphasis is on encouraging adolescents to abstain from sex until they are married. This seems to be the very opposite of traditional Africa. Delaying sexual debut may be a positive thing, but the problem is the way it has been idealised. Some people therefore believe adolescents should neither be taught about sex at all nor be given any access to contraceptives because it would promote sexual activity. These attitudes have contributed to denying vital information and services to adolescents.

Another major factor shaping adolescent sexual health is their vulnerability fuelled by patriarchal norms and other factors, such as poverty. Sexual abuse such as non-consensual sex is quite pervasive in societies, including sub-Saharan Africa.¹⁷ Non-consensual sex encompasses unwanted penetrative or non-penetrative sex, attempted rape, unwanted touch, verbal harassment, as well as exchange or transactional sex.¹⁸ This may be experienced in many forms, such as through the use of physical force, threats, intimidation, emotional manipulation, deception, and material and non-material incentives. The defining characteristic of sexual abuse is therefore the lack of agency on the part of the adolescent who engages in a sexual act without having made a real choice to do so.

Various studies document that, typically, the perpetrators of child and adolescent sexual abuse are persons who enjoy positions of power and authority in relation to the victim, such as religious leaders, employers, teachers, guardians and older students. In addition, places that are usually regarded as safe, such as churches, schools, workplaces, health institutions and the home are the very sites where abuse has been perpetrated.¹⁹ Sexual abuse has particularly flourished in schools and is perpetrated by teachers or fellow students.²⁰

Adolescent sexual behaviour is also influenced by peers.²¹ One aspect of this socialisation is the sharing of information about sex. This in itself is not a problem. However, when the information is inaccurate, adolescents

16 Moore & Rosenthal (n 14 above)

17 WHO *World report on violence and health* (2002).

18 SJ Jejeebhoy *et al* 'Sex without consent: Young people in developing countries' (2005) 9.

19 Jejeebhoy *et al* (n 18 above) 22-23.

20 WHO (n 17 above).

21 J Brooks-Gunn & FF Furstenberg 'Adolescent sexual behaviour' (1998) 44 *Journal of American Psychologists* 249-257.

share and propagate distorted notions about sex and sexuality. This can lead to adolescents engaging in risky or harmful behaviour when they act on misinformation.

With advancements in technology, the media plays a big role in influencing the behaviour of adolescents. A great deal of visual and audio entertainment is liberal with regard to sex. A study by Pardun *et al* on mass media influence on young adolescents revealed that 83 per cent of teen television shows contained some sexual content.²² Music, magazines and the internet are other sources of sexual content. Although this study was based on American adolescents, the results are applicable within sub-Saharan urban youth cultures. These sources of information compete with cultural and traditional sexual norms in influencing the behaviour of young people. Accessing such sexual materials is not in itself the challenge. Rather, it is managing how these influence the adolescent. Ultimately, it falls back on how parents or parent-figures interact with the adolescent to help them engage positively with information on sex and sexuality from peers and other sources.

In summation, the social environment that shapes attitudes and behaviours toward sex and sexuality may not always be reliable guides for adolescents. The following risk factors impacting on adolescent sexual health are highlighted: hurried sexual activity; distorted, partial or incomplete information on sexuality and sexual health; barriers to sexual health services; and non-consensual sex and forced sex.

1.3 Negative outcomes of sexual health

The risk factors identified in the previous section predispose adolescents to negative sexual health consequences. These consequences can be categorised into physical, mental and psychosocial, somewhat reflecting the definition of sexual health discussed under section 1.1 above. When these categories are conflated, the physical tends to overshadow the mental, emotional and social aspects of sexual health.

1.3.1 Physical outcomes

Due to our embodied nature, the physical outcomes are the ones that easily come to our attention. The physical consequences of the meeting of physical bodies in sexual activity such as sexual intercourse are perceivable or palpable to the self or others. For instance, the consequences of unprotected sex can include early and unplanned pregnancies, STIs, and

22 CJ Pardun *et al* 'Linking exposure to outcomes: Early adolescents' consumption of sex content in six media' (2005) 8 *Mass, Media and Society* 75.

unsafe abortions.²³ It is also possible to determine from physical investigation whether the sexual activity was forcible.

Adolescents may engage in unprotected sex because they were simply naïve or unprepared and did not have adequate education and information. It might be that contraceptives were not readily available or that they failed to negotiate safe sex because it was non-consensual, or they lacked communication skills. However, it may also be out of agency.

Pregnancy is one physical manifestation of sexual activity which in itself is not negative. However, for unmarried adolescents this may be very negative and a threat to health where the adolescent seeks an unsafe abortion as a way to deal with unwanted pregnancy.

1.3.2 Mental or emotional outcomes

Sexual activity can also have mental and emotional consequences. Where it is non-consensual and not a result of sexual self-determination, the mental or emotional consequence may be quite serious. Sexual abuse, for instance, has been associated with a wide range of mental health repercussions for the victims. According to Family Health International:

Emotional harm caused by childhood sexual abuse appears to undermine normal, healthy psychological development that would enhance victims' ability to protect their sexual health. In numerous studies, victims have reported guilt, anxiety, and depression; feelings of worthlessness and powerlessness; inability to distinguish sexual from affectionate behaviour; difficulty in maintaining appropriate personal boundaries; and inability to refuse unwanted sexual advances.²⁴

The report by WHO documents studies that have shown an association between sexual abuse in childhood and psychological problems that persist in adulthood, such as depression, suicidal tendencies, substance abuse, sexual risk-taking, low self-esteem and other emotional and behavioural problems.²⁵

In contrast to physical outcomes, mental health or emotional outcomes may not be immediately recognised as relating to sexual abuse. Mental health problems resulting from sexual abuse can be more pervasive than meets the eye. Survivors themselves may not realise that their emotional problems are related to sexual abuse. Unfortunately there are fewer facilities in Africa that have the expertise and capacity to deal with

23 T Matasha *et al* 'Sexual reproductive health among primary and secondary school pupils in Mwanza, Tanzania: Need for intervention' (1998) 10 *AIDS Care* 571.

24 Family Health International 'Non-consensual sex' (2005) 23 *Network* 4.

25 WHO (n 17 above).

mental and emotional issues relating to sexuality as compared to those that address their physical counterparts.

1.3.3 Psychosocial or behavioural outcomes

Sexual abuse can also have social manifestations, including that victim survivors fail to enjoy satisfying intimate and sexual relationships.²⁶ Research has also shown that children who have been sexually abused often engage in sexual behaviour, as adolescents and as adults, that puts them at risk of unintended pregnancies and STIs. Such behaviour includes unprotected sex, having multiple sexual partners, early sexual debut and prostitution.²⁷

It has also been thought that sexual acting-out is another consequence of sexual abuse. Acting-out has been defined as

the release of out-of-control aggressive or sexual impulses in order to gain relief from tension or anxiety. Such impulses often result in antisocial or delinquent behaviours. The term is also sometimes used in regard to a psychotherapeutic release of repressed feelings, as occurs in psychodrama.²⁸

In contexts where acting-out behaviours are not understood, the victim may, on top of being misunderstood, be chastised or ostracised for exhibiting behaviour that is not socially acceptable or appears to go against social norms. Again, such cases require facilities that have the expertise and capacity to manage behavioural illness which in many settings in sub-Saharan Africa are of very limited availability, if at all.

2 Imagining possibilities through treaties on the rights of the child

2.1 Key principles of the Conventions

In 2006, the African Union (AU) reconfirmed efforts to address the sexual and reproductive challenges facing Africa.²⁹ Key principles of the Convention on the Rights of the Child (CRC) and the African Charter on the Rights and Welfare of the Child (African Children's Charter) could guide the implementation of laws and policies to address sexual health of

26 L Heise & M Ellesberg 'Violence against women: Impact on sexual and reproductive health' in E Murphy & K Ringheim (eds) *Reproductive health, gender and human rights: A dialogue* (2005) 47.

27 As above.

28 J Schonbeck 'Acting out - Children's health' <http://childrenshealth.yourdictionary.com/acting-out> (accessed 1 October 2011).

29 AU *Maputo Plan of Action for the operationalisation of the continental policy framework for sexual and reproductive health and rights 2007-2010* (2006).

adolescents in sub-Saharan Africa, namely, non-discrimination, the best interests of the child, life, survival and development, the views of the child and evolving capacities. They form the pillars on which the Committee on the Rights of the Child (CRC Committee) and the African Committee of Experts on the Rights and Welfare of the Child (African Children's Committee) have anchored the interpretation and application of treaty provisions of CRC and the African Children's Charter, respectively.

Equality or non-discrimination is a central principle in international human rights law and is reflected in all major treaties, including the Charter of the United Nations (UN Charter), the Universal Declaration, the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR). CRC states the principle in article 2. The CRC Committee has reminded state parties of the obligation to ensure that all children enjoy the rights in the Convention without discrimination with regard to race, colour, sex, language, religion, sexual orientation and other grounds.³⁰ It has also stated that '[n]on-discrimination obligation requires states actively to identify individual children and groups of children the recognition and realisation of whose rights may demand special measures'.³¹ Health services should be specifically designed to provide sexual health services for adolescents, otherwise they may be inadvertently excluded.³²

The African Children's Charter provides for the principle of non-discrimination in article 3. In the communication brought on behalf of children of Nubian descent, where the allegation of discrimination was raised, the African Children's Committee reiterated:

Minimal access to health facilities, a lower level of contact with health promoting measures and medical assistance, and a lack of provision of primary and therapeutic health resources and programmes is inconsistent with respect for the child's right to the highest attainable standard of health. African jurisprudence places a premium on both the right to health care and the right to the underlying conditions of health.³³

Another important principle is that policies, laws and programmes must be in the best interests of the child. This is stated in articles 3 and 4 of CRC and the African Children's Charter, respectively. In General Comment 5 of the CRC Committee it was said:

30 UN CRC Committee General Comment 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child, 1 July 2003, CRC/GC/2003/4 para 6.

31 CRC Committee General Comment 5: General measures of implementation of the Convention on the Rights of the Child, 27 November 2003, CRC/GC/2003/5 para 12.

32 CRC Committee General Comment 3: HIV/AIDS and the rights of the child, 17 March 2003, CRC/GC/2003/3 para 17.

33 Communication 002/2009 *Institute for Human Rights and Development in Africa (IHRDA) and Open Society Justice Initiative (OSJI) (on behalf of children of Nubian descent in Kenya) v Kenya* para 59.

Every legislative, administrative and judicial body or institution is required to apply the best interests principle by systematically considering how children's rights and interests are or will be affected by their decisions and actions - by, for example, a proposed or existing law or policy or administrative action or court decision.³⁴

If adolescent sexual health is a contentious issue, then the question of what should be the best interests of the adolescent with regard to sex, stirs it. For instance, is it in the best interests of the adolescent that condoms be made accessible in schools?

The third principle is survival and development. The CRC Committee has asked states to interpret 'development' in its broadest sense as a holistic concept, embracing the child's physical, mental, spiritual, moral, psychological and social development.³⁵ As adolescents become sexually mature and active, they need to acquire the necessary skills to avoid harm and to cultivate positive attitudes and behaviours to promote sexual health. In order to ensure survival, the government should also put in place measures to protect adolescents from sexual violence and redress or mitigate harm.

Adolescents themselves should be involved in identifying their own challenges and participate in finding their own solutions. This is pursuant to the principle that the views of the child need to be respected.³⁶ In Africa, child participation is particularly problematic.³⁷ It is even more difficult when it concerns sexuality. Most times, there is no dialogue between parents and adults and adolescents on sexuality, such that the subject tends to be consigned to secrecy and shame. The failure to engage in such dialogue creates a chasm between adults and adolescents and constitutes a barrier to adolescents contributing their views about addressing the sexual health challenges they encounter. Yet, the CRC Committee encourages states to

introduce measures enabling children to contribute their views and experiences to the planning and programming of services for their health and development. Their views should be sought on all aspects of health provision, including what services are needed, how and where they are best provided, discriminatory barriers to accessing services, quality and attitudes of health professionals, and how to promote children's capacities to take increasing levels of responsibility for their own health and development.³⁸

34 n 33 above.

35 As above.

36 Arts 12 & 13 CRC; art 7 African Children's Charter.

37 PY Ankut *The African Charter on the Rights and Welfare of the Child: Linking principles with practice* (2008) <http://www.fairplayforchildren.org/pdf/1299577504.pdf> (accessed 1 October 2011).

38 CRC Committee General Comment 12 (2009): The right of the child to be heard, 20 July 2009, CRC/C/GC/12.

The fifth principle of evolving capacities relates to the extent to which parental responsibility should be exercised with cognisance of the evolving autonomy of the child.³⁹ Parental responsibility may compromise the adolescent's own responsibility for their health, for instance, where a parent hinders the adolescent's access to services because the parent thinks it is not appropriate. This principle helps to negotiate the space between parental responsibility and the autonomy of the adolescent in order to ensure the best outcome for the adolescent.

2.2 Right to health services

2.2.1 Universal access to contraceptives

Access to contraceptives is not universal for adolescents in sub-Saharan Africa for a number of reasons. The following description of some of the reasons is captured from Arowojolu *et al.*:

Unfortunately, the use of contraceptives among Nigerian youths is poor due to the fear of side effects and the negative cultural attitudes of parents/guardians to contraceptive use. Various other factors ... include the role of gatekeepers in facilitating or hindering their access to reproductive health services, the judgmental attitude of providers when they serve the youths and the poor organisation of services designed to meet youths' needs.⁴⁰

It is a similar story in other countries, such as Malawi, South Africa and Tanzania. The levels of contraceptive use amongst adolescents are low and the reasons include lack of adequate knowledge and myths about contraceptives. Another is due to health providers who discourage adolescents from accessing contraceptives.⁴¹

The failure of universal access to contraceptives is rooted in discrimination against adolescents and the stigmatisation of their sexuality. This results in governments failing to provide services such as the distribution of condoms in schools, and the failure to provide all the necessary means to promote the use of contraceptives through comprehensive education and information. Even the term 'family planning', which is the description of the service encompassing contraceptives, is already discriminatory since the connotation is that one must be married.

39 Art 14(2) CRC; art 9(2) African Children's Charter.

40 AO Arowojolu *et al.* 'Sexuality, contraceptive choice and AIDS awareness among Nigerian undergraduates' (2002) 6 *African Journal of Reproductive Health* 60-70.

41 V Rasch *et al.* 'Adolescent girls with illegally-induced abortion in Dar es Salaam: The discrepancy between sexual behaviour and lack of access to contraception' (2000) 8 *Reproductive Health Matters* 52-62; K Wood & R Jewkes 'Blood blockages and scolding nurses: Barriers to adolescent contraceptive use in South Africa' (2006) 14 *Reproductive Health Matters* 109-118; E Jackson *et al.* 'A strategic assessment of unsafe abortion in Malawi' (2011) 19 *Reproductive Health Matters* 133-143.

In resonance with CRC and the African Children's Charter, the African Commission on Human and Peoples' Rights (African Commission) decision in *Purohit & Another v The Gambia* extols the principle of non-discrimination:

Article 2 and 3 of the African Charter basically form the anti-discrimination and equal protection provisions of the African Charter. Article 2 lays down a principle that is essential to the spirit of the African Charter and is therefore necessary in eradicating discrimination *in all its guises* ... These provisions are non-derogable and therefore must be respected in all circumstances in order for anyone to enjoy all the other rights provided for under the African Charter.⁴²

Stigmatising the sexuality of adolescents and not taking into account what is in the best interests of their sexual health under the pretext of protecting them from immorality is one guise of discrimination that is leading to high levels of sexual ill-health amongst adolescents on the continent. Laws and policies should create an enabling environment for adolescents to access sexual and reproductive health services. Sexual and reproductive services should be provided without unnecessary barriers, such as requiring parental consent. For instance, countries like South Africa and Malawi have put in place laws and policies that are 'adolescent-friendly'. South Africa's Children's Act says that any child from the age of 12 should not be prohibited from having access to condoms where they are freely distributed.⁴³ Malawi's Gender Equality Act recognises the right to adequate sexual and reproductive health, including the right to access family-planning services.⁴⁴ It further requires that health officers provide family planning services to any person demanding the services, irrespective of marital status or whether that person is accompanied by a spouse.⁴⁵ Arguably, such laws enable adolescents to access contraceptives, and this is very much in line with the principles of non-discrimination and the best interests of the child.

One of the arguments against universal access to contraceptives is that this is not in the best interests of the child, because they are not mature enough to appreciate the consequences and other implications. Eventually, questions of evolving autonomy arise such as: What issues should be left for the child to decide on and when should parental consent or control take precedence?

Many countries have limitations on sexual intercourse with girls based on age, and this has implications on consent to sexual health services. For instance, sex with a girl below 16 is criminalised in Malawi. This means

42 *Purohit & Another v The Gambia* (2003) AHRLR 96 (ACHPR 2003) para 49 (our emphasis).

43 Children's Act 38 of 2005 sec 134.

44 Gender Equality Act of 2013 sec 19.

45 Gender Equality Act of 2013 sec 20(1)(c).

that a person who has sexual intercourse with a girl below 16 is guilty of an offence, notwithstanding the defence that she consented. It is implied here that a girl below 16 does not have the capacity to consent. However, sexual debut has been documented to be as low as ten years. A number of studies have shown that over 50 per cent of adolescents initiated sexual intercourse before the age of 15 in Malawi.⁴⁶ What, then, should be the policy direction about an unmarried 15 year-old girl seeking contraceptive services?

The principle on how to deal with this scenario was discussed in *Christian Lawyers Association v National Minister of Health (Christian Lawyers case)*.⁴⁷ The plaintiffs challenged the provisions of the Choice of Termination of Pregnancy Act that allow women under the age of 18 years to choose to have their pregnancies terminated without parental consent or control. The plaintiff's argument was that girls below 18 years old are not capable on their own, that is, without parental consent or control, to make an informed decision whether or not to have a termination of pregnancy which serves their best interests. However, the court disagreed with the plaintiff, and in its judgment held:

Actual capacity to give informed consent, as determined in each and every case by the medical practitioner, based on the emotional and intellectual maturity of the individual concerned and not on arbitrarily predetermined and inflexible age or fixed number of years, is the distinguishing line between those who may access the option to terminate their pregnancies unassisted on the one hand and those who require assistance on the other.

The court went on to say that the human rights principle behind its judgment was the right to self-determination. This right should not arbitrarily be denied of adolescents simply because of their age.

2.2.2 Privacy and confidentiality

Adolescents can be very sensitive about privacy and confidentiality, so that any infringement, actual or perceived, would discourage them from seeking sexual and reproductive health care. Privacy and confidentiality rank extremely high on what adolescents consider important factors for accessing care.⁴⁸ In the case of *The Queen on the Application of Sue Axon v The Secretary of State for Health & Another*, the court was asked, amongst other remedies, to make a declaration that a doctor is under no obligation to

46 AC Munthali *et al Adolescent sexual and reproductive health in Malawi: A synthesis of research evidence* (2004) 15.

47 2004 10 BCLR 1086 (T).

48 J Senderowitz *Making reproductive health services youth friendly* (1999) 12; DM Ready *et al* 'Effect of mandatory parental notification on adolescent girls' use of sexual health care services' (2002) 288 *Journal of American Medical Association* 710-714; CA Ford & A English 'Limiting confidentiality of adolescent health services: What are the risks?' (2002) 288 *Journal of American Medical Association* 752-753.

keep confidential advice and treatment which he proposes to provide in respect of contraception, sexually-transmitted infections and abortion, and must therefore not provide such advice and treatment without the parents' knowledge, unless to do so would or might prejudice the child's physical or mental health, so that it is in the child's best interests not to do so. The court took judicial notice of the fact that

the need to ensure that young people have a right to confidentiality is an important feature of the Nordic Resolution on Sexual and Reproduction Health and Rights of Young People, which was developed and adopted by the Family Planning Associations of Denmark, Iceland, Finland, Norway and Sweden in 1998. Those countries have enjoyed particular success in reducing rates of teenage pregnancy.⁴⁹

The court denied the relief sought. Part of the court's reasoning was that granting the relief would sanction a general rule that doctors could pass confidential information about adolescents, and this would deter young people from seeking health services.

Some countries, including Malawi, do not have political, legal or policy regimes that offer strong protection of privacy and confidentiality for adolescents. The Children's Act of South Africa, however, provides strong protection for confidentiality, but whether this is being implemented, of course, is another matter.

If privacy and confidentiality are in the best interests of adolescents, then the right must be jealously guarded with legal and policy mechanisms that first of all ensure implementation. Secondly, enforcement should be accompanied by sanctions for those who breach the duty of care owed to adolescents. In order to encourage compliance by healthcare providers, the adolescent should have readily-accessible means of redress without fear of repercussions. An example would be to set up a monitoring body within the health facility or system to receive and address any complaints.

It is also important to pay attention to the source of payment for services. Where adults are responsible for meeting the expenses, it may be difficult to prevent interference from curious parents who want to know what care the adolescent is accessing. In many sub-Saharan African countries, public health services have not paid due attention to the privacy of adolescents. One solution could be to have youth centres that provide care for free, or the government could provide free insurance for sexual and reproductive health services for all children, including adolescents. Whichever solution is envisaged, there will be an initial demand for substantial resources to be allocated toward sexual and reproductive health care for adolescents.

49 *The Queen on the Application of Sue Axon v The Secretary of State for Health & Another* [2006] EWHC 37 para 68.

It is therefore crucial to enact legislation and regulations governing the rights and duties of health service providers and users so that, when an infringement occurs, clear mechanisms for redress are readily accessible. However, more than just having good legislation and policies, it should be accompanied with effective implementation, including creating public awareness about such laws and policies so that informed citizenry participate in making them effective, including adolescents themselves.

2.2.3 Mental and psychosocial services

Health systems in sub-Saharan African countries have invested minimally in mental and emotional health. They lack the structure and expertise for providing counselling or other appropriate care for mental health and psychosocial problems. The following extract from a report by Kiima and Jenkins captures the situation in Kenya:

Although most donor and development agency attention is focused on communicable diseases in Kenya, the importance of non-communicable diseases including mental health is increasingly apparent, both in its own right and because of its influence on health, education and social goals. Mental illness is common, but the specialist service is sparse and primary care is struggling to cope with major health demands.⁵⁰

Physically healthy persons, including adolescents, face a continuum of emotional and psychological challenges. The challenges range from minor issues that can be resolved without needing specialised intervention to major issues that need more intensive care. Some of these include feelings of shame or guilt over a mutual or coercive sexual encounter, minor or major depression when intimate relationships collapse, and issues of sexual self-esteem. Where health systems are biased towards material needs, such as access to condoms, without integrating services to address emotional and psychological needs, they will fail to address sexual health holistically. For instance, an adolescent may have access to condoms, but fail to negotiate their use because of a lack of emotional resources to negotiate condom use.⁵¹

Governments have the duty to make sure that everyone, including adolescents, has access to comprehensive mental and emotional health services. However, to get health systems to integrate this crucial service is no small feat. Mental and emotional health services compete with other services for scarce resources. Nevertheless, it is not impossible to expand

50 D Kiima & R Jenkins 'Mental health policy in Kenya – An integrated approach to scaling up equitable care for poor populations' (2010) 4 *International Journal of Mental Health Systems*. <http://www.ijmhs.com/content/4/1/19> (accessed 31 December 2011).

51 Moore & Rosenthal (n 14 above).

investment in mental and emotional health, if only there would be the political will.

Kiima and Jenkins report on how Kenya has tried to 'introduce sustainable mental health policy and implementation across the country, within the context of extremely scarce resources'.⁵² They show that this has not been a futile engagement when they observe:

The limitations of the programme have included limited financing, frequent changes in senior ministry personnel, and changes in ministry structures. However, despite the shortage of resources, and the international and national focus on communicable disease, mental health is in the health sector strategic plan, a sustainable programme of implementation has been achieved despite enormous constraints, and other sectors are very keen to integrate mental health into their work.⁵³

In order to advance the sexual health of adolescents and improve the quality of life, there is a need for governments to pay attention to the emotional and psychosocial needs of adolescents by implementing legislative, policy and other measures. It may require a considerable amount of resources, but this does not exonerate governments from taking steps to advance the realisation of the right to health related to sexuality.

2.2.4 Access to safe abortion

Unsafe abortion in sub-Saharan Africa threatens the lives, survival and development of adolescents. This is the experience of many sub-Saharan African countries, such as Malawi, Kenya, Tanzania and Uganda, which have or had restrictive abortion laws.⁵⁴ In these countries, the incidences of unsafe abortions are high, especially among young people, because girls who need the service get it clandestinely. Those who have resources can get relatively safe clandestine abortions. The burden of unsafe abortions in these countries is borne by those who are economically vulnerable and marginalised. Due to a lack of means, adolescents are compelled to choose the cheapest abortion services which tend to be the most dangerous forms. Therefore, to deny them access to safe abortion is tantamount to infringing their right to survival and development. Even if the law restricting access to abortion may not have intended to discriminate, the effect of its application disproportionately burdens adolescents with unsafe abortions.

52 Kiima & Jenkins (n 50 above).

53 As above.

54 Ministry of Health *Abortion in Malawi: Results of a study of incidence and magnitude of complications due to unsafe abortion* (2011) 20; H Gebreselassie *et al* 'The magnitude of abortion complications in Kenya' (2004) 111 *International Journal of Obstetrics and Gynaecology* 1-7; AK Mbonye 'Abortion in Uganda: Magnitude and implications' (2000) 4 *African Journal of Reproductive Health* 104-108; Rasch *et al* (n 41 above).

Article 14(2)(c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol) provides that states should ensure that medical abortion is provided, including in cases of sexual assault, rape, incest, and danger to the mental and physical health of the woman or to the life of a foetus. Unwanted or unplanned pregnancy for adolescents is likely to be more distressing because of limitations in emotional, physiological and financial resources with which to cope. It is therefore important to give particular attention to adolescent girls. The Ethiopian Penal Code is a good example in this regard. It allows the termination of pregnancy if the pregnant female is unfit to bring up her child because of physical or mental deficiency due to factors such as minority.⁵⁵

Even in circumstances where the legal framework provides for access to safe abortion, young girls can face barriers because of minority status. This was the bone of contention in the *Christian Lawyers* case discussed earlier. The plaintiffs argued that the Choice on Termination of Pregnancy Act⁵⁶ allowed minors to access abortion services without parental consent, and was therefore in conflict with the provisions of the Constitution of South Africa. However, the court held that the essence of the legislation was to give women and girls the right to decide, taking into account that girls below 18 years may well have the capacity to consent and, therefore, that age alone does not prevent them from accessing services without the need for parental consent. This illustrates how South Africa takes the obligation to provide access to abortion to adolescents seriously, and ensures that minority status does not become an insurmountable barrier to services.

2.3 Protection from sexual exploitation and the right to sexual self-determination

Sexual abuse is quite pervasive in societies, including sub-Saharan Africa. Non-consensual sex is harmful to adolescents in a range of ways. Adolescents are prone to abuse generally due to their physical and emotional vulnerability and socio-economic dependence. On the one hand, adolescents need protection from unscrupulous persons who may take advantage of their vulnerability. On the other hand, they need an environment that supports sexual self-determination and agency.

In sub-Saharan African countries, laws already exist to protect adolescents from sexual exploitation, such as rape. However, in countries that adopted British colonial laws, legislation protecting sexual abuse has been couched in the classical notions of sexual assault, rape and

55 The Criminal Code of the Federal Democratic Republic of Ethiopia, Proclamation 414 of 2004 art 551(1) (d).

56 Choice on Termination of Pregnancy Act 92 of 1996 sec 5.

defilement. In common law, rape is defined as unlawful sexual intercourse with a woman against her will. The essential elements of the crime are penetration of the vagina by the penis, the use of force, and a lack of consent. The deficiency of protection here was unmasked by a South African Magistrate's Court in *S v Masiya*.⁵⁷ The accused was prosecuted for the rape of a nine year-old girl, and the facts established that there had been anal penetration. The prosecution had asked that the accused be convicted of the lesser offence of sexual assault. However, the Court rejected this argument. The Court was of the opinion that the common law definition of rape did not pass constitutional muster and, therefore, took the opportunity to extend the definition to include anal penetration. On appeal, the Constitutional Court agreed with the Magistrate's Court in principle. It said:

The inclusion of penetration of the anus of a female by a penis in the definition will increase the extent to which the traditionally-vulnerable and disadvantaged group will be protected by and benefit from the law. Adopting this approach would therefore harmonise the common law with the spirit, purport and objects of the Bill of Rights.⁵⁸

Laws intended for protection against sexual exploitation could also potentially stifle healthy sexual development. As noted above, many countries have adopted the common offence of 'defilement' to protect persons below a certain age from penetrative sexual intercourse. However, Graupner and Bullough remind us that everyone, including adolescents, has the right to sexual self-determination.⁵⁹ One of the rights that needs to be respected is privacy. The right to privacy enshrines the right to personal development, including the establishment of intimate and sexual ties with other human beings. State regulation in the sexual life of adults and adolescents should not interfere with privacy, unless this is clearly necessary for the prevention of harm to others. Graupner cautions that:

It is easy to hold that sexual contact with a five year-old is always abuse, but it is much harder to hold that sexual relation with a 12 year-old in each and every case is abusive, and it is definitely impossible to hold that sexual contact with a 16 year-old is abusive in each and every case. If the age of limit is set too high, the law easily can come into conflict with the need of adolescents to sexual liberty and it could easily turn from a means of protection to a threat itself for the sexual self-determination of juveniles.⁶⁰

For instance, in Uganda, where sexual intercourse with a girl under 18 is an offence, should criminalisation include voluntary sex between two 17

57 *S v Masiya* Case SHG 94/04 11 July 2005, unreported.

58 *Masiya v Director of Public Prosecutions & Others* Case CCT 54/06 [2007] ZACC 9 para 39.

59 H Graupner & VL Bullough 'Introduction' in H Graupner & VL Bullough *Adolescence, sexuality, and criminal law: Multidisciplinary perspectives* (2004) 2.

60 H Graupner 'Sexual consent: The criminal law in Europe and outside Europe' in Graupner & Bullough (n 59 above) 114.

year-olds? Why should legislation indiscriminately render every 17 year-old girl incapable of consent to sexual intercourse? This could in some circumstances amount to discrimination against the persons involved on the basis of age. It may hinder normal sexual development, be against the principle of best interests of the child, and would not be taking into account the evolving capacities of adolescents.

To further this argument, reference is made to a 1998 report by the Law Reform Commission of Tanzania on sexual offences. The report stated:

Research revealed that sexual abuse-related offences are on the increase and that the rate of defilement and unnatural offences is alarmingly high. The victims are mostly teenage girls, while the culprits are mostly in the same age group.⁶¹

The report mentioned boys under 16 being sentenced to strokes for the offence of defilement.⁶² While the report does not give the facts behind these cases, one can argue that there was a real possibility that adolescents voluntarily engaging in sex were being punished for what could have been a non-problematic experience of sexuality. Such indiscriminate laws serve as powerful tools for the stigmatisation of the sexuality of unmarried adolescents rather than the protection the freedoms and dignity.

The Tanzanian report purported to examine legislation on sexual offences from the perspective of protecting the right to personal integrity, dignity and liberty of women. However, its analysis of sexual rights as they affect adolescents was inadequate. Disturbingly, the report recommended that the age of defilement be raised to 18. This could increase the number of adolescents whose sexuality is stigmatised.

In a report on a study on the impact of defilement law in Uganda, Parikh concluded as follows:

I argue that existing class, gender, and age hierarchies have shaped how the Defilement Law has been applied locally, such that despite the stated aim of 'protecting' young women, the law reinstates patriarchal privilege (especially against men of lower social class) while simultaneously increasing the regulation of adolescent female sexuality and undermining their autonomy.⁶³

Governments should re-evaluate laws that are designed to protect girls from sexual intercourse, so that they do not infringe on the sexual rights and autonomy of adolescents. Without the careful crafting of legislation,

61 Law Reform Commission of Tanzania *Report on criminal law as a vehicle for the protection of the right to personal integrity, dignity and liberty of women* (1998) para 4.15.

62 n 61 above, para 4.73.

63 SA Parikh 'They arrested me for loving a schoolgirl.' *Ethnography, HIV, and a feminist assessment of the age of consent law as a gender-based structural intervention in Uganda* (2012) 74 *Social Science and Medicine* 1774.

such laws will be complicit in perpetuating stereotypes and will run counter to democratic and human rights principles. In this regard, the case of *Teddy Bear Clinic for the Abused Children & Another v Minister of Justice and Constitutional Development & Another (Teddy Bear Clinic case)*⁶⁴ must be applauded for bringing to bear human rights principles on adolescent sexuality. The case hinged on sections 15 and 16 of the Sexual Offences Act, which criminalise the performance of certain consensual sexual acts (by adults and children) with children who are between 12 and 16 years old (adolescents).⁶⁵ The issue before the court was whether it was constitutionally permissible for children to be subject to criminal sanctions in order to deter early sexual intimacy and combat the associated risks. The applicants in this case argued that sections 15 and 16 of the Act unjustifiably infringe children's constitutional rights to dignity, privacy and bodily and psychological integrity, as well as the principle in section 28(2) of the Constitution that a child's best interests must be of paramount importance in all matters concerning the child. The court concluded that the said provisions criminalise what constitutes developmentally-normative conduct for adolescents, and adversely affect the very children the Act seeks to protect. The effects of these provisions were found not to be rationally related to the state's purpose of protecting children. The court therefore found the said provisions to be unconstitutional in that they infringed the rights of adolescents (12 to 16 year olds) to dignity and privacy and, further, in that they violate the best-interests principle contained in section 28(2) of the Constitution.

2.4 Sex education and information

Sexual education and information is one way in which the government can deliberately engage with adolescents on human rights principles in relation to their sexuality and sexual health. This enables adolescents to critically reflect on social norms and participate in addressing the challenges that confront them.⁶⁶ Article 14 of the African Women's Protocol, as well as article 13 of CRC, recognise the importance of linking reproductive health services with education and information.

While Africa has not yet developed much jurisprudence on sexual health education, the European Committee of Social Rights was asked to deal with this issue when Interights, a not-for-profit organisation, challenged the government of Croatia on delivery of sex education in the school system. Interights claimed that the delivery was inadequate and that the content of sexual education perpetuated negative stereotypes about

64 *Teddy Bear Clinic for Abused Children & Another v Minister of Justice and Constitutional Development & Another* (CCT 12/13) [2013] ZACC 35.

65 Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007.

66 A Mckay *Sexual ideology and schooling: Towards democratic sexuality education* (1999) 149.

gender and sexual orientation. The Committee said that the obligation to provide sexual health education requires that

the form and substance of the education, including curricula and teaching methods, are relevant, culturally appropriate and of sufficient quality, in particular that it is objective, based on contemporary scientific evidence and does not involve censoring, withholding or intentionally misrepresenting information, for example as regards contraception and different means of maintaining sexual and reproductive health.⁶⁷

The African continent could have recourse to this decision when interpreting governmental duty to provide sex education and information. The failure to provide sex education and information has negative consequences for adolescents. In Tanzania, for example, a study reported by Silberschmidt and Rasch showed that, although access to contraceptives for young people was allowed, the notion was more theoretical than practical, as most young people lacked information regarding their rights to sexual health, and did not realise that it was their entitlement to access contraceptives. As a result, most girls end up pregnant, which frequently results in unsafe abortions.⁶⁸

3 Conclusion

Adolescents in sub-Saharan Africa face a number of challenges to maintain the highest attainable standard of sexual and reproductive health. Governments need to implement human rights agreements, including CRC and the African Children's Charter, to advance the sexual health of the adolescent generation. Governments must formulate deliberate policies with the aim of transforming social and cultural norms to promote the sexual health of adolescents. In certain circumstances, what is needed is no less than a radical transformation of attitudes and beliefs. Governments must satisfy, as much as possible, the obligations to provide sexual health commodities and services, and the requisite sex education and information to adolescents.

The principles articulated in the treaties on the rights of the child are standards that have been negotiated at international and regional levels, and many countries have agreed to abide by them. While there is troubled consensus on sexual and reproductive rights, countries that have been bold to address sexual health concerns of young people have better indicators on sexual health amongst their adolescent populations. The African Children's Committee of Experts could play a greater role in advancing the

⁶⁷ Complaint. 45/2007 *International Centre for the Legal Protection of Human Rights (INTERIGHTS) v Croatia* (30 March 2009).

⁶⁸ M Silberschmidt & V Rasch 'Adolescent girls, illegal abortions and 'sugar daddies' in Dar es Salam: Vulnerable victims and active social agents' (2001) 52 *Social Science and Medicine* 1815-1826.

sexual health of adolescents in Africa. It is important for stakeholders to use this institution to raise the profile of the sexual health of adolescents.

Finally, adolescents themselves should be in the vanguard. In order to change the trend characterised by the multitude of sexual health problems that adolescents are facing, adolescents must be groomed to become agents of the change they need.

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CHAPTER 10

PROMOTING SEXUAL AND REPRODUCTIVE RIGHTS THROUGH LEGISLATIVE INTERVENTIONS: A CASE STUDY OF CHILD RIGHTS LEGISLATION AND EARLY MARRIAGE IN NIGERIA AND ETHIOPIA

Ayodele Atsenuwa

Summary

The International Conference on Population and Development, held in Cairo, Egypt, in 1994, affirmed sexual and reproductive health as integral aspects of human health, an act which has fostered the progressive development of the contents of ‘the human right to sexual health’ and ‘the human right to reproductive health’. Early marriage has been implicated in the overall poor status of human rights of women (especially the girl child) and, in particular, women’s sexual and reproductive health. It limits women’s ability to control their sexuality and reproduction. The obligations of states towards advancing and protecting human rights often require them to enact legislation to domesticate the norms and standards elaborated in international instruments or to provide legislative frameworks conducive to the fulfilment of obligations arising from them. This chapter examines legislative interventions to address the problem of early marriage in Nigeria. It reviews two pieces of legislation, namely, the Child Rights Act of 2003 and the Jigawa State Child Rights Law of 2007, a state level version of the Child Rights Act. It interrogates the posture of the CRA towards early marriage and sexuality with a view to assessing the potential of, and prospects for, promoting sexual and reproductive rights as human rights. It argues that the CRA is problematic in its denial of autonomy and agency to all children, regardless of age or other circumstances in relation to sexuality and choice of time of marriage, and finds an urgent and compelling need to explore how the concept of evolving capacities of children may be used to address this problem. It also examines Nigeria’s legal pluralism, assessing its implication for the CRA’s status as a model law and the prospects of the Jigawa CRL as a model of a culturally-responsive variant of the CRA.

1 Introduction

The importance of health to human beings is best captured in the colloquial saying that ‘health is wealth’. To foster the promotion and protection of human health, a human right to health has been affirmed as

the right of every person.¹ The right to health goes beyond a right to be free from disease or infirmity, and it imposes an obligation on states to take steps to promote the health of all persons.² Sexual and reproductive health (SRH) are integral aspects of human health and, since the International Conference on Population and Development (ICPD) held in Cairo, Egypt, in 1994, one of the strategies adopted to promote SRH has been the articulation and progressive development of the contents of the human right to sexual health and the human right to reproductive health.³

The Cairo Conference defined reproductive health as a state of complete physical, mental and social well-being - not merely the absence of disease or infirmity - in all matters relating to the human individual's reproductive system and to its functions and processes.⁴ Although it did not proffer a definition of sexual health,⁵ it cautiously stated that reproductive health includes 'sexual health, the purpose of which is the enhancement of life, pleasure and personal relations, and not merely counselling and care related to reproduction and sexually-transmitted diseases'.⁶

Sexual health was subsequently defined by the World Health Organisation (WHO) as 'a state of physical, emotional, mental and social well-being related to sexuality and not merely the absence of disease,

- 1 The human right to health was first articulated by the WHO. The Preamble to its Constitution (1946) states: 'The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. The right is affirmed in other treaties including the International Covenant on Economic, Social and Cultural Rights (CESCR) art 12; African Charter on Human and Peoples' Rights (ACHPR) art 16; Convention on the Rights of the Child (CRC) art 24; and Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol) art 14.'
- 2 'Health' is defined in the Preamble to the WHO Constitution as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.
- 3 The idea of human rights has always been a revolutionary one. Through all stages of its history, it has been employed as a tool of social transformation. It is strategically deployed to interrogate existing normative values and standards and legitimising 'new' ones to justify extracting duties of respect and protection for them. See, generally, A Atsenuwa 'Human rights protection of vulnerable and marginalised groups' in AO Obilade & C Nwankwo (eds) *Text for human rights teaching in schools* (1999); C Tomuschat *Human rights: Between idealism and realism* (2008).
- 4 Para 7, ICPD Programme of Action (PoA) 1994. The Fourth World Conference on Women held in Beijing, China, in 1995 also adopted this definition in the Beijing Platform for Action (PFA) para 94.
- 5 The climate surrounding the Cairo Conference provides the explanation for the cautious approach to the issue of sexual health and rights. Although many state and non-state actors identified with the critical importance of addressing reproductive health issues as part of global population and development concerns, some others opposed it on the ground that it was a ruse to promote the ideas of women's access to contraception, the liberalisation of abortion laws, the decriminalisation of homosexuality, etc. RP Petchesky 'Reproductive and sexual rights: Charting the course of transnational women's NGOs' (2000) <http://www.unrisd.org/unrisd/website/document.nsf/0/0F13BFA8DC76E8EE80256B660040D735?OpenDocument> (accessed 3 October 2011).
- 6 PoA (n 4 above) paras 7.2-7.3.

dysfunction or infirmity'.⁷ It connotes that a person has a right to a sexual life that is not only free from disease, injury, violence, disability, unnecessary pain and risk of death, but also free from shame, guilt and false belief about sexuality and includes the capacity to enjoy and control one's own sexuality responsibly.⁸ It is aimed at the enjoyment of life and personal relations.

The definitions of SRH proffered by ICPD and WHO acknowledge that SRH is affected by the broader context of people's lives, including their economic circumstances, education, social and gender relationships, and the traditional and legal structures within which they live. SRH is often negatively and gravely impacted by factors which include ignorance, cultural and religious restrictions on women's decision-making power, gender-based violence, early marriage, a lack of access to contraceptives, including contraceptive information, a lack of access to qualitative healthcare services in pregnancy, the general absence of accountability in healthcare delivery, the increasing incidence and changing dimensions of sexual violence and exploitation, as well as an array of laws which restrict sexual expression and other forms of discrimination.

The move away from the conceptualisation of health in the narrow terms of absence of disease or infirmity and the recognition that social factors weigh heavily in the shaping of individuals' health status have helped to deepen the understanding that the extent to which a society is able to secure and promote all other human rights has implications for the level of protection and enjoyment of SRH rights by individuals in that society.⁹ Thus, in the early years, SRH rights were not regarded as entirely new rights, but contextual expansions of civil, political, economic, social and cultural rights.¹⁰ The constellation of rights that make up reproductive rights are the right to reproductive decision making, including voluntary choice in marriage, family formation and determination of the number,

7 WHO *Sexual and reproductive health research priorities for WHO for the period 1998-2003* (1997) 4-5.

8 The Beijing PFA had taken the bold step of affirming the right of women to have control over their sexuality (para 96).

9 A notable effort at articulating the linkage between health and other human rights is General Comment 14 (2000) on the right to health adopted by the ESCR Committee. WHO currently adopts and promotes a human rights-based approach to its health development work; WHO *Engaging for health - Eleventh General Programme of Work 2006-2015: A global health agenda* http://whqlibdoc.who.int/publications/2006/GPW_eng.pdf (accessed 30 January 2012).

10 PoA (n 4 above) paras 7.2-7.3; RJ Cook *et al Reproductive health and human rights: Integrating medicine, ethics and law* (2003); International Council on Human Rights Policy (ICHRP) 'Sexuality and human rights: Discussion paper' (2009) http://www.ichrp.org/files/reports/47/137_web.pdf (accessed 12 February 2012). The IPPF Declaration on sexual rights describes sexual rights as 'a set of entitlements related to sexuality that emanate from the rights to freedom, equality, privacy, autonomy, integrity and dignity of all people'. International Planned Parenthood Federation (IPPF) 'Sexual rights: An IPPF declaration' (2008) <http://www.ippf.org/NR/rdonlyres/9E4D697C-1C7D-4EF6-AA2A-6D4D0A13A108/0/SexualRightsIPPFdeclaration.pdf> (accessed 13 April 2012).

timing and spacing of one's children; the right to have access to information and means needed to exercise voluntary choice; and equality and equity for men and women, to enable individuals to make free and informed choices in all spheres of life, free from discrimination based on gender.

The emergence of the discourse on SRH rights was no doubt revolutionary, but more revolutionary has been the emergence of the idea of sexual rights, which includes the right to sexual health and much more, namely, rights relating to sexuality that are not necessarily hinged on or derivable from reproductive health concerns.¹¹ According to Cook *et al*, the development of the idea of sexual rights as distinct from being an aspect of human reproduction became possible only as humans began to be able to dissociate human sexuality from reproduction.¹² The idea of 'sexual rights', as distinct from the right to sexual health and the right to reproductive health, was lent legitimacy by Paul Hunt, former UN Special Rapporteur on the Right to Health in a 2004 report in which he wrote:¹³

[T]he correct understanding of fundamental human rights principles, as well as existing human rights norms, leads ineluctably to the recognition of sexual rights as human rights. Sexual rights include the right of all persons to express their sexual orientation, with due regard for the well-being and rights of others, without fear of persecution, denial of liberty or social interference ... The contents of sexual rights, the right to sexual health and the right to reproductive health need further attention, as do the relationships between them.

Theorising as well as social and political action have helped to develop the content of sexual rights beyond sexual health. A definition of sexual rights with some form of official imprimatur states that sexual rights embrace the right of all persons, free of coercion, discrimination and violence, to (1) the highest attainable standard of sexual health, including access to sexual and reproductive healthcare services; (2) seek, receive and impart information related to sexuality; (3) sexuality education; (4) respect for bodily integrity; (5) choose their partner; (6) decide to be sexually active or not; (7) consensual sexual relations; (8) consensual marriage; (9) decide whether or not, and when, to have children; and (10) pursue a satisfying, safe and pleasurable sexual life.¹⁴ Jurisprudence emerging out of some regional and national courts has elaborated on sexual rights to non-

11 Cook *et al* (n 10 above); ICHRP (n 10 above).

12 n 10 above, 13-14.

13 P Hunt 'Report of the Special Rapporteur on the Right to Health' UN Doc E/CN.4/2004/49 [http://www.unhcr.ch/Huridocda/Huridoca.nsf/\(Symbol\)/E.CN.4.2004.49.En](http://www.unhcr.ch/Huridocda/Huridoca.nsf/(Symbol)/E.CN.4.2004.49.En) (accessed 2 October 2011).

14 WHO *Defining sexual rights: Report of a technical consultation on sexual health* http://www.who.int/reproductive-health/gender/sexual_health.html#3 (accessed 6 February 2012). It is noted that, although developed by a Technical Meeting convened by WHO, the world body registers a disclaimer of some sort to the definition. The Institute for the Advanced Study of Human Sexuality (IASHS) has identified ten basic sexual rights, namely, freedom of any sexual thought; fantasy or desire; the right to sexual

discrimination and privacy for same-sex sexual activity, sexual and gender orientation, sexuality information, and (hetero)sex assault, same-sex conjugal visits, homosexual parent(s)' rights to custody of a child, and so on.¹⁵ However, far-reaching as these developments are, some caution has been registered against celebrating the emergence of the power of sexual rights as a consensus claim on the ground that the fact or frequency of use of the unifying phrase 'sexual rights' in international and national fora as well as in academic and policy literature does not resolve completely the problem of the lack of clarity of the legal contents of the rights.¹⁶

Furthermore, controversy over the idea of sexual rights continues to rage, as reflected in the strong opposition of some members of the United Nations (UN) to the report submitted by the UN Special Rapporteur on the Right to Education, Vernor Munoz, in July 2010, in which he alluded to a right to comprehensive sexual education¹⁷ and their vociferous rejection of the adoption of the Yogyakarta Principles¹⁸ as a human rights standard. At the 21st session of the UN Human Rights Council held in 2012, a group of Arab, Islamic and African states again disassociated themselves from a paper to provide technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity and specifically its

entertainment, freely available in the marketplace, including sexually-explicit materials dealing with the full range of sexual behaviour; the right not to be exposed to sexual material or behaviour; the right to sexual self-determination; the right to seek out and engage in consensual sexual activity; the right to engage in sexual acts or activities of any kind whatsoever, providing they do not involve non-consensual acts, violence, constraint, coercion or fraud; the right to be free of persecution, condemnation, discrimination, or societal intervention in private sexual behaviour; recognition by society that every person, partnered or un-partnered, has the right to the pursuit of a satisfying consensual socio-sexual life free from political, legal or religious interference and that there needs to be mechanisms in society where the opportunities of socio-sexual activities are available to disabled persons, chronically-ill persons, those incarcerated in prisons, hospitals or institutions, those disadvantaged because of age, lack of physical attractiveness, or lack of social skills, and the poor and the lonely; the right of all persons who are sexually dysfunctional to have available non-judgmental sexual health care; and the right to control conception, <http://www.iashs.edu/rights.html> (accessed 3 October 2011).

- 15 These cases are briefly discussed in M O'Flaherty & M Fisher 'Sexual orientation, gender identity and international human rights law: Contextualising the Yogyakarta Principles' (2008) *Human Rights Law Review* 8:2; Cook *et al* (n 10 above) 517-525, where an annotated table of cases provides summaries of some of the cases.
- 16 ICHRP (n 10 above). The divergence in the nature and content of rights elaborated as sexual rights by the IASHS and IPPF is, indeed, well illustrative of the absence of consensus.
- 17 UN General Assembly, Official Records, 3rd Committee, Summary record of the 29th meeting held in New York on Monday, 25 October 2010, paras 11, 14-15 & 22-23.
- 18 The set of 29 principles were adopted in November 2006 by a group of experts in international law at a meeting in Yogyakarta, Indonesia, and launched on 3 March 2007 at the UN Human Rights Council in Geneva, http://www.yogyakartaprinciples.org/principles_en.htm (accessed 3 October 2011).

reference to 'sexual and reproductive health rights' on grounds that 'there is no international consensus on sexual rights'.¹⁹

However, in spite of the contentious nature of sexual rights as human rights, many rights composing the body of sexual rights, for instance, the right to the highest attainable standard of sexual health, including access to sexual and reproductive healthcare services, the right to consensual sexual relations and right to consensual marriage, are not in dispute. These rights have been identified as important for protecting vulnerable members of society, such as women and children, and are critically linked to progress or otherwise made with respect to other settled claims of right, for instance, the right to health, the right to education and the protection of human dignity. Hence, the discussion in this chapter assumes the idea of sexual rights as human rights as valid, although accepting that the scope of the body of rights and the contents remain disputed.

The obligation of states under international law to promote, protect and fulfil human rights often requires them to enact legislation to domesticate the norms and standards elaborated in international instruments or to provide legislative frameworks conducive to the fulfilment of obligations arising from them. As the spectrum of sexual and reproductive rights is broad, legislative interventions may be needed to address a range of issues, such as marriage and civil partnerships, adoption, assisted-conception, sexual orientation, trans-sexuality and gender identity, abortion, prostitution, access to sexuality and reproductive health information and education, sexual violence, and health systems financing. This chapter examines the experience with legislative interventions addressed to the problem of early marriage.

Early marriage has been implicated in the overall poor status of the human rights of women (especially the girl child) globally. Early marriage limits women's ability to control their sexuality and reproduction. It violates the sexual autonomy and bodily integrity of girl brides. Girl brides who submit to sex because of fear, intimidation or a sense of entrapment in marriage, can hardly be said to engage in consensual sex and it is unlikely that they will feel less sexually violated simply because the forced sex occurs in marriage. Girl brides who do not meet the legitimate expectation of their spouses have been known to suffer dire physical consequences.²⁰

19 Human Rights Monitor Quarterly *Human Rights Council worrying signs of regression at 21st session* Issue 4, 2012 6, http://www.ishr.ch/sites/default/files/hrm/files/hrmq-issue_4_2012.pdf (accessed 9 October 2011).

20 Hauwa Abubakar was a nine year-old Nigerian girl bride who, according to media reports, died because of her unwillingness to participate in sexual activity with her husband. Probably because she had been provided little if, at all, any sexuality education prior to marriage, she panicked at sexual intercourse so that she often ran away from her husband's house to her parents, but they always returned her. On one occasion, and probably to prevent her from running away again, her husband, who

There is a strong correlation between early marriage and early childbearing, which affects women's overall health and economic status. Having limited decision-making powers, women who marry early tend to have more children. In many countries, brides are often pressured to start having children early as motherhood confers status on the bride. Early pregnancy and motherhood increase risks to life and health of these young women. A lack of decision-making powers and the burden of child care limit their ability to use their skills and ability to take advantage of opportunities to mitigate gendered barriers that make them vulnerable to poverty. There is evidence that the burden of sexual and reproductive ill-health, in particular those emanating from pregnancy, maternal mortality and morbidity, and gender-based violence, disproportionately affects poorer women and vulnerable women, especially those who marry very early.²¹

The incidence of early marriage is high and fairly widespread in Nigeria. By geographical zones, the incidences are as follows: north west zone, 33,3 per cent; north east, 14,3 per cent; north central, 11,2 per cent; south-south, 8,6 per cent; south east, 5,8 per cent; and the lowest in the south west with 5,4 per cent.²² The Nigeria Demographic and Health Survey (NDHS) 2008 shows that about one in four women aged 25 to 49 (24 per cent) are married by the age of 15. Sixty per cent of women aged 25 to 49 are married by the age of 20. About half (46 per cent) of women aged 20 to 49 at the time of the survey were married by the age of 18, and 58 per cent were married by the age of 20.²³ Although there is evidence of a general decline, when the NDHS results are disaggregated, the critical dimensions of the practice with its implications are evident. The median age at first marriage ranges from 15,2 years in the north west to 22,8 years in the south east. The median age at first marriage increases from 15,5 years among women with no education to 22 years among women with secondary education.²⁴ Women who reside in urban areas tend to marry later than their counterparts in rural areas (21,1 years compared to 16,9 years).

was more than 60 years older, chopped off her two legs at the knees with a poison-laced cutlass. Houston Chronicle Archives 'Child bride's death outrages Nigerians: Every woman in this country felt shivers' http://www.chron.com/CDA/archives/archive.mpl/1987_459676/child-bride-s-death-outrages-nigerians-every-woman.html (accessed 29 September 2011).

- 21 KG Santhya *et al* *Early marriage and reproductive health risks: Experiences of young women and men in Andhra Pradesh and Madhya Pradesh, India* (2008) 55-57.
- 22 CRC Committee *Nigeria: third and fourth periodic report of states parties due in 2008* CRC/C/NGA/3-4.
- 23 The proportion of women getting married by age 15, however, decreased from 30% among women currently aged 45 to 49 to 12% among those aged 15 to 19, while the median age at first marriage increased from 17,3 years among women aged 45 to 49 to 19,8 years among women aged 20 to 24, suggesting an overall decline in the practice. A comparison of the findings with results from the 2003 NDHS survey indicates that the median age at first marriage among women aged 20 to 24 has increased from 19,1 to 19,8 years – Federal Ministry of Statistics *Nigeria demographic and health survey* (2008) 94.
- 24 Federal Ministry of Statistics (n 23 above) 95.

The choice of early marriage in Nigeria for this case-study is also informed by the fact that it is one of the few issues in sexual and reproductive health and rights to which national legislation has been directed.²⁵ The legislation reviewed for this purpose is the 2003 Child Rights Act (CRA), enacted by the federal government, and the Jigawa State Child Rights Law 2007, which is a state-level version of the Act, both of which prohibit early marriage. The aim is to interrogate the posture of the Act and the Law towards early marriage with a view to assessing their potential and prospects for promoting SRH in a multicultural and plural legal context that also draws legal norms from traditional culture and religion.

This chapter is divided into five sections. Section one provides an introduction to SRH and SRH rights in terms of meaning, history and development, and delineates the objective and scope of the chapter. Section two offers some clarification of the concept of early marriage for the purpose of the chapter. Section three reviews the contemporary context of early marriage to situate the need for international and national legislative interventions. Section four undertakes a review of the Act and the Law to assess their prospects for promoting SRH by the prohibition of early marriage in the context of a plural legal system. The conclusions and proposals for reform are presented in Section five.

2 Clarifying the concept of early marriage

Early marriage is also known as child marriage.²⁶ It is early because it features at least one party who, by reason of age, is deemed not ready for marriage. Some posit that it is more appropriately described as ‘forced

25 Various provisions in Nigeria’s criminal statutes and other legislation, such as the CRA and the Child’s Rights Laws (CRLs) of states, the Trafficking in Persons (Enforcement and Administration) Act 2003, as amended in 2005, and various states’ laws prohibiting female circumcision address aspects of sexual and reproductive rights of children’ A Atsenuwa ‘National legislations, policies and practices congruent and incompatible with the provisions of the Convention on Elimination of All Forms of Discrimination Against Women (CEDAW) and the Protocol to the African Charter on Human and People’s Rights on Women in Africa’ in AM Imam *et al* (eds) *Adopting women’s human rights legislation in Nigeria: A synthesis analysis and report* (2010) 108. But these provisions aside, there is general hostility towards sexual and reproductive rights discourse in Nigeria indicated by the resistance to the domestication of CEDAW and the Protocol to the Rights of Women in Africa because of their stance on sexual and reproductive rights on women; Imam *et al* (above). In November 2011, international and local advocacy to demand decriminalisation of consensual homosexual activities between adults and to end discrimination on grounds of sexual orientation produced a backlash in the form of the passage of a law criminalising same-sex marriage and accessory acts by the senate. A previous campaign had produced a similar response from the government of President Obasanjo in 2005; Imam *et al* (above). Some academic scholars are no less vehement in their opposition of sexual rights; E Uzodike *Trends of human rights campaigns in family law* (2011) 7-10.

26 International Planned Parenthood Federation (IPPF) *Ending early marriage: A guide for global policy* (2005) <http://www.unfpa.org/webdav/site/global/shared/documents/publications/2006/endchildmarriage.pdf> (accessed 3 August 2012).

marriage' because it is not possible for such marriages to have been contracted with the full and informed consent of a child-party (or child-parties) to the marriage. The argument is that the minor status of any child party limits his or her capacity to make free and informed decisions about the marriage. The absence of full and informed consent, therefore, introduces the element of coercion. However, it is possible, and it is not unknown for a person whose age as at the time of marriage has passed the benchmark age of a child to be coerced into marriage. Thus, while it is correct that all early marriages are 'forced' marriages, not all 'forced marriages' are early marriages.

'Early marriage' is defined as 'the marriage of a child, that is, a girl or a boy who has not attained 18 years'. Benchmarking the age at 18 years follows the standard of the UN Convention on the Rights of the Child (CRC), which defines a child as a person who has not attained the age of 18 years.²⁷ There are strong objections to adopting 18 years as the minimum age of marriage by those who reference the historical and widespread nature of the practice of early marriage to argue that marriage is appropriate at an age earlier than CRC specifies. The idea of a universal age of marriage is not considered appropriate, in part because societies have a different understanding of what it means to be a child as well as different socio-economic and cultural realities.²⁸ Some scholars and activists have argued that, instead of looking for a universal age at which girls and boys should not marry, the focus should, instead, be on eliminating the unwanted effects of early marriage.²⁹

In support of the CRC approach, it is argued that, while it is not incorrect to deduce benchmarks from the aggregate of beliefs held as well as values and practices predominant at a point in time, where the objective is to develop a new standard, it is possible and, in fact, preferable to deduce benchmarks by another means. CRC is a standard-setting instrument, and such instruments usually espouse ideals and prescribe standards that are considered higher and better than may be broadly accepted at the time of espousal. Further, the CRC standard has wider acceptability because the process of its making was participatory and its outcomes were the negotiated and aggregated minimum standards acceptable to state parties.

27 Art 1. The definition is not closed, as the Convention allows states to retain some element of control in specifying the legal age of majority, a fact that has been a major criticism of the instrument. Nonetheless, there is almost universal agreement now on 18 years as the age of legal majority. The African Charter on the Rights and Welfare of the Child stipulates 18 years and state parties cannot specify a lower age for any purpose. Nigeria is party to CRC and African Children's Charter, having ratified both without any reservations, and the CRA adopts 18 years as the benchmark.

28 Bayisenge cites scholars who have proposed that governments should be allowed to set the age of marriage below 18 years of age, but that the onus is on them to demonstrate that this lower age does not result in any discrimination or adverse consequences for women. See J Bayisenge 'Early marriage as a barrier to girls' education: A developmental challenge in Africa' <http://www.ifuw.org/fuwa/docs/Early-marriage.pdf> (accessed 2 August 2012).

29 As above.

A marriage is deemed 'early' also because it comes before the widely-accepted age of maturity, and for this reason it places the under-aged party at risks that society considers unacceptable to ignore. Maturity is a status that societies confer on their members at some point in time in their lives, and to it rights and obligations are attached. Thus, even though biology may play an indicative role, maturity is socially determined, that is, in the determination of the question of when to confer maturity, social considerations outweigh the biological. While the onset of puberty was adopted in many historical societies, in modern societies, the ability to determine chronological age has enabled more specificity. With knowledge derived also from science,³⁰ modern societies lay claim to having better tools for determining the question of maturity and being better positioned to relate this to a chronological age to be specified as the age of legal majority. For example, evidence from medical science shows that girls below 18 years are usually not physiologically ready for the likely consequences of marriage, namely, early sexual initiation, pregnancy and childbirth.³¹

Modern societies recognise that they are more complexly organised than their predecessors and consider that they owe a duty to ensure that their members are equipped to take on the social and legal responsibilities that come with the status of maturity before it is accorded. The idea of the rights of the child and the corresponding obligations of governments and parents are strategic to equipping children in modern societies for adulthood.³² Societies willingly bind themselves to the obligation of ensuring that children (that is, those who have not attained the age of 18 years and who, for that reason, are not deemed mature) are protected against practices such as early marriage that may place their future at risk. With the adoption of CRC, there is an indication of global agreement that 'maturity' sets in at 18 years, and societies can justifiably confer rights and responsibilities on the individual at that age.

Boys and girls may be victims of early marriage, but girls have been more victimised by the practice in terms of incidence and impact. Global statistics indicate a disproportionate vulnerability of girls to early marriage when compared to boys. The Nigerian situation is no different;³³ hence,

30 The term 'science' is used here broadly to include the bodies of knowledge classified as physical sciences (in particular, biology) and social sciences.

31 Global statistics implicate teenage pregnancy in the high rates of maternal mortality and morbidity in many parts of the world.

32 It may be said that all human rights of children, whether classified as survival rights, developmental rights, protection rights or participation rights, aim at the same end: protecting and equipping the child for effective participation in social life and optimal self-actualisation in adulthood. There are, however, contrary perspectives to this. Campbell, eg, advocates that, in relation to children, what is needed is a rights theory that gives more emphasis to the rights of the child as a child rather than those of the child as a future adult. TD Campbell 'The rights of the minor: As person, as child, as juvenile, as future adult' (1992) 6 *International Journal of Law, Policy and Family* 1.

33 NDHS (n 23 above) 94.

the scope of this chapter is limited to the problem of early marriage as it affects the girl-child.

Marriage, as used here, is not limited to marriages contracted under statutory laws, but includes marriages under customary and religious laws. Nigeria operates a plural legal system which permits marriages to be legally contracted under three different systems of law, namely, the modern law system,³⁴ customary law and Islamic law. Although there are young women in informal unions and who are just as vulnerable as their married peers,³⁵ they are not included within the scope of this work, which pertains to formal marriages, that is, those given 'legal backing'.

3 Context of early marriage

The practice of early marriage may be located within two periodic contexts. First is the historical context in which early marriage was a global practice replete with rationalisations and justifications, and second is the contemporary context replete with evidence of the negative impact of the practice, which is compelling a gradual shift towards its elimination. This chapter is concerned with the contemporary context.

Early marriage is traditional to Africa and, even though more women are now marrying at later ages, it remains the norm in many places.³⁶ Available studies show that its contemporary context is similar from place to place.³⁷ Since early marriage is traditional, many people justify the practice by reference to its being part of culture and strongly defend its retention on this ground. However, it is also true that the core

34 The 'modern law system' is used to refer to the body of law and institutions made up of received English law (where applicable), statutes and case law (derived from decisions of courts). It is so used only to contrast this body of law from the body of law derived from customs indigenous to African peoples and known as customary law. AV Atsenuwa *Feminist jurisprudence: An introduction* (2001) 6-9. This usage of the term, however, does not imply an unquestioning acceptance of the idea of superiority of this system of law or the colonialist's depiction of Western law as 'modern' and so superior in contrast to the colonised peoples' laws labelled as 'primitive' and inferior (as above).

35 The emerging trend is to expand the scope of early marriage to include informal unions in which there are young girls, it being argued that they are equally as vulnerable as child brides, and cohabitation creates similar human rights concerns as marriage; UNICEF *Early marriage: A harmful traditional practice: A statistical exploration* (2005) 8 http://www.unicef.org/publications/files/Early_Marriage_12.10.pdf (accessed 12 February 2012); S Singh & R Samara 'Early marriage among women in developing countries' (1996) 22 *International Family Planning Perspectives* 148-157, where the authors include 'consensual and cohabiting unions' in their definition of marriage.

36 I Cisse & AA Iknane *Study on early marriage and reproductive rights: Timbuktu region* (2008) 37-39 <http://www.norad.no/en/tools-andpublications/publications/publication?key=152657> (accessed 2 October 2011); PM Adebuseye (ed) *Matan Kwarai: Insights into early marriage and girls' education in Northern Nigeria* (2011); Singh & Samara (n 35 above).

37 Bayisenge (n 28 above). See also Singh & Samara (n 35 above).

considerations of many who participate in the practice in contemporary times are more structural than cultural.³⁸

Early marriage has been identified as an economic survival strategy.³⁹ Poor families are more inclined to give their daughters away in marriage early as a way of reducing the burden of the number of mouths to feed. At times, the decision is hinged on the presumption that, where the husband-to-be is wealthier, a daughter's marriage to him will inure in his extending economic support to the family. At other times, it is the short-term consideration of bride price and other gifts accruable to the family on marriage. This fact also explains why the trend in early marriage is marriage of young girls to much older men (who, presumably, have had time to accumulate wealth). Even when families betroth girls to boys who are their peers, usually economic considerations are at the heart of such arrangements.

In traditional societies, where a woman's status is determined by whether she is under male authority, marriage confers a higher social status on a woman who is married. It sends the message that the female has met the prescribed standards of appeal and found fit to be a wife, and for this she is conferred with a higher status than her peers who are unmarried. The appeal of girls for marriage drops with age for a number of reasons, for example, fear of reduced fertility, the belief that older girls are set in their ways and will not be amenable to submission to their husbands, and that late marriage is evidence of character flaws or reputational deficits in the individual girl or her family. In the words of Bayisenge:⁴⁰

Local perceptions on the ideal age for marriage, the desire for submissive wives, extended family patterns and other customary requirements, are all enshrined in local customs or religious norms.

Thus, it is not surprising that in communities where child marriages are prevalent, there is strong social pressure on families to conform. Failure to conform often results in ridicule, disapproval or family shame.⁴¹

Although poverty is often a reason for the practice, early marriage contributes to poverty. Girls who are married early are often denied access to education or taken out of school, diminishing their opportunities to acquire critical life skills to enable them to escape poverty-related conditions. Some families consider that the potential rewards of educating

38 Cisse & Iknane (n 36 above).

39 Bayisenge (n 28 above); N Otoo-Oryortey & S Pobi 'Early marriage and poverty: Exploring links and key policy issues' (2003) 11 *Gender and Development* 42-51; N Nour 'Health consequences of child marriage in Africa' *Emerging Infectious Disease* (serial on the Internet) 2006 http://wwwnc.cdc.gov/eid/article/12/11/06-0510_article.htm (accessed 15 January 2012).

40 Bayisenge (n 28 above).

41 E Akpan 'Early marriage in Eastern Nigeria and health consequences of vesico-vaginal fistulae (VVF) among young mothers' (2003) 11 *Gender and Development* 70-76.

daughters are too far off, so that their education is not viewed as a wise investment. It is believed that, once married, a woman's assets, just as herself, are subject to the control of the husband, and a girl's education will benefit her husband's household in the long run and not her natal household. Having few assets that they control, girls who marry early are disproportionately economically dependent on their husbands relative to girls who marry later. This absence of economic power correlates with their general lack of decision-making powers.

Some studies and anecdotal evidence indicate that early marriage can contribute to intergenerational poverty. Poorer mothers may be less equipped to provide financial support for their children and may acquiesce to early marriage for their own daughters. Having entered early into marriage, such women often have less access to life skills to share with their own daughters.

Girls who marry early are less likely to be equipped for the physiological and psychological experiences of pregnancy and childbirth. Physiologically, young mothers are not fully mature for childbirth. Studies have shown that young mothers are more likely to be affected by eclampsia and obstructed labour than women in their twenties. Also, with less decision-making powers, they are less likely to seek antenatal care and advice. Hence, they are at a higher risk of maternal mortality and morbidity than older mothers. Often also lacking in parenting skills, economic resources and decision-making powers, there tends to be higher rates of child morbidity and mortality among babies of young mothers.

A recent United States-based study suggests that early marriage is linked to mental health challenges.⁴² The study found that girls who marry early are more likely to suffer from mental health problems. It identified psychological disorders such as depression, anxiety, bipolar disorder, and drug and alcohol addiction. Girls who marry early in developing countries have reported a sense of betrayal by their natal families, especially as most of these girls are ill-prepared for marriage. Younger girls are often inadequately prepared to take on their new roles and responsibilities as co-wives in polygamous families, to deal with in-laws, to tackle household chores, as well as to meet the sexual demands of their spouses. This places them under a lot of emotional pressure. The sense of isolation and vulnerability experienced by young wives may result in psychological disorders.

42 <http://www.gbcghana.com/index.php?id=1.334928.1.543940> (accessed 3 October 2011).

4 Child Rights Act 2003, Jigawa State Child Rights Law 2007, early marriage and sexual and reproductive health

The Child's Rights Act and the Jigawa State Child's Rights Law domesticate the norms and standards in various international instruments relating to SRH-related rights and other rights of children. The question, however is, how well do they, or can they, advance SRH of children in Nigeria? To guide this interrogation, this chapter asks and seeks to find the answers to some narrower questions, namely:

- (a) What ideas of sexual and reproductive rights are reflected in the CRA's posture towards early marriage and sexuality? Are the CRA provisions on early marriage really attuned to emerging sexual and reproductive rights values and standards?
- (b) What are the prospects of the CRA and the Jigawa Law for promoting SRH by prohibiting early marriage in the context of a plural legal system that draws normative values from traditional culture and religion?

4.1 The idea of sexual and reproductive rights reflected in the CRA's posture towards early marriage and sexuality

Section 21 of the CRA provides that '[n]o person under the age of 18 years is capable of contracting a valid marriage and, accordingly, a marriage so contracted is null and void and of no effect whatsoever'. Section 22 prohibits child betrothal and renders any betrothal null and void. According to section 23, a person who marries a child or to whom a child is betrothed or who promotes the marriage of a child or who betroths a child commits an offence punishable on conviction with a fine of N500 000,⁴³ or imprisonment for a term of five years, or both.⁴⁴

Advocacy against early marriage in Nigeria has hinged more on the negative effects of the practice on girl child education and SRH of girls and women, especially risks relating to early pregnancy, such as vesico-vagina fistulae and other labour-related complications. There is little evidence that sufficient, if at all any, attention has been given to the issues of autonomy

43 This amount is approximately US \$3 200 at the current exchange rate of N156 to US \$1.

44 There were earlier legislative interventions aimed at eliminating early marriage. The Age of Marriage Law, enacted in 1956 by the eastern region of Nigeria, stipulated 16 years as the age of marriage, and rendered null and void any marriage in breach of the law. Four native authorities in the former northern region also passed Declarations of Native Marriage Law and Custom Orders which fixed marriageable ages as follows: Biu, 14 years; Idoma, 12 years; Tiv, puberty; and Borgu, 13 years. More recent are the Bauchi State Withdrawal of Girls from Schools for Marriage (Prohibition) Law 1985 and the Cross River State Girl Child Marriage and Female Circumcision (Prohibition) Law 2000.

and agency of adolescents in relation to their sexuality and reproduction in the context of early marriage. What can be surmised from the legislation is the complete denial of autonomy and agency in relation to sexuality and reproduction to all persons under the age of 18 years. Section 31(1) provides that no person shall have sexual intercourse with a child and a contravention of that provision amounts to the crime of rape punishable with imprisonment for life. Subsection (3) reinforces this position by providing that

[w]here a person is charged with an offence under this section, it is immaterial that (a) the offender believed the person to be of or above the age of eighteen years; or (b) the sexual intercourse was with the consent of the child.

While it is possible to rationalise section 31 on grounds of the protection of young children from sexual abuse and sexual exploitation,⁴⁵ there is a need to ask whether all children are similarly situated in terms of competence to make decisions about their sexual behaviour. Is it truly impossible for a girl or boy of 16 or 17 years to give free, informed and full consent to consensual sexual activities? How respectful of rights is a rights-based legislative framework that denies autonomy and agency, the core values of human rights to, say, a 17 year-old who is a second year university undergraduate or an apprentice-in-training when it states that he or she cannot transact consensual sexual activity with anyone, even a partner close in age?⁴⁶ How appropriate is this legal stance in the face of evidence that, globally and, in Nigeria, no less, adolescents are increasingly sexually active of choice?⁴⁷ Prior to the Act, the age of maturity for consensual sex (deducible from criminal legislation) was 16 years. Could it be that, under the guise of protecting children's rights, the gatekeepers of morality have employed the CRA to constrict the scope of sexual autonomy and agency for some groups of children?

When related to the strict rule of a minimum age of marriage, the problem with this legal stance on sexual activity is more obvious. Admittedly, given what is known about the context of early marriage, the arguments in favour of interventions to eliminate the practice are persuasive.⁴⁸ As Cook *et al* posit:

45 *R v G* [2008] UKHL 37.

46 Even if the zero tolerance reflected by the law could be justified by concern with the vulnerability of girls to sexual exploitation, especially when there is a high age difference between the parties, how is it to be defended when the parties are similarly aged? Some jurisdictions, such as Canada, have responded to this challenge by adopting the 'close-in-age' exception to criminal liability for sexual transactions with children.

47 NDHS 2008. The National Reproductive Health Policy and Strategy to Achieve Quality Reproductive and Sexual Health for all Nigerians (2001) recognises that adolescents in Nigeria engage in sexual activities, affirms their sexual and reproductive rights and adopts strategies to promote these rights.

48 See earlier discussions in section three.

Laws setting a legal minimum age of marriage ... can help ensure that young women are of sufficient age and maturity to be able voluntarily to consent to marriage and avoid the physical health risks of premature childbearing and mental health consequences of early marriage.⁴⁹

This position (outlawing child marriages and stipulating 18 years as the age of marriage), according to the CEDAW Committee, is defensible from a child rights and equity perspective, because this is the minimum age when young people attain 'full maturity and capacity to act'.⁵⁰ In sum, '[t]he right to marry and found a family is not always absolute, and may be circumscribed by, for example, laws ... particularly on the legal minimum ages of marriage.'⁵¹

The problem with this perspective is that it does not deny that an adolescent girl may attain sexual maturity early, but contends that she will often not be physically mature enough to conceive a child, nor will she be cognitively or psychologically mature enough for marriage and the related responsibilities of being a wife and mother.⁵² It therefore justifies the legal prohibition of marriage at this age on these bases. As logical as this approach appears, it ignores the fact that not all sexually-mature adolescents are willing to accept and co-operate with the expediency of being denied autonomy and agency until they attain the age of 18 years.

Social acceptance of sexual activity outside of marriage in many parts of the world has served to mediate the tensions experienced by sexually-mature adolescents who delay marriage, but this is not an option always open to or, arguably, even preferred by adolescents in other parts of the world. Many countries have resolved the dilemma by reducing the age of consensual sexual activity even when they fix the age of marriage at 18 years. In some countries, co-habitation at lower than 18 years is not unknown, even when formal union is not legally permitted. Recognising that such social or legal environments are not universally applicable, the questions must be asked: What should happen to young persons who are sexually mature and who want to be sexually active but who would rather have sexual interactions within marriage? Should they be legally precluded as does this law?⁵³

49 Cook *et al* (n 10 above) 180.

50 General Recommendation 21 (1994) para 36.

51 Cook *et al* (n 10 above) 180.

52 IPPF (n 26 above) 8.

53 The story of Farouk Abdulmutallab, the Jihadist and underwear bomber who attempted to blow up an aircraft on 22 December 2009, is illustrative of how this legal stance may present psychological challenges to some individuals. Unverifiable web postings suggest that the young man had, between 2005 and 2007, begun to experience frustration at not being 'socially permitted' to marry, even though he had a desire for sexual relations. For him and, premised on his religious beliefs, marriage was the only legitimate context for sexual expression. One of the posting is very telling: 'The Prophet (SAW) advised young men to fast if they can't get married but it has not been helping me much and I seriously don't want to wait for years before I get married. But

Beyond autonomy considerations, fixing the age of sexual consent at 18 years effectively criminalises behaviour in which large numbers of young people are engaged in societies throughout the world.⁵⁴ Rendering sexual activity by young people criminal can only reduce access of young people to the sexual and reproductive health care and advice that they need for their protection and safety. As Lansdowne puts it: 'In consequence, measures designed to provide protection can have the reverse impact.'⁵⁵

These challenges call for re-engaging with the idea of a fixed age limit for early marriage. Additional support for the call for a re-engagement is found in the fact that the idea of 'the rights of the child' acknowledges that all those classed together as children are not all at the same stage of development. The concept of 'evolving capacities' of children introduced into international human rights discourse through CRC establishes that, as children acquire enhanced competencies, there is a reduced need for direction and a greater capacity to take responsibility for decisions affecting their lives.⁵⁶ The CRA adopts the 'concept of evolving capacities' of children in one of its aspects, but does not extend this to the context of early marriage.⁵⁷ The unwillingness to extend the notion of evolving capacities to the context of early marriage reflects the perspective of the CRA on the scope and nature of sexual and reproductive rights of children of different ages. The Act could have employed the doctrine of evolving capacities to mediate the tension arising out of the need to protect children who do not have the competence to give free, full and informed consent and whose choice may not be respected, and children who have sufficient maturity and competence to make a choice to enter into marriage.

The importance of considering the Nigerian context is underscored by the vehement resistance to the passage of the CRA by legislators from the northern parts of the country and continuing resistance indicated by the refusal of 12 northern states to pass the Law as state legislation.⁵⁸ It is noteworthy that some of the northern states that have passed the law did not adopt the benchmark of 18 years for the purpose of marriage. For

53 I am only 18 ... It would be difficult for me to get married due to social norms of getting to the late 20s when one has a degree, a job, a house, etc before getting married.' http://en.wikipedia.org/wiki/Umar_Farouk_Abdulmutallab (accessed 30 January 2012).

54 G Lansdowne 'The evolving capacities of children' (2005) <http://www.unicef-irc.org/publications/pdf/evolving-eng.pdf> (accessed 30 January 2012).

55 Lansdowne (n 54 above) 39.

56 Art 5 of CRC provides that '[s]tates parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, *in a manner consistent with the evolving capacities of the child*, appropriate direction and guidance in the exercise by the child of the rights recognised in the present Convention' (my emphasis).

57 Sec (2) provides for the application of the concept in relation to rights relating to freedom of religion.

58 The 12 states that are yet to pass new children's rights legislation conforming with the Child Rights Act, 2003 are Adamawa, Bauchi, Borno, Enugu, Gombe, Kaduna, Kano, Katsina, Kebbi, Sokoto, Yobe and Zamfara. States which have passed such laws are

example, the Jigawa CRL specifies ‘puberty’ as the age of marriage and the state government has admitted that it was minded to take this position because of the people’s cultural values. Rationalising the position, Musa Imam, Secretary of Jigawa State Judicial Reform Commission, which reviewed the law stated that ‘[w]e substituted the age limit of 18 years in the original draft with “puberty”, which we find acceptable with (*sic*) our people’.⁵⁹ A survey by IRIN found that residents of Jigawa State regarded the law as no more than ‘a paper tiger’, with one resident saying that ‘[e]ven if the government decides to enforce the law, people will defy it because to us it is better to marry off your daughter and go to jail than to have a grandchild outside marriage’.⁶⁰ Even among those who accept that early marriage negatively impacts the girl child, the response has not been to jettison the practice. Rather, there is some attempt to provide other safeguards, such as prenuptial contracts stipulating support for the completion of education of the girl child as a covenant to be observed by the husband.⁶¹ These responses reflect the people’s firm belief in the value of early marriage and how ready they are to defy the law in its defence. Such vehement opposition should not be deemed irrelevant and ignored; rather, it calls for re-visiting the rigid minimum age of marriage approach taken by the CRA.

Expediency dictates exploring whether and how the concept of evolving capacities of children may better inform how to protect and promote the sexual and reproductive rights of children. In the discourse of the human rights of children, there are different positions on the idea of adopting a chronological age to benchmark childhood. On the one hand are those who advocate the fixed age limit, while on the other hand are those who advocate the removal of the age limit. In between are advocates for ‘fixed age limit’ with a right to establish competence at an earlier age.⁶² Encasing all these approaches, however, is the mixed model, which seeks to mediate the tensions between the three positions, and it is one worthy of consideration in addressing the practical challenges to the fixed age limit approach of the CRA. The advantages of the mixed model include that it avoids over-reliance on prescribed age-limits in personal decision making, encourages serious consideration of children’s capabilities, provides

Abia, Akwa-Ibom, Anambra, Benue, Cross River, Delta, Ebonyi, Edo, Ekiti, Imo, Jigawa, Kwara, Lagos, Nassarawa, Ogun, Ondo, Osun, Oyo, Plateau, Rivers, Niger, Bayelsa, Kogi and Taraba; UNICEF Nigeria Fact Sheet ‘Child Rights Legislation in Nigeria’ April 2011.

59 Women Living under Muslim Laws (WLUML) ‘Nigeria: Early marriage adds to socio-economic woes’ <http://www.wluml.org/node/4904> (accessed 3 October 2011).

60 Hamisu Umar, a resident of Kandi village, 20km outside Dutse, the Jigawa state capital quoted in WLUML (n 59 above).

61 Adebusoye (n 36 above).

62 The model of a fixed age limit with a right to establish competence earlier combines the establishment of fixed age limits, automatically entitling children to exercise certain rights, with the recognition that children may be entitled to exercise certain rights earlier if they demonstrate the necessary capacity; IPPF (n 26 above).

potential for greater respect for children's capabilities, provides flexibility and respects differences in children's evolving capacities.⁶³

4.2 Prospects of effectiveness of the CRA and Jigawa CRL in Nigeria's plural legal system

Nigeria's legal pluralism is a complex one with implications for the prospects of the CRA as effective legislation in addressing the problem of early marriage. As noted earlier, Nigeria is a federal state with law-making powers shared between the different tiers of government, namely, the federal, state (36 in number) and local government tiers. Where the Constitution shares legislative powers on a matter between the federal and state governments, as it does on children's welfare, this limits the powers of the federal tier to make laws for the state tier.⁶⁴ As a result, legislation is as diverse as can be and, indeed, nothing precludes 37 variants of the CRA emerging in the country.

Also, the Constitution recognises statute-based laws, customary law and Islamic law as sources of law and treats them, to some extent, as separate law systems, providing separate court systems for them.⁶⁵ It is not unusual for the norms and standards of these different systems of law to be in conflict, and the basic rule for resolving such conflicts is that a rule of custom is enforceable as law only in so far as it is not repugnant to natural justice, equity and good conscience, and not contrary to any written law.⁶⁶ Recent developments have, however, introduced some uncertainties to the law. Islamic law used to be categorised as customary law but, in recent times, some legal scholars have challenged this and argued that it is hierarchically superior to customary law.⁶⁷ This view has found some support from the courts.⁶⁸ Some states have also elevated Islamic law above customary law by giving it statutory flavour.⁶⁹

Statutory marriage is exclusively within the legislative remit of the federal government. Thus, there is only one Marriage Act which regulates

63 n 62 above, 49.

64 Under the Constitution, the federal government has exclusive legislative powers over matters specified in the Exclusive List and shares power with state governments over matters in the Concurrent List (sec 4 of the Constitution).

65 n 34 above.

66 AO Obilade *Nigerian legal system* (1979).

67 JA Yakubu 'Colonialism, customary law and post-colonial state in Africa' (2005) 30 *Africa Development* 201-220; MT Ladan 'Access to justice and the justice sector reform in Nigeria' paper presented at the First International Conference on the State of Affairs of Africa, organised by the International Institute for Justice and Development (IIJD), Boston, 26-28 October 2006, <http://www.gamji.com/article6000/news6682.htm> (accessed 6 February 2012).

68 *Yinusa v Adesubokan Bello* (1968) NMLR97; IO Agbede 'Legal pluralism and the problems of ascertaining personal laws: A consideration of *Yinusa v Adesubokan* (1971) *Nigerian Bar Journal* 69-73.

69 The introduction of Shari'a-based criminal statutes by some of the northern states now gives statutory flavour to Islamic law norms.

statutory marriages throughout the country. The age of marriage under the Marriage Act was 16 years with parental consent and 21 years without parental consent.⁷⁰ However, section 274(1) of the CRA states that the provisions of the Act supersede the provisions of all enactments relating to children and any other matter pertaining to children already provided for in the Act, and section 274(2) states:

Where any provision of this Act is inconsistent with that of any of the enactments specified in subsection (1) of this section, the provision of this Act shall prevail and that other provision shall, to the extent of its inconsistency, be void.

The net effect of sections 21 and 274 of the CRA is that 18 years is the minimum age of marriage under the Marriage Act, and even parental consent cannot lower it.

However, the effect of the CRA on the regimes of customary law and Islamic law is not as easily deducible. Both customary law and Islamic law regard attainment of puberty as signifying readiness for marriage, but neither specifies a chronological age correlate. Customary law even permits betrothal as early as at birth. The effect of the CRA on this norm is determined by the place of the marriage.

The federal government has powers to make laws for matters within its legislative competence as well as for governance of federal territories, such as the Federal Capital Territory of Abuja. With the passage of the CRA, both customary law and Islamic law norms which fix the age of marriage at puberty and permit child betrothal are no longer enforceable as law within the territory.⁷¹ Marriage under customary and Islamic law outside the Abuja Territory is within the law-making powers of state governments and states desirous of establishing the same legal standards as the Act have to pass their own laws. Twenty-three states have done so to date and, in these states, customary law and Islamic law that permit marriage earlier than 18 years no longer apply by reason of their conflict with a written law.⁷²

The issue is not as straightforward in the 13 states that have not passed their own Child Rights Laws. These states are preponderantly Muslim in population and the refusal of their various governments to pass the law has hinged on the claim that the standard espoused by the Act in relation to

70 Cap M6 Laws of the Federation of Nigeria (LFN) 2004. Although the law did not expressly prescribe these ages, there is some consensus among legal scholars that the provisions lead ineluctably to these conclusions. A Oyajobi 'Better protection for women and children under the law' in A Kalu & Y Osinbajo (eds) *Women and children under Nigerian law* (1989).

71 It is noted that the practice persists in spite of this legal position.

72 As above.

early marriage is against Islamic tenets.⁷³ The Minister for Women Affairs and Social Development at the time, Hajia Zainab Maina, was informed during an advocacy visit to the Adamawa State House of Assembly (one of the 13 states) by the Speaker of the House that the criminalisation of marriage of a girl child (that is a girl who is under 18 years) by the Child Rights Act was unacceptable as it conflicts with Islamic law in some aspects, and the only condition upon which it could be passed as state legislation was if it could be made subordinate to Islamic law.⁷⁴ Arguably, the likely outcome of such subordination is a law such as that of Jigawa State which adopts a benchmark of 'puberty'. The problem with such a law is that it does not move the legal framework any further from where it was prior to law reform. In fact, rather than protect against early marriage, it legitimises it by statute. Under both Islamic and customary law, the onset of puberty for girls is determined by gynaecological indicators such as breast development and commencement of menstruation, which may begin as early as ten years, which means that the legal framework makes it possible for girls as young as ten to be legally married.

In merely stating 'puberty' and not defining puberty or providing some chronological guide, the law adds little or nothing for the effective protection of children, which is the essence of a law on the minimum age of marriage. The approach leaves the question whether puberty was reached as at the time of marriage as one for the judge to resolve, which becomes relevant only if a case gets to court. Thus, the law shifts from being standard-setting legislation to inform and move cultural practice in another direction to being remedial. Even in being remedial, its assumptions are weak – that someone will complain so that the law can be invoked. The NDHS of 2008 shows that early marriage is more widespread in rural areas where communities tend to be more impervious to change. Thus, even though it is not impossible for complaints to be lodged against early marriage in such settings, the chances of that happening are low as most members of the community 'value and uphold' the practice. Who then will report breaches of the law? Certainly not the

73 Continuing support for the cultural practice of early marriage does not mean that the people are blind to its negative implications for aspects such as girl-child education and there is evidence of increasing use of pre-nuptial agreements (albeit unwritten) specifying that husbands who take child-brides will enable and support the education of the girls they take as wives - Adebuseye (n 36 above). Various remedial interventions such as married women's schools have been put in place by governments.

74 <http://allafrica.com/stories/201108011614.html> (accessed 3 October 2011). This is a widely-shared sentiment. It is reported that Senator Ahmed Sani Yerima (former governor of Zamfara State) responded to allegations that he married an eight year-old Egyptian girl in Abuja, saying that he had done nothing wrong in Islam and reiterated that he would only regulate his conduct by Islamic standards and even where this conflicts with the Constitution, he would give precedence to Islam. The Registered Trustees of the Supreme Council for Shari'a in Nigeria filed an action against the National Human Rights Commission (NHRC) alongside the Senate President, Speaker, House of Representatives and NAPTIP for opposing Yerima's marriage to a minor without considering the provisions of Islamic laws; <http://www.guardian.co.uk/global-development/video/2010/dec/22/early-marriage-ghana> (accessed 3 October 2011).

parents who are key parties to marriage ceremonies and, even less likely, the child-bride who might not even recognise the abuse of her right and, where she does, can hardly be expected stand up to her parents or community. Maybe some non-governmental organisations (NGOs) who become aware of such incidents will, but what are the chances of this, given their predominant location in the big cities? In the absence of a systemised and well-implemented child protection scheme designed to monitor the welfare of children, the law will be no more than a paper tiger.

5 Conclusion and recommendations

The CRA presents a positive policy climate central for transforming the sexual and reproductive health status of girl children in Nigeria. However, rigid adherence to the benchmark of 18 years for marriage may create problems for its efficacy, given the disregard for the fact of evolving capacities of children and a cultural context, at least in some parts of the country, which provides strong support for the practice. The underlying aspirations of the notions of sexual rights and reproductive rights, which include SRH, are emancipation, autonomy and agency. In the case of children, it is accepted that this cannot be absolute. The challenge is how to balance protective and emancipatory rights, and it is contended that the concept of evolving capacities of children may be helpful to work around the challenges. Thus, there is an urgent and compelling need to explore how this concept can be deployed to address the problems of (a) the impracticality of the CRA in its denial of the reality of adolescents' sexual activities, and (b) hostility towards the CRA model for its cultural insensitivity.

At first glance, the Jigawa Law appears to have something to offer as a model legal framework for children's rights legislation in the context of societies with strong attachments to Islamic law or other customary law, both of which confer maturity for marriage earlier than the CRA. On closer review, the age of puberty specified by the law is too imprecise to let it stand. Puberty was the legal norm that has been criticised for rendering children vulnerable to sexual abuse and exploitation. Against this backdrop, there is some value in setting a minimum age of marriage, but not in the rigid manner of the CRA. The mixed model, which recognises the concept of evolving capacities and allows for specifying a lower age below which there is no room for demonstrating competence, and above which there is graduated competence, is one that is useful for consideration.

In conclusion, a lesson that must not be lost from the Nigerian experience of the CRA and the Jigawa CRL is the reminder of the limits of standard-setting laws in (re)shaping peoples norms and behaviour. Conceptualising law as an instrument of social engineering suggests that law's normative values and standards can run ahead of the ones held by the

people at a point in time. However, experience has also shown that, where the gap between legal norms and non-legal but predominant and culturally-accepted norms are so wide, the law is likely to lag behind.

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Summary

Great progress has been made over the last two decades in the investigation and prosecution of sexual and gender-based violence, in particular by the *ad hoc* International Criminal Tribunals for the Former Yugoslavia (ICTY) and Rwanda (ICTR). Yet the practice and jurisprudence of these tribunals makes clear that significant challenges remain, including inconsistency in how to understand – and therefore how to prove and adequately link to higher level perpetrators – crimes of sexual violence committed in the context of conflict, mass violence or repression. This chapter examines these challenges and explores whether human rights law, particularly the requirement that access to justice be free from gender-based discrimination, can be used to help address the challenges. It suggests that application of the fundamental human rights principle of non-discrimination would encourage international tribunals to develop a better, more nuanced understanding of when, why and how sexual violence takes place during conflict or other instances of mass violence and, therefore, assist them in better evaluating how the elements of sexual violence crimes should be interpreted, what theories of criminal responsibility can and should be used to prosecute such crimes, and/or whether such crimes should be selected for investigation and prosecution.

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1 Introduction

Sexual and gender-based violence during conflict and periods of repression has been a problem of enormous magnitude in every region of the globe.¹ While not merely an African problem, sexual violence has been committed in epidemic proportions in many parts of Africa, including Rwanda, Uganda, the Democratic Republic of the Congo (DRC), Sierra Leone and Sudan.² Yet, historically, these crimes were rarely prosecuted, particularly when government leaders were responsible for tolerating, encouraging or orchestrating these crimes.³ As discussed below, however, the last two decades have seen an incredible transformation in the treatment of sexual and gender-based violence under international law. Indeed, great strides have been made in the investigation and prosecution of such crimes, in particular by the *ad hoc* International Criminal Tribunals for the Former Yugoslavia (ICTY) and Rwanda (ICTR).

Nevertheless, many challenges remain, including (i) ambiguity in the jurisprudence regarding whether prosecuting rape in the context of mass atrocity crimes requires proof of 'non-consent of the victim'; (ii) critique of theories of criminal responsibility that have been relied upon to find perpetrators – particularly top political or military leaders – accountable for crimes of sexual violence; and (iii) inadequate investigation and prosecution of crimes of sexual and gender-based violence, even where evidence of such crimes arguably warrants further investigation and/or prosecution. This chapter examines these challenges and explores whether human rights law, particularly the requirement that access to justice be free from gender-based discrimination, can be used to help address the challenges. It concludes that the obligation to comply with the non-discrimination principle requires a gender-sensitive approach to the issues of how the elements of sexual violence crimes should be interpreted, what theories of criminal responsibility can and should be used to prosecute such crimes, and what crimes should be selected for investigation or prosecution.

- 1 Rape as a weapon of war: Accountability for sexual violence in conflict' Subcommittee on Human Rights and the Law, US Senate Committee on the Judiciary, 110th Cong (2008) (statement of Dr KD Askin, Senior Legal Officer, Open Society Justice Initiative) (Askin Testimony) http://judiciary.senate.gov/hearings/testimony.cfm?id=3225&wit_id=7081 (accessed 26 November 2012).
- 2 Askin Testimony (n 1 above), recounting stories of survivors of sexual abuse from the DRC and discussing travelling to Rwanda, Uganda and Sierra Leone, 'where sexual violence has been committed in epidemic proportions, affecting millions of lives'.
- 3 Askin Testimony (n 1 above): 'There was widespread acknowledgment that atrocities such as massacres, torture, and slave labour were prosecutable, but there was skepticism, even by legal scholars and military officials, as to whether rape was sufficiently serious to be prosecutable in an international tribunal set-up to redress the worst crimes.' C Steains 'Gender issues' in RS Lee (ed) *The International Criminal Court: the making of the Rome Statute* (1999) 357-358: '[I]t was only in relatively recent times that sexual and gender violence in armed conflict shifted from the periphery of the international community's focus towards the centre of debate, and was recognized as an important issue in serious need of redress.'

2 Advances in the prosecution of sexual and gender-based violence crimes before international criminal tribunals

As mentioned above, historically, sexual and gender-based violence committed in times of conflict, mass violence or repression was rarely prosecuted, even when tolerated, encouraged or orchestrated by senior leaders.⁴ In the past two decades, however, incredible advances have been made in the effort to end impunity for such crimes. In a departure from the statutes governing the international military tribunals established in the wake of World War II, for instance, the statutes of the Yugoslav and Rwanda Tribunals expressly include the crime against humanity of rape.⁵ Importantly, these tribunals have recognised that sexual violence may constitute a number of additional crimes, including the war crimes of torture⁶ and outrages upon personal dignity,⁷ the crimes against humanity of enslavement⁸ and persecution;⁹ and sexual violence as an act of genocide.¹⁰ In addition, the 1998 Rome Statute establishing the International Criminal Court (ICC) incorporates many of these advances, enumerating a broad range of sexual and gender-based crimes as war crimes and crimes against humanity.¹¹ Thus, for example, the Rome Statute includes specific gender-based crimes – including rape, sexual slavery, enforced prostitution, forced pregnancy and enforced sterilisation – under both the war crimes and crimes against humanity provisions, and

4 As above.

5 Statute of the International Tribunal for the Prosecution of Persons Responsible for Serious Violations of International Humanitarian Law Committed in the Territory of the Former Yugoslavia since 1991 (25 May 1993), Annex to UN Doc S/25704 (1993) (ICTY Statute) art 5 (including rape in the enumerated crimes against humanity); Statute of the International Criminal Tribunal for Rwanda (8 November 1994), Annex to UN Doc S/955 (1994) (ICTR Statute) art 3.

6 *Prosecutor v Delalic & Others* (16 November 1998) IT-96-21-T, Trial Judgment, para 475 (noting that '[t]he crime of rape is not itself expressly mentioned in the provisions of the Geneva Conventions relating to grave breaches, nor in common article 3, and hence its classification as torture and cruel treatment').

7 *Prosecutor v Furundzija* (10 December 1998) IT-95-17/1-T, Trial Judgment, para 274 (finding the accused guilty of outrages upon personal dignity, including rape).

8 *Prosecutor v Kunarac & Others* (22 February 2001) IT-96-23-T and IT-96-23/1-T, Trial Judgment, para 436.

9 *Prosecutor v Brdjanin* (1 September 2004) ICTR-96-4-T, Trial Judgment, para 15.

10 *Prosecutor v Akayesu* (2 September 1998) ICTR-96-4-T, Trial Judgment, para 113 (explaining that genocide entails causing serious bodily or mental harm to members of the group).

11 Steains (n 3 above) 358 (noting that the gender provisions in the Rome Statute developed in the 'wake of a number of important developments in the field of international humanitarian law and advances in the international community's response to violence against women and women's human rights'). See also V Oosterveld 'Gender-sensitive justice and the International Criminal Tribunal For Rwanda: Lessons learned for the International Criminal Court' (2005) 12 *New England Journal of International and Comparative Law* 128 (describing the lessons learned from the *ad hoc* tribunals' experiences, notably the need for a 'wide-ranging approach' to ensuring the effective investigation and prosecution of such crimes by incorporating articles into the Rome Statute).

adds a residual 'sexual violence' clause that allows the Court to exercise jurisdiction over other serious sexual assaults of comparable gravity to the named gender-based crimes.¹² Moreover, for the first time, the Rome Statute also includes 'gender' within the list of prohibited grounds of persecution as a crime against humanity.¹³ In addition, the Court's Elements of Crimes recognise that, although rape is not listed as a form of genocide under the Rome Statute, genocide committed by acts causing 'serious bodily or mental harm' may include 'acts of torture, rape, sexual violence or inhuman or degrading treatment'.¹⁴ Similarly, the statute of the Special Court for Sierra Leone (SCSL), which was established in 2002 to try serious international crimes committed in Sierra Leone during its civil war,¹⁵ recognises a range of sexual violence-based war crimes and crimes against humanity, including rape, sexual slavery, enforced prostitution and forced pregnancy.¹⁶ Additionally, the SCSL has held that the act of forced marriage constitutes a crime against humanity as an 'other inhumane act' under the SCSL Statute.¹⁷

Equally important, the jurisprudence of these tribunals has recognised that an accused need not have physically perpetrated a crime in order to be found directly liable for that crime. Thus, in addition to convicting the accused for physically perpetrating crimes of sexual violence,¹⁸ the tribunals have held the accused criminally responsible for instigating,¹⁹

12 Rome Statute of the International Criminal Court (17 July 1998) 2187 UNTS 90 (1998) (Rome Statute) art 7(1)(g) (defining crime against humanity as 'any of the following acts when committed as part of a widespread or systematic attack directed against any civilian population ... (g) rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilization, or any other form of sexual violence of comparable gravity'); Rome Statute (above) art 8(2) (defining war crimes as 'any of the following acts ... (xxii) committing rape, sexual slavery, enforced prostitution, forced pregnancy, as defined in article 7, paragraph 2(f), enforced sterilization, or any other form of sexual violence also constituting a grave breach of the Geneva Conventions'). Art 8(2)(e)(vi) enumerates the same crimes as art 8(2)(b)(xxii) committed in the context of non-international armed conflicts.

13 Rome Statute (n 12 above) art 7(h).

14 International Criminal Court Elements of Crimes (9 September 2002) UN Doc PCNICC/2000/1/Add.2 (2000) (ICC Elements of Crimes) art 6(b).

15 Statute of the Special Court for Sierra Leone (16 January 2002) UNSC Res 1315, Annex to UN Doc S/RES/1315 (2000) (SCSL Statute).

16 SCSL Statute (n 15 above) art 2(g) (noting that the Special Court shall have the power to prosecute persons who commit rape, sexual slavery, enforced prostitution, forced pregnancy, and any other form of sexual violence); SCSL Statute (n 15 above) art 3(e) (noting that the Special Court shall have the power to prosecute persons who commit outrages upon personal dignity, in particular humiliating and degrading treatment, rape, forced prostitution, and any form of indecent assault).

17 *Prosecutor v Brima & Others* (22 February 2008) SCSL-2004-16-A, Appeals Judgment, paras 199-203 (AFRC Appeals Judgment) (holding that forced marriage constitutes a crime against humanity of an 'other inhumane act' under the SCSL statute).

18 See eg *Kumarac* (n 8 above) paras 699-704.

19 *Akayesu* (n 10 above) para 692; *Prosecutor v Gacumbitsi* (17 June 2004) ICTR-2001-64-T, Trial Judgment, para 292.

ordering,²⁰ and aiding and abetting²¹ such crimes. This has had significant consequences for the prosecution of crimes of sexual violence committed in the context of conflict, mass violence or repression, as such crimes are often tacitly encouraged or tolerated, even if not perpetrated or officially sanctioned, by the accused in positions of authority.²²

Moreover, the *ad hoc* tribunals have recognised another direct form of liability that allows an accused to be held responsible whenever he or she intentionally takes part in criminal conduct with a plurality of actors. As developed by the *ad hoc* tribunals, particularly the ICTY, this theory – known as ‘joint criminal enterprise’ (JCE) or ‘common purpose’ liability – allows the tribunals to hold perpetrators accountable not only for the crimes originally intended by the group, but also for other crimes that were the natural and foreseeable consequences of the intended crimes, as long as the perpetrator was aware of the risk that such crimes were likely to be committed and willingly took the risk.²³ As the Yugoslav tribunal noted in the *Kvočka* case, even where sexual violence is not explicitly part of the original criminal plan,

[a]ny crimes that were natural or foreseeable consequences of the joint criminal enterprise ... including sexual violence, can be attributable to participants in the criminal enterprise if committed during the time [the accused] participated in the enterprise.²⁴

There, the accused had been charged with crimes related to events that took place within three camps established in the North-West of Bosnia and Herzegovina, shortly after the Serb takeover of the city of Prijedor, to hold persons suspected of sympathising with the opposition to the takeover.²⁵ Although the tribunal found that the primary criminal enterprise was to persecute and subjugate non-Serbs detained in the camp,²⁶ it noted that the accused could also be held criminally responsible for acts of sexual violence committed during the time they participated in the enterprise, as these were natural and foreseeable consequences of that enterprise. As the tribunal reasoned:

In Omarska camp, approximately 36 women were held in detention, guarded by men with weapons who were often drunk, violent, and physically and mentally abusive and who were allowed to act with virtual impunity. Indeed, it would be unrealistic and contrary to all rational logic to expect that none of

20 *Akayesu* (n 10 above) para 692; *Prosecutor v Gacumbitsi* (7 July 2006) ICTR-2001-64-A, Appeals Judgment, para 185-87.

21 *Akayesu* (n 10 above) para 692; *Prosecutor v Nikolic* (18 December 2003) IT-94-2-S, Sentencing Judgment, para 119.

22 KD Askin ‘Prosecuting gender crimes committed in Darfur: Holding leaders accountable for sexual violence’ in S Totten & E Markusen (eds) *Genocide in Darfur: Investigating the atrocities in Sudan* (2006) 144.

23 *Prosecutor v Tadic* (15 July 1999) IT-94-1-A, Appeals Judgment, para 220.

24 *Prosecutor v Kvočka* (2 November 2001) IT-98-30/1-T, Trial Judgment, para 327.

25 *Kvočka* (n 24 above) paras 2 & 15-21.

26 *Kvočka* paras 319-20.

the women held in Omarska, placed in circumstances rendering them especially vulnerable, would be subjected to rape or other forms of sexual violence. This is particularly true in light of the clear intent of the criminal enterprise to subject the targeted group to persecution through such means as violence and humiliation.²⁷

Similarly, in the *Krstic* case, the Yugoslav tribunal found General Krstic guilty of the ‘incidental murders, rapes, beatings and abuses’ that occurred in the context of the intended forced massive transfers of Bosnian Muslims from Srebrenica because:

[T]here is no doubt that these crimes were the natural and foreseeable consequences of the ethnic cleansing campaign. Furthermore, given the circumstances at the time the plan was formed, General Krstic must have been aware that an outbreak of these crimes would be inevitable given the lack of shelter, the density of the crowds the vulnerable condition of the refugees, the presence of many regular and irregular military and paramilitary units in the area and the sheer lack of sufficient numbers of UN soldiers to provide protection.²⁸

Significantly, the tribunals have also recognised that, even if certain crimes are not part of the original intended criminal conduct, the recurrence of these crimes can become part of the original joint criminal enterprise if participants in the JCE know about them and take no effective measures to prevent them. As the ICTY explained in the *Krajisnik* case:

Whether other crimes were ‘original’ to the common objective or were added later is of course a matter of evidence, not logical analysis. The Chamber’s preference is for a strictly empirical approach which does not speculate about the crime-profile of the original JCE objective, but conceptualizes the common objective as fluid in its criminal means. An expansion of the criminal means of the objective is proven when leading members of the JCE are informed of new types of crime committed pursuant to the implementation of the common objective, take no effective measures to prevent recurrence of such crimes, and persist in the implementation of the common objective of the JCE. Where this holds, JCE members are shown to have accepted the expansion of means, since implementation of the common

27 *Kvočka* para 327. Note, however, that ultimately the Trial Chamber in *Kvočka* did not hold any of the accused responsible for crimes beyond the original criminal enterprise of persecuting non-Serbs. *Prosecutor v Kvočka* (28 February 2005) IT-98-30/1-A, Appeal Judgment, para 86 (*Kvočka* Appeal Judgment). Further, while the Trial Chamber convicted the accused of persecution as a crime against humanity, based in part on acts of rape and sexual assault, *Kvočka* (n 24 above) paras 752, 755, 758, 761 & 764, the Appeal Chamber later overturned this conviction with respect to the accused Kvočka on the basis that the Trial Chamber had failed to determine whether the rapes and sexual assaults occurred during Kvočka’s period of employment at the Omarska camp. *Kvočka* Appeal Judgment (above) paras 329-334.

28 *Prosecutor v Krstic* (2 August 2001), IT-98-33-T, Trial Judgment, para 616-17. See also *Prosecutor v Karemera & Others* (2 February 2012), ICTR-98-44-T, paras 1476, 1490 (finding the accused responsible for rapes and sexual assaults committed against Tutsi women and girls because these crimes were the natural and foreseeable consequences of the joint criminal enterprise to destroy the Tutsi population in Rwanda).

objective can no longer be understood to be limited to commission of the original crimes. With acceptance of the actual commission of new types of crime and continued contribution to the objective, comes intent, meaning that subsequent commission of such crimes by the JCE will give rise to liability under JCE form 1.²⁹

This has meant that the tribunals may hold participants in a JCE accountable when sexual violence that accompanies other criminal conduct recurs and remains unaddressed by those participants.³⁰ Again, these developments have had important implications for the prosecution of sexual and gender-based violence as, historically, crimes of sexual violence were perceived as 'incidental' or 'opportunistic' in relation to other 'core' crimes,³¹ and therefore, not subject to prosecution.

One other important development in this area relates to indirect criminal responsibility, which allows tribunals to hold an accused in a position of superior authority responsible for acts committed by his or her subordinates if he or she knew or should have known such crimes had been or were about to be committed and did nothing to prevent the crimes or punish the perpetrators.³² This theory was used, for instance, by the Rwanda tribunal in the *Nyiramasuhuko* case, to hold Pauline Nyiramasuhuko, the former Minister of Family and Women's Development in Rwanda and the first female accused to be brought before any international criminal tribunal, criminally responsible for rape, both as

29 *Prosecutor v Krajisnik* (27 September 2006) IT-00-39-T, Trial Judgment, para 1098.

30 See eg *Krajisnik* (n 29 above) paras 1098, 1105 & 1118. Although the Appeals Chamber later reversed the Trial Chamber's findings with respect to the accused's liability for the expanded crimes, it did so because the Trial Chamber had failed to make specific findings regarding, among other things, when leading JCE members became 'aware' of the commission of expanded crimes. *Prosecutor v Krajisnik* (17 March 2009) IT-00-39-A, Appeal Judgment, paras 170-178 (*Krajisnik* Appeal Judgment). Indeed, the Appeals Chamber explicitly noted that the Trial Chamber's approach – of deriving intent to commit the expanded crimes from 'acceptance of the actual commission of new types of crime and continued contribution to the objective' – did not constitute an error of law. *Krajisnik* Appeal Judgment (above) para 200.

31 See P Viseur Sellers & K Okuizumi 'International prosecution of sexual assaults' (1997) 7 *Transnational Law and Contemporary Problems* 61-62 (noting that '[s]exual assaults committed during armed conflict are often rationalized as the result of a perpetrator's lust, libidinal needs, or stress'); C Eboe-Osuji 'Rape and superior responsibility: International criminal law in need of adjustment' International Criminal Court Guest Lecture Series of the Office of the Prosecutor (2005) 6 (arguing that 'the theory of individualistic opportunism proceeds ... from the ... modest premise that rape is a crime of opportunity which, during conflict, is frequently committed by arms-bearing men, indulging their libidos, under cover of the chaotic circumstances of armed conflict').

32 ICTY Statute (n 5 above) art 7(3): 'The fact that any of the acts referred to in articles 2 to 5 of the present Statute was committed by a subordinate does not relieve his superior of criminal responsibility if he knew or had reason to know that the subordinate was about to commit such acts or had done so and the superior failed to take the necessary and reasonable measures to prevent such acts or to punish the perpetrators thereof.' See also *Prosecutor v Kordić & Čerkez* (17 December 2004) IT-95-14/2-A, Appeals Judgment, para 839.

a crime against humanity and as a war crime of outrages upon personal dignity.³³

3 Challenges remaining in the investigation and prosecution of sexual and gender-based violence in the context of mass atrocities

Despite these advances, considerable challenges remain in the effort to hold senior military and civilian officials accountable for crimes of sexual and gender-based violence, including (i) ambiguity in the jurisprudence regarding whether prosecuting rape in the context of mass atrocity crimes requires proof of ‘non-consent of the victim’; (ii) critique of theories of criminal responsibility that have been relied upon to find perpetrators – particularly top political or military leaders – accountable for crimes of sexual violence; and (iii) inadequate investigation and prosecution of crimes of sexual and gender-based violence, even where evidence of such crimes arguably warrants further investigation and/or prosecution.

3.1 Ambiguity regarding whether prosecuting rape in the context of mass atrocity crimes requires proof of non-consent of the victim

Notwithstanding the advances discussed in the previous section, the jurisprudence of the tribunals reflects ongoing tension about how to understand – and therefore how to prove – crimes of sexual violence in the context of conflict, mass violence or repression. In particular, the jurisprudence reflects ambiguity about whether to require ‘non-consent of the victim’ as an element in the prosecution of rape, and how to interpret that element.

For instance, although the first *ad hoc* tribunal case which addressed the legal elements of rape defined rape without reference to non-consent, requiring only that the prosecution show ‘a physical invasion of a sexual nature, committed on a person under circumstances which are coercive’,³⁴ later ICTY and ICTR cases introduced non-consent as an element of the crime by requiring proof that the sexual act was committed without the consent of the victim and that the perpetrator knew such consent was

33 *Prosecutor v Nyiramasuhuko & Others* (24 June 2011) ICTR-98-42-T, Trial Judgment, paras 6088 & 6183. In this case, the superior responsibility theory was critical, as the prosecution failed to charge Nyiramasuhuko with direct criminal responsibility despite significant evidence that she had issued direct orders for soldiers under her effective control to rape Tutsi women before loading them onto trucks and taking them to various places in Butare to be killed. *Nyiramasuhuko* paras 6087 & 6182.

34 *Akayesu* (n 10 above) para 598.

absent.³⁵ While the tribunals concede in these later cases that a lack of consent can be established through the ‘existence of coercive circumstances under which meaningful consent is not possible’,³⁶ the absence of consent remains central to the definition of rape, leading to a conflation of the concepts of non-consent and coercion.³⁷ Additionally, in its first case involving allegations of rape, the SCSL defined the elements of rape as including ‘non-consensual penetration’ of the victim.³⁸ Much like the *ad hoc* tribunals, the Special Court acknowledged that ‘[c]onsent of the victim must be given voluntarily, as a result of the victim’s free will, assessed in the context of the surroundings’, and that ‘in situations of armed conflict, coercion is almost always universal’,³⁹ yet it made it clear that the prosecution of rape, even in the context of mass atrocity crimes, requires proof of the non-consent of the victim. On the other hand, the ICC’s Elements of Crimes do not explicitly require that the prosecution establish a lack of consent.⁴⁰ Nevertheless, they do require a showing that the perpetrator committed a physical invasion of a sexual nature against the victim ‘by force, or threat of force or coercion, abuse of power, against such a person or another person, or by taking advantage of a coercive environment, or that the invasion was committed against a person incapable of giving genuine consent’.⁴¹ Notably, the Court has yet to interpret this phrase, and, as one commentator has noted, there is a risk that ‘judges of the ICC will deviate from the more principled focus on coercion ... and will [instead] attempt to embrace, in a single test, concepts [of non-consent and coercion]’⁴² that have marked the jurisprudence of the *ad hoc* tribunals.

As the former legal advisor on gender issues to the Yugoslav and Rwanda tribunals, Patricia Viseur Sellers, has noted, the existence of different and potentially-inconsistent international legal definitions of rape have the potential to undermine the extent to which survivors of rape can exercise their right to equal protection, in particular, their right to equal access to justice.⁴³ As Viseur Sellers cautions, the different definitions might well mean that ‘a 16 year-old girl victim of the Sierra Leone civil war

35 *Kunarac* (n 8 above) para 460; *Gacumbitsi* (n 20 above) para 153.

36 *Gacumbitsi* (n 20 above) para 153.

37 For a discussion of the non-consent issue in the jurisprudence of the international tribunals, see generally K. O’Byrne ‘Beyond consent: Conceptualising sexual assault in international criminal law’ (2011) 11 *International Criminal Law Review* 500-502 504-508.

38 *Prosecutor v Brima & Others* (20 June 2007) SCSL-04-16-T, Trial Judgment, paras 693 (AFRC Trial Judgment).

39 AFRC Trial Judgment (n 38 above) para 694.

40 ICC Elements of Crimes (n 14 above) arts 7(1)(g)-1, 8(2)(b)(xxii)-1 & 8(2)(e)(vi)-1.

41 As above.

42 Byrne (n 37 above) 513.

43 P Viseur Sellers ‘The prosecution of sexual violence in conflict: the importance of human rights as means of interpretation’ United Nations Office of the High Commissioner for Human Rights (2007) 27, http://www2.ohchr.org/english/issues/women/docs/Paper_Prosecution_of_Sexual_Violence.pdf (accessed 10 January 2012).

[is] less protected against gender violence than, for example, a 16 year-old girl whose perpetrator will be judged by the ICC'.⁴⁴

3.2 Critique of theories of criminal responsibility used to find top officials accountable for crimes of sexual and gender-based violence

A second obstacle to the prosecution of sexual and gender-based crimes is that the theories of criminal responsibility that courts have relied on to find perpetrators, particularly top political or military leaders, accountable for crimes of sexual violence have been either criticised or inconsistently applied in cases involving gender-based violence.

For instance, as mentioned earlier,⁴⁵ the JCE theory of liability allows tribunals to hold accountable perpetrators who intentionally take part in a JCE, not only for the intended crimes, but also for other crimes that were the natural and foreseeable consequences of the intended crimes. Yet, many remain critical of this theory of liability. Indeed, commentators have taken the position that this form of liability holds individuals liable for conduct too distant from the actions of the accused and, thus, 'endanger[s] the principle of individual and culpable responsibility by introducing a form of collective liability, or guilt by association'.⁴⁶ As one commentator has argued, this extended form of JCE liability might as well be called 'just convict everyone'.⁴⁷ Thus, even though this mode of liability has been useful in holding perpetrators of sexual and gender-based violence accountable,⁴⁸ it is unclear whether and to what extent it will continue to be used successfully to prosecute such crimes.

Perhaps more significantly, even modes of responsibility that are not as controversial – such as holding accused persons responsible on the theory of superior responsibility discussed above⁴⁹ – have been inconsistently applied in cases involving gender-based violence. As noted earlier, under the doctrine of superior responsibility, a superior can be held responsible for the acts of his or her subordinates where (i) a superior-subordinate relationship exists; (ii) the superior knew or had reason to know that the criminal act was about to be or had been committed; and (iii) the superior failed to take the necessary and reasonable measures to

44 Viseur Sella (n 43 above).

45 *Tadic* (n 23 above) and accompanying text.

46 S Manacorda & C Meloni 'Indirect perpetration versus joint criminal enterprise: Concurring approaches in the practice of international criminal law?' (2011) 9 *Journal of International Criminal Justice* 166-67. See also AM Danner & JS Martinez 'Guilty associations: Joint criminal enterprise, command responsibility, and the development of international criminal law' (2005) 93 *California Law Review* 111.

47 ME Badar 'Just convict everyone!' - Joint perpetration: From *Tadic* to *Stakic* and back again' (2006) 6 *International Criminal Law Review* 302.

48 See *Kvočka* (n 27 above) and accompanying text.

49 See nn 32-33 above and accompanying text.

prevent the criminal act or to punish the physical perpetrator thereof.⁵⁰ Although the tribunals have acknowledged that the knowledge element of the superior responsibility test can be established through circumstantial evidence,⁵¹ in the *Kajelijeli* case, the ICTR effectively applied a higher standard of evidence, refusing to find that the accused knew or had reason to know of numerous acts of sexual violence committed by his subordinates despite testimony placing him at the scene of the rapes or in the immediate vicinity of the rapes,⁵² and indicating that he had been present when his subordinates had told victims that they would be sexually assaulted,⁵³ as well as other evidence that he was ‘informed of all the acts perpetrated by his [subordinates]’, was in ‘permanent contact’ with them and received reports from them on what they had done.⁵⁴ Thus, although the tribunals have recognised that circumstantial evidence can be used to prove that a superior had reason to know crimes had been or were about to be committed by his subordinates, here the tribunal appeared to reject that standard, requiring direct evidence of a superior’s knowledge of his subordinates’ actions, either by showing that the accused was physically present at the scene of the crime or that he had given his subordinates direct orders to commit the crime.⁵⁵ As one commentator has noted:

While in theory it should not be particularly complicated to hold political/civilian or military leaders criminally responsible, either as individuals or as superiors, for sexual violence when the crimes are widespread or systematic, not to mention notorious, in practice there has been enormous reluctance to hold leaders and non-physical perpetrators accountable for sex crimes, as opposed to other crimes.⁵⁶

3.3 Inadequate investigation and prosecution of sexual and gender-based violence

Despite the jurisprudential advances mentioned above, international tribunals have been critiqued for inadequately investigating and prosecuting crimes of sexual and gender-based violence even where evidence of such crimes arguably warrants investigation and/or prosecution.⁵⁷ For instance, as indicated earlier, the statute of the SCSL

50 See n 32 above and accompanying text.

51 See eg *Prosecutor v Galic* (30 November 2006) IT-98-29-A, Appeals Judgment, paras 117, 182 & 518 (affirming, at least in principle, that a conviction of superior responsibility may be made on the basis of circumstantial evidence alone).

52 *Prosecutor v Kajelijeli* (1 December 2003) ICTR-98-44A-T, Trial Judgment, dissenting opinion of Ramaroson J paras 17, 19, 37, 42 & 73 (*Kajelijeli* Ramoroson dissenting opinion).

53 *Kajelijeli* Ramoroson dissenting opinion paras 19, 33 & 38.

54 *Kajelijeli* Ramoroson dissenting opinion paras 17 & 39.

55 *Kajelijeli*(n 52 above) paras 683 & 924.

56 Askin (n 22 above) 155.

57 See eg B Nowrojee “‘Your justice is too slow.’ Will the ICTR fail Rwanda’s rape victims?” United Nations Research Institute for Social Development Occasional Paper 10, 2005; S Kendall & M Staggs ‘Silencing sexual violence: recent developments in the CDF case at the Special Court for Sierra Leone’ University of California Berkeley War

includes a range of gender-based crimes against humanity and war crimes.⁵⁸ Nevertheless, despite significant evidence relating to crimes of sexual violence committed by the Civilian Defence Force (CDF) – a pro-government militia that fought during Sierra Leone’s 11-year civil war – the prosecution omitted any allegations with respect to these crimes in its initial indictment against the three leaders of the CDF.⁵⁹ Although it later moved to amend the indictment to include such crimes, the Court refused to allow the amendment.⁶⁰

A more recent example occurred in the case of Thomas Lubanga Dyilo, the first person tried by the ICC. Human rights groups criticised the Office of the Prosecutor (OTP) for failing to include sexual violence charges in the original indictment against Lubanga, despite allegations that girls had been kidnapped into Lubanga’s militia and were often raped and/or kept as sex slaves.⁶¹ Notwithstanding such criticism, the prosecutor refused to seek an amendment of the indictment against Lubanga to include gender-based crimes.⁶²

Crimes Studies Centre, 2005, http://socrates.berkeley.edu/~warcrime/Papers/Silencing_Sexual_Violence.pdf (accessed 10 January 2012); SM Pritchett ‘Entrenched hegemony, efficient procedure, or selective justice? An inquiry into charges for gender-based violence at the International Criminal Court’ (2008) 17 *Transnational Law and Contemporary Problems* 265; S SáCouto & K Cleary ‘The importance of effective investigation of sexual violence and gender-based crimes at the International Criminal Court’ (2009) 17 *American University Journal of Gender Social Policy and Law* 339; Women’s Initiatives for Gender Justice ‘Gender report card on the International Criminal Court’ 2005-2010, <http://www.iccwomen.org/publications/index.php> (accessed 10 January 2012).

58 See n 16 above and accompanying text.

59 *Prosecutor v Norman & Others* (4 February 2004) SCSL-03-14-I, Indictment, paras 22-29 (describing the multiple charges filed against Norman, Fofana and Kondewa, including murder).

60 *Prosecutor v Norman & Others* (20 May 2004) SCSL-04-14-PT, Decision on Prosecution Request for Leave to Amend the Indictment, para 10 (describing various crimes that were committed, including rape, sexual slavery and other inhumane acts).

61 See ‘DR Congo: ICC charges raise concern’ joint letter from *Avocats Sans Frontières et al* to the Chief Prosecutor of the International Criminal Court, 31 July 2006, http://hrw.org/english/docs/2006/08/01/congo13891_txt.htm (accessed 10 January 2012): ‘We are disappointed that two years of investigation by your office in the DRC has not yielded a broader range of charges against Mr Lubanga ... We believe that you, as the prosecutor, must send a clear signal to the victims in Ituri and the people of the DRC that those who perpetrate crimes such as rape, torture and summary executions will be held to account.’ Statement by the Women’s Initiatives for Gender Justice on the arrest of Germain Katanga’ Women’s Initiatives for Gender Justice Press Release, 18 October 2007: ‘The lack of charges for sexual violence against Lubanga was seen by many local DRC NGOs and ourselves to be a significant omission given the availability of information, witnesses and documentation from multiple sources including the United Nations and various human rights organisations showing the widespread commission of rape and other forms of sexualised violence by the UPC militia group.’ ‘ICC prosecutor leaves unfinished business in Ituri, DRC’ Redress Press Statement, 13 February 2008, revised 20 February 2008: ‘There is resentment that Thomas Lubanga and the UPC militia that he led are getting away too lightly. Arrested by the ICC in March 2006, Lubanga is said to be responsible for widespread killings and countless incidents of sexual violence. Yet, Lubanga has only been charged with recruiting and using child soldiers.’

62 *Prosecutor v Lubanga* (29 January 2007) ICC-01/04-01/06, Decision on the Confirmation of Charges.

Unfortunately, these are not isolated examples. According to a detailed analysis of trends in the prosecution of sexual violence in the Rwanda tribunal from November 1995 to November 2002, for instance, the number of indictments of sexual violence levelled-off between 1996 and 2001, and then decreased sharply through the end of 2002.⁶³ In two of the later cases in which crimes of sexual violence were charged, the prosecution later sought to withdraw the charges due to insufficient evidence.⁶⁴ Similar problems have occurred at the ICC. For instance, in the case against militia leaders Germain Katanga and Mathieu Ngudjolo, the prosecutor dropped charges of sexual slavery as both a war crime and a crime against humanity after a pre-trial chamber judge excluded the statements of witnesses supporting those charges on the grounds that the witnesses were not adequately protected.⁶⁵ The situation was resolved after the witnesses were eventually accepted into the Court's witness protection programme,⁶⁶ and the prosecution amended its charges not only to reinstate those relating to sexual slavery, but also to include allegations of rape as a war crime and a crime against humanity.⁶⁷ However, the tug-of-war over these victims' statements indicates the vulnerability of sexual violence charges if the supporting evidence is limited and subject to challenge. Notably, a recent report analysing charges for gender-based crimes at the ICC shows that

[t]hese charges are the most vulnerable category of crimes, in that they tend to be either omitted from filings or fail to reach the trial phase of the proceedings. This vulnerability is based on a number of factors involving both the Office of the Prosecutor and the pre-trial chambers, including failures at the investigation phase, insufficient evidence, incorrect characterisation of acts or restrictive interpretations of the definition of some gender-based crimes. In some instances, gender-based crimes have not always been fully investigated by the Office of the Prosecutor, or have not been included by the

- 63 G Breton-Le Goff 'Analysis of trends in sexual violence prosecutions in indictments by the International Criminal Tribunal for Rwanda (ICTR) from November 1995 to November 2002' (2002) 3, http://www.womensrightscoalition.org/site/advocacy/Dossiers/rwanda/rapeVictimssDeniedJustice/analysisoftrends_en.php (accessed 11 January 2012). See also Oosterveld (n 11 above) 127, citing Changing the International Tribunal letter from Human Rights Watch to UN Security Council Members, Rwanda and the Security Council, 1 August 2003 (noting a significant drop in the number of indictments, including charges for crimes of sexual violence from 1999 to 2003).
- 64 *Prosecutor v Ndindabahizi* (20 August 2003) ICTR-2001-71-I, Decision on Prosecution Motion for Leave to Amend Indictment, para 1; *Prosecutor v Muvunyi* (23 February 2005) ICTR 2000-55A-PT, Decision on the Prosecutor's Motion for Leave to File an Amended Indictment, para 54.
- 65 *Prosecutor v Katanga & Chui* (25 April 2008) ICC-01-04-01-07, Decision on Evidentiary Scope of the Confirmation Hearing, Preventive Relocation and Disclosure under Art 67(2) of the Statute and Rule 77 of the Rules, para 39 (allowing the testimony of a witness for whom the prosecution could show adequate protection, but barring the statements of two other witnesses who had not been included in the Witness Protection Programme).
- 66 *Prosecutor v Katanga & Chui* (28 May 2008) ICC-01/04-01/07, Decision on Prosecution's Urgent Application for the Admission of the Evidence of Witnesses 132 and 287, paras 6-7.
- 67 *Prosecutor v Katanga & Chui* (26 June 2008) ICC-01/04-01/07, Submission of Amended Document Containing the Charges Pursuant to Decision, paras 32-33.

Prosecutor in his request for an arrest warrant or summons to appear, even in situations where such information was provided to the prosecutor by NGOs. Charges for gender-based crimes have also not been included or have been minimally included in situations in which the prosecutor's request to open an investigation contains significant amounts of information showing that such crimes were committed.⁶⁸

In sum, sexual and gender-based crimes have often been left out of the prosecution's investigation or case against the accused, even where evidence of such crimes arguably warrants investigation and prosecution.

4 Looking at human rights law to fill the gaps

The obvious question raised by these challenges is: What can be done about them? One potential answer that has not received much attention is the application to these issues of one of the most fundamental principles in human rights law, namely, the principle of non-discrimination, in particular the requirement that access to justice be free from gender-based discrimination. As discussed below, the application of this principle to the analysis of the issues raised in the section above would require decision makers to take a gender-sensitive approach to such issues which, in turn, would help address the outstanding challenges that have made it difficult to hold senior military and civilian officials accountable for crimes of sexual and gender-based violence.

4.1 Connection between gender-based violence and gender-based discrimination

As the Committee that oversees states' compliance with the United Nations (UN) Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) acknowledged as early as 1992, '[g]ender-based violence is a form of discrimination that seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men'.⁶⁹ Regional human rights bodies have similarly emphasised that gender-based violence 'is one of the most extreme and pervasive forms of discrimination, severely impairing and nullifying the enforcement of women's rights'.⁷⁰ Indeed, gender-based violence is often a product of

68 Women's Initiatives for Gender Justice 'Gender report card on the International Criminal Court' 2011 (WIGJ 2011 ICC Gender Report Card) 122, <http://www.iccwomen.org/documents/Gender-Report-Card-on-the-International-Criminal-Court-2011.pdf> (accessed 10 January 2012).

69 CEDAW Committee General Recommendation 19 on violence against women, UN Doc HRI/GEN/1/Rev7 (1992) para 1.

70 *Jessica Lenahan (Gonzales) v United States*, Inter-American Commission of Human Rights, IAmComm of HR (21 July 2011), Case 12.626, Report 80/11, para 110.

discrimination, particularly the social, economic and political subordination of women and girls.⁷¹

Understanding this connection affects the way in which courts might analyse allegations of sexual and gender-based violence in two ways. First, it requires courts to acknowledge that gender-based violence and sexual violence, in particular, that take place during periods of conflict, mass violence or repression, are frequently part of a broader picture of discrimination. Indeed, it requires courts to recognise, for instance, that rape, forced nudity, sexual torture and other similar acts are often used to facilitate other crimes precisely because of the gendered way in which such crimes are viewed in many societies. For instance, deep and enduring social stigma often attaches to victims of gender crimes, enabling perpetrators not only to harm the individual victim, but also to tear at the fabric of her community.⁷²

In the case against the Revolutionary United Front (*RUF* case),⁷³ for example, the SCSL recognised how the RUF was able to rely on pre-existing societal discrimination against victims of sexual violence to accomplish their goal of terrorising civilians, noting that the sexual violence crimes they committed not only ‘abused, debased and isolated the individual victim’, but also ‘deliberately destroyed [their] existing family nucleus’.⁷⁴ By relying upon the societal stigma associated with sexual violence, they were able to ensure that ‘[v]ictims of sexual violence were ostracised, husbands left their wives, and daughters and young girls were unable to marry within their community’.⁷⁵ The Court therefore concluded that the RUF had adopted a ‘calculated and concerted pattern ... to use sexual violence as a weapon of terror’ against civilians, thereby breaking their will and ensuring their submission to RUF control.⁷⁶

71 CEDAW Committee General Recommendation 19 (n 69 above) para 11 (‘Traditional attitudes by which women are regarded as subordinate to men or as having stereotyped roles perpetuate widespread practices involving violence or coercion, such as family violence and abuse, forced marriage, dowry deaths, acid attacks and female circumcision. Such prejudices and practices may justify gender-based violence as a form of protection or control of women. The effect of such violence on the physical and mental integrity of women is to deprive them the equal enjoyment, exercise and knowledge of human rights and fundamental freedoms.’) See also JG Gardam & MJ Jarvis *Women, armed conflict and international law* (2001) 25.

72 See eg ‘Rape and sexual assault’ in *Final Report of the United Nations Commission of Experts established pursuant to Security Council Resolution 780 (1992)*, S/1994/674/Add.2, vol V, annex IX.I.C (1994); R Seifert ‘War and rape: A preliminary analysis’ in A Stiglmeier (ed) *Mass rape: The war against women in Bosnia-Herzegovina* (1994) 62-64.

73 *Prosecutor v Sesay & Others* (2 March 2009) SCSL-04-15-T, Trial Judgment (*RUF* case).

74 *RUF* case (n 73 above) para 1349.

75 As above.

76 *RUF* case (n 73 above) para 1347.

This fuller understanding helps to explain the interconnected, and cumulative, nature of harms in situations of conflict, mass violence or repression,⁷⁷ and therefore allows for a better evaluation of how to understand and charge gender-based crimes, how to link them to the accused and whether they should be investigated and prosecuted.

Second, acknowledging the link between gender-based violence and gender discrimination requires courts to examine how their interpretation of the elements of gender-based crimes and modes of responsibility in relation to such crimes – as well as whether gender-based crimes should be investigated in the first place – may impact the right of gender-based violence survivors to equal access to justice. Notably, the notion that the way in which international criminal tribunals address sexual and gender-based violence must adhere to the principle of non-discrimination found in human rights law is codified in the Rome Statute establishing the ICC, which in article 21(3) states:

The application and interpretation of the law pursuant to this article [including the Rome Statute, the Elements of Crimes and the Rules of Procedure and Evidence] must be consistent with internationally-recognized human rights, and be without adverse distinction founded on grounds such as gender.⁷⁸

Thus, as commentators have argued, '[w]hile it makes sense that ... human rights law cannot be used to define [international crimes such as persecution], such law can surely be used to aid interpretation where there is an absence of international criminal law jurisprudence'.⁷⁹ It is argued further that the principle of non-discrimination can and should guide courts when considering possible interpretations of ambiguous or uncertain provisions, or when certain actors within the court such as the prosecutor are tasked with exercising their discretion.

4.2 Using the non-discrimination principle to address challenges in the investigation and prosecution of sexual and gender-based violence in the context of mass atrocities

What does this mean in practice? The section below explores the question of how the non-discrimination principle can be used to interpret the requisite elements of sexual violence crimes – in particular the crime of rape – and the theories of criminal responsibility used to prosecute such crimes. Similarly, it examines the application of the non-discrimination

⁷⁷ For a discussion of the interconnected and cumulative nature of harms experienced by women in conflict, see F NíAoláin 'Exploring a feminist theory of harm in the context of conflicted and post-conflict societies' (2009) 35 *Queen's Law Journal* 235-236.

⁷⁸ Rome Statute (n 12 above) art 21(3).

⁷⁹ W Brown & L Grenfell 'The international crime of gender-based persecution and the Taliban' (2003) 4 *Melbourne Journal of International Law* 360-361.

principle to the question of what crimes or suspects should be selected for investigation and/or prosecution.

4.2.1 *Application of non-discrimination principle to crimes of rape and sexual violence*

As mentioned above, the jurisprudence and statutes of the international tribunals reflect ambiguity about whether to require ‘non-consent of the victim’ as an element in the prosecution of rape, and how to interpret that element. Similar uncertainty surrounds the interpretation of the Rome Statute’s ‘sexual violence’ clause that allows the Court to exercise jurisdiction over other serious sexual assaults of comparable gravity to the enumerated sexual and gender-based crimes.⁸⁰ Indeed, as with rape, the definition of sexual violence under the ICC Elements of Crimes requires proof that a perpetrator has committed an act of a sexual nature against the victim

by force, or threat of force or coercion, abuse of power, against such a person or another person, or by taking advantage of a coercive environment, or the invasion was committed against a person incapable of giving genuine consent.⁸¹

Although this definition appears to allow for an interpretation of sexual violence crimes based on the existence of coercive circumstance rather than the lack of consent, there is a risk, as mentioned above, that judges of the ICC will follow the jurisprudence of the *ad hoc* tribunals in adopting a single test which conflates the concepts of coercion and non-consent.⁸² The application of the non-discrimination principle to this issue leads to a few observations.

First, understanding the link between gender-based violence and gender-based discrimination requires putting the acts of sexual violence and, therefore, the issue of consent, into the broader context of the circumstances in which the alleged acts took place. This means that, rather than focusing primarily on the individual and whether she consented to the acts alleged, the courts should be asking questions about the context in which the acts took place and the vulnerability of the individual to such acts given that context. Notably, the idea of taking context into account when analysing cases involving rape is consistent with the approach taken by the European Court of Human Rights (European Court) which is tasked with monitoring states’ compliance with the European Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention).⁸³ For instance, in *MC v Bulgaria*, a case involving the rape of a 14 year-old girl with mental disabilities in a state where the

80 See n 12 above.

81 ICC Elements of Crimes (n 14 above) art 7(1)(g).

82 See Byrne (n 37 above) 513.

age of consent is 14, the investigators failed to prosecute the alleged perpetrators because of the absence of evidence of significant physical resistance by the victim.⁸⁴ Although not explicitly referring to the principle of non-discrimination, the Court held that the ‘development of law and practice in [this] area reflects the evolution of societies towards effective equality and respect for each individual’s sexual autonomy’.⁸⁵ As such, the lack of consent – interpreted through a ‘context-sensitive assessment of the evidence’⁸⁶ – rather than physical resistance by the victim was the appropriate focus of inquiry in assessing whether the victim had been raped.⁸⁷ As the Court concluded:

Any rigid approach to the prosecution of sexual offences, such as requiring proof of physical resistance in all circumstances, risks leaving certain types of rape unpunished, thus jeopardising the effective protection of the individual’s sexual autonomy.⁸⁸

Second, as other commentators have pointed out, an act of sexual violence will only qualify as an international crime if it was committed in circumstances which are almost always inherently coercive; that is, circumstances involving the intended destruction of a group of people (genocide), a widespread and systematic attack against civilians (crimes against humanity), or an armed conflict (war crimes).⁸⁹ In those circumstances, the issue of non-consent becomes largely irrelevant.⁹⁰

Third, so-called ‘gender-neutral’ crimes occurring in these contexts, such as torture, persecution, enslavement and inhumane acts, are not dependent upon the establishment of either the victim’s non-consent or the

83 European Convention for the Protection of Human Rights and Fundamental Freedoms 3 September 1953 213 UNTS 222, as amended by Protocols 3, 5, 8 and 11 which entered into force on 21 September 1970, 20 December 1971, 1 January 1990 and 1 November 1998 respectively.

84 *MC v Bulgaria* (2003) EHR 646.

85 *MC v Bulgaria* (n 84 above) para 165.

86 *MC v Bulgaria* (n 84 above) para 161.

87 *MC v Bulgaria* (n 84 above) para 165.

88 *As above*.

89 See eg W Schomburg & I Peterson ‘Genuine consent to sexual violence under international criminal law’ (2007) 101 *American Journal of International Law* 128-131.

90 Schomburg & Peterson (n 89 above) 138. Note that other commentators have argued that eliminating non-consent risks diminishing victims’ agency and autonomy. See eg K Engle ‘Feminism and its (dis)contents: Criminalising wartime rape in Bosnia and Herzegovina’ (2005) 99 *American Journal of International Law* 807. An excellent response to this contention – made in the context of an analysis of rape as torture – can be found in M Grahn-Farley ‘Examining Janet Halley’s critique of rape as torture’ in S Kuovo & Z Pearson (eds) *Feminist perspectives on contemporary international law: Between resistance and compliance?* (2011) 109-129, arguing that Halley’s analysis of rape as torture and as threatening to undermine victims’ agency is problematic because it disregards the facts of the *Kumarac* case on which Halley relies to make her argument, including the testimonies of the women and girls who were victims of rape in that case.

existence of coercive circumstances.⁹¹ If an act of physical and/or mental harm can be prosecuted as one of these crimes, where a lack of consent is not required, but the prosecution of rape continues to require proof of non-consent, survivors of rape whose cases are prosecuted as such may end up with more limited access to justice than survivors of other types of harm.⁹² Interestingly, in a number of cases, acts of sexual violence against men were prosecuted not as rape or acts of sexual violence, but as acts of persecution or other inhumane acts. In the ICTY case of *Prosecutor v Milosevic*, for instance, evidence showing that men were forced to engage in oral sex with other men was charged not as rape but as persecution,⁹³ thereby avoiding the issue of consent. Similarly, in the ICC case of *Prosecutor v Mathuara & Others (Mathuara case)*, the pre-trial chamber characterised acts of forcible circumcision as ‘other inhumane acts’,⁹⁴ despite the fact that the prosecutor had classified them as a form of sexual violence,⁹⁵ again circumventing the potentially-thorny question of how to interpret the coercion requirement. Notably, in the *Mathuara* case, the chamber did not explain why forced circumcision was not a form of sexual violence, noting only that the acts alleged were ‘more properly qualified’ as ‘other inhumane acts’ ‘in light of the serious injury to body that forcible circumcision causes, and in view of its character, similar to other underlying acts constituting crimes against humanity’.⁹⁶ As one commentator has noted, ‘[c]haracterising male sexual assault acts under crimes such as torture or inhumane acts [rather than rape or sexual violence] and possibly privilege[s] male victim/survivors over women’.⁹⁷ Conversely, requiring proof of non-consent in cases prosecuted as rape or sexual violence may undermine the extent to which survivors of such crimes can exercise their right to equal access to justice.

Although the issue could certainly benefit from further study, at a minimum, the analysis above suggests that in resolving potentially-ambiguous language related to the prosecution of rape and sexual violence, including whether non-consent should be required, courts should

91 See ICC Elements of Crimes (n 14 above) art 7(1)(f) (defining the crime against humanity of torture); art 7(1)(h) (defining the crime against humanity of persecution); art 7(1)(c) (defining the crime against humanity of enslavement); and art 7(1)(k) (defining the crime against humanity of other inhumane acts).

92 Moreover, even if rape is prosecuted as one of these other crimes, such as torture or persecution, there is a risk that survivors of rape would still be subject to questions of consent, as acts amounting to rape would be at the heart of the prosecution.

93 *Prosecutor v Milosevic* (22 November 2002) IT-02-54-T, Amended Indictment, para 35(c); *Prosecutor v Milosevic* (6 May 2003) IT-02-54-T, transcript http://icty.transcripts.dyndns.org/trials/slobodan_milosevic/030506IT.htm (accessed 13 January 2012) (testimony of male witness regarding incident where men were forced to engage in oral sex with other men).

94 *Prosecutor v Mathuara & Others* (8 March 2011) ICC-01/09-02/11, Decision on the Prosecutor’s Application for a Summons to Appear for Francis Kirimi Muthaura, Uhuru Muigai Kenyatta and Mohammed Hussein Ali, para 27.

95 *Mathuara* case (n 94 above) para 27.

96 *Mathuara* case (n 94 above) para 27.

97 Viesur Sellers (n 43 above) 39.

be particularly wary of interpretations that might result in discrimination against survivors of such crimes.

4.2.2 Application of non-discrimination principle to modes of criminal responsibility

Similar observations apply with respect to the challenges discussed above regarding the theories of responsibility that courts have relied upon to hold perpetrators of gender-based violence accountable. When sexual and gender-based violence is understood as part of a broader picture of discrimination, and therefore seen in the broader context in which it occurs, courts are better able to recognise, as the Special Court did in the *RUF* case,⁹⁸ how sexual violence can contribute to a perpetrator's goals of destruction or persecution, not only of the survivor, but also of the group or community to which she belongs. Understood this way, sexual violence crimes that at first might not appear to be part of a group's common criminal purpose could be properly characterised as such, avoiding the need to rely on the controversial JCE theory of liability, which allows an accused to be held criminally liable for the natural and foreseeable consequences of a group's intended crimes.⁹⁹

At the same time, the recognition of the link between sexual and gender-based violence and gender-based discrimination also creates an incentive for courts to question whether they are, in fact, requiring a higher level of proof when assessing certain modes of liability, such as superior responsibility in cases involving sexual and gender-based crimes than in other types of cases and, if so, whether they are effectively undermining the right of survivors of sexual and gender-based violence to equal access to justice.

4.2.3 Application of the non-discrimination principle to the selection of crimes and suspects for investigation and/or prosecution

Finally, the non-discrimination principle could also help answer the question of whether sexual and gender-based crimes should be selected for investigation and prosecution. As mentioned earlier, historically, sexual and gender-based crimes were rarely prosecuted. Indeed, sexual violence offences, particularly against women and girls, were often ignored, seen as an inevitable by-product of war, or considered less important than other forms of violence.¹⁰⁰ The harm inherent in acts of sexual violence was thus

98 See nn 73-76 above and accompanying text.

99 See nn 46-47 and accompanying text.

100 See n 3 above and accompanying text.

compounded by the discriminatory characterisation of those acts as falling outside the boundaries of core international crimes.¹⁰¹ As commentators have noted, the prosecution of sexual and gender-based violence crimes today marks a break with the past history of discriminatory marginalisation of such crimes.¹⁰² Indeed, the public prosecution of these crimes constitutes a 'form of political recognition for women' – an acknowledgment that the harms women experience during conflict, mass violence or repression should be 'treated seriously by an international community that previously ignored them'.¹⁰³ In the light of this history, applying the non-discrimination principle to the question of which crimes should be selected for investigation and prosecution suggests that sexual and gender-based crimes should feature prominently in a prosecutor's investigation and charging strategy from the outset.

This view is supported by article 21(3) of the Rome Statute which, as noted above, requires the application and interpretation of the Court's governing documents to 'be consistent with internationally-recognised human rights, and be without any adverse distinction founded on grounds such as gender'.¹⁰⁴ The provision has been characterised as one of the 'more important provisions of the Rome Statute',¹⁰⁵ and included to 'reaffirm the international community's commitment to the principle of non-discrimination in the context of the International Criminal Court'.¹⁰⁶ Prioritising the investigation and prosecution of crimes historically marginalised by the international community is arguably what article 21(3) requires.

5 Conclusion

In sum, it is submitted that the tribunals have had a mixed record at best when it comes to the prosecution of gender crimes. Significant advances have been made in the effort to end impunity for sexual and gender-based violence committed in the context of war, mass violence or repression. However, persistent challenges remain. It is hoped that the application of the fundamental human rights principle of non-discrimination will encourage international tribunals to develop a better, more nuanced

101 See eg GJ McDougall 'Contemporary forms of slavery, systematic rape, sexual slavery and slavery-like practices during armed conflict' 22 June 1998 E/CN.4/Sub.2/1998/13, para 18 (noting that 'even more damaging than the veil of silence that surrounds rape and sexual violation is the tendency to marginalise acts of violence when committed against women'). Notably, the absence of effective responses to gender-based violence committed in 'peace time' has also been found to constitute discrimination. See *Jessica Lenahan (Gonzales) v United States* (n 70 above) paras 160-63.

102 D Buss 'Performing legal order: Some feminist thoughts on international criminal law' (2011) 11 *International Criminal Law Review* 409.

103 Buss (n 102 above) 414.

104 Rome Statute (n 12 above) art 21(2).

105 Steains (n 3 above) 371; M deGuzman 'Article 21, applicable law' in O Triffterer (ed) *Commentary on the Rome Statute of the ICC* (2008) 712.

106 DeGuzman (n 105 above) 712.

understanding of when, why and how sexual violence takes place during conflict or other instances of mass violence and, therefore, assist them in better evaluating how the elements of sexual violence crimes should be interpreted, what theories of criminal responsibility can and should be used to prosecute such crimes, and/or whether such crimes should be selected for investigation and prosecution.

It goes without saying that the application of this principle hinges, in large part, on the acquisition of increased gender competence and gender expertise among the investigators, prosecutors and judges tasked with adjudicating these crimes. While progress has been made in this regard, there is still a long way to go.¹⁰⁷ If the tribunals continue to operate on the basis of limited gender competence and expertise, they risk permitting and promoting discriminatory interpretations of the laws, rules and policies that affect the potential for redress for victims of sexual and gender-based violence. In doing so, they risk failing to achieve one of the most fundamental aims of the international justice system: to ensure that 'the most serious crimes of concern to the international community as a whole [do] not go unpunished'.¹⁰⁸

107 Eg, despite the fact that art 44(2) of the Rome Statute requires the prosecutor and the registrar to consider the importance of legal expertise on violence against women in hiring staff within their respective organs, commentators have highlighted that gender expertise remains limited at the ICC. See eg Women's Initiatives for Gender Justice 'Gender report card on the International Criminal Court' (2010) 64, http://www.iccwomen.org/news/docs/GRC10-WEB-11-10-v4_Final-version-Dec.pdf (accessed 13 January 2012) 62 (recommending the appointment of 'more staff with gender expertise' in the ICC's Office of the Prosecutor in order to 'ensure the integration of gender issues within the heightened case load expected for 2011', noting that '[g]ender expertise within the OTP is essential ... to support institutional capacity on these issues, and to enhance the integration of gender issues in the discussions and decisions regarding investigations, the construction of case hypotheses, the selection of cases and prosecution strategy').

108 Rome Statute (n 12 above) Preamble.

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Summary

The concept of sexual rights consists of sets of rights recognised under international and regional human rights instruments, including everyone's right to enjoy freedom from coercion, discrimination and violence around sexuality, irrespective of their sexual orientation or gender identity. The violation of these sexual rights can be both a cause and consequence of poverty. The aim of this chapter is to frame the linkage between violations of women's sexual rights and poverty in the African context. Any effort towards the eradication of poverty in the region improves the realisation and protection of the sexual rights of women. Realising sexual rights, in turn, helps to end poverty.

1 Introduction

The concept of sexual rights consists of sets of rights that everyone should enjoy, including freedom from coercion, discrimination and violence around sexuality irrespective of their sexual orientation or gender identity. Sexual rights embrace human rights that are already recognised under international and regional human rights documents and other consensus statements. However, the realisation of women's sexual rights in practice depends on crucial enabling conditions. Deciding about sexual autonomy is not possible without full information about safer sex, the possibility of preventing the body from being violated by others, the opportunity to protect oneself from unwanted pregnancy or the freedom to express and enjoy one's sexual orientation without fear of violence or discrimination.

Women's lack of realisation of human rights is not reducible to an issue of poverty. However, women's inability to enforce human rights means that they are more vulnerable to poverty than men. Poverty drives women into activities where they become vulnerable to human rights abuses. Acknowledging the importance of sexuality as a determinant of

poverty would be a step in the right direction. Attacking poverty improves the protection and realisation of the sexual rights of women.

The aim of this chapter is to frame the linkage between violations of women's sexual rights and poverty in the African context. This contribution recognises that women in Africa do not form a homogenous group. Different groups, such as rural women, women in urban settings, elderly women, HIV-positive women, women with disabilities, refugee women, internally-displaced women and women in pastoralist communities have specific needs that require looking at the intersections within the uneven power system for interventions. The first section explores sexual rights under the African human rights system. The second section briefly discusses the concept of poverty, while the final section is dedicated to a discussion that explores the connections between the denial of sexual rights and poverty. The intersection of sexuality and poverty has a wide spectrum. However, the discussion in this chapter is limited to three focus areas: reproductive decision making, sexual violence, and discrimination based on sexual orientation and the linkage with poverty. The chapter concludes with a reflection on how to maximise the synergies between poverty reduction endeavours and the recognition of sexual rights of women in Africa.

2 Sexual rights under African human rights system

The concept of sexual rights consists of sets of rights that everyone should enjoy, including freedom from coercion, discrimination and violence around sexuality whatever their sexual orientation or gender identity. The World Health Organisation (WHO) defines sexual rights as human rights that are already recognised in regional and international human rights documents and other consensus statements.¹ These include the right of all persons to be free from coercion, discrimination and violence; the right to the highest attainable standard of sexual health, including access to sexual and reproductive healthcare services; the right to seek, receive and impart information relating to sexuality; sexuality education; respect for bodily integrity; the right to choose their partner; the right to decide to be sexually active or not; the right to consensual sexual relations; the right to consensual marriage; the right to decide whether or not and when to have children; and the right to pursue a safe, satisfying and pleasurable sexual life.

Hence, sexual rights are rights around sexuality which are relevant to all human beings. Commentators have also underlined that sexual rights

1 WHO http://www.who.int/reproductive-health/gender/sexual_health.html#2 (accessed 25 August 2012).

embrace human rights that are already recognised under international human rights instruments and consensus documents.² Therefore, sexual rights offer the potential of an approach that goes beyond identity politics. Instead of rights being associated with particular categories of people, such as women, gay men, lesbians and transgender people, sexual rights imply that everyone should have the right to personal fulfilment and freedom from coercion, discrimination and violence around sexuality.³

The African Charter on Human and Peoples' Rights of 1981 (African Charter), the main regional instrument, enshrines provisions that protect the sexual rights of individuals. Among these provisions are the rights to the respect and dignity inherent in a human being;⁴ freedom from inhuman and degrading treatment;⁵ liberty and security of the person;⁶ and the right to enjoy the highest attainable state of physical and mental health.⁷ The African Charter also emphasises that states must undertake to adopt legislative or other measures to give effect to the rights in the African Charter.⁸

Although the African Charter is the primary treaty providing a framework for human rights in the region, over time, it became clear that the issue of gender was not being given serious consideration at the institutional level.⁹ The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol)¹⁰ resulted from years of activism by women's rights supporters in the region. The African Women's Protocol seeks to reinvigorate the African Charter's commitment to women's equality by adding rights relevant to African women and clarifying governments' obligations with respect to women's rights.

2 A Miller 'Sexual but not reproductive: Exploring the junction and disjunction of sexual and reproductive rights' (2000) 4 *Health and Human Rights* 70. Also see generally R Petchesky 'Sexuality rights: Inventing a concept, mapping international practice' in RG Parker (ed) *Framing the sexual subject: The politics of gender, sexuality and power* (1999); S Correa & S Jolly 'Sexuality, development, and human rights' unpublished paper commissioned for the Swedish Ministry of Foreign Affairs Expert Group on Development Issues workshop 'Sexual rights, development and human rights: Making the linkages' (2006) 9; B Klugman 'Sexual rights in Southern Africa: A Beijing discourse or a strategic necessity?' (2000) 4 *Health and Human Rights* 145; C Ngwenya 'Sexuality rights as human rights in Southern Africa with particular reference to South Africa' (2002) 15 *South African Public Law* 1 2.

3 Miller (n 2 above) 71.

4 See art 5 of the African Charter on Human and Peoples' Rights OAU Doc CAB/LEG/67/3/Rev 5, adopted by the Organisation of African Unity, 27 June 1981, entered into force 21 October 1986.

5 As above.

6 Art 6 African Charter.

7 Art 16(1).

8 Art 1.

9 F Banda *Women, law and human rights: An African perspective* (2005) 66.

10 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, adopted by the 2nd ordinary session of the African Union General Assembly in 2003 in Maputo, Mozambique, CAB/LEG/66.6 (2003).

From the perspective of sexual rights, the African Women's Protocol provides broad protection for women in Africa. For example, the Women's Protocol is the first human rights instrument in the world to explicitly set forth the reproductive rights of women to medical abortion when pregnancy results from sexual assault, rape or incest, or when the continuation of a pregnancy endangers the health or life of the mother, or when there is danger to the life of the foetus.¹¹ In addition, the Women's Protocol calls for an end to all forms of violence against women, including unwanted or forced sex, whether it takes place in private or in public, and a recognition of protection from sexual and physical violence as inherent in the right to dignity.¹²

The African Women's Protocol is the only treaty to specifically address women's rights in relation to HIV. In addition to guaranteeing women's rights to protection from sexually-transmitted infections, including HIV, the Women's Protocol guarantees women's rights to adequate, affordable and accessible health services.¹³ It also articulates the state's duty to protect girls and women from practices and situations that increase risk of infection, such as child marriage, sexual violence in times of conflict, and female genital mutilation.

3 Understanding poverty

There is little agreement over the definition of poverty. Hence, there are different approaches to defining poverty and each has different policy implications.¹⁴ Among these approaches, the capabilities approach is the most inspiring one. The capabilities approach, developed by Sen *et al*, argues that development should be seen as the expansion of human capabilities.¹⁵ Poverty is understood to be much broader than material deprivation. Sen mentions five distinct freedoms: political freedoms; economic facilities; social opportunities; transparency guarantees; and protective security. Freedom, he says, is a principal determinant of individual initiative and social effectiveness. Freedom is good, primarily because it enhances the ability of individuals to help themselves.¹⁶

Nussbaum adopted Sen's capabilities approach and expanded on its gender dimensions.¹⁷ She notes that there is a strong correlation between gender inequality and poverty, which leads to an 'acute failure of central

11 Art 14 African Women's Protocol.

12 Art 2.

13 Art 14.

14 R Laderchi *et al* 'Does it matter that we do not agree on the definition of poverty? A comparison of four approaches' (2003) 31 *Oxford Development Studies* 245.

15 See generally A Sen *Development as freedom* (1999).

16 As above.

17 See generally MC Nussbaum *Women and human development: The capabilities approach* (2000).

human capabilities'. Nussbaum argues that the capabilities approach is especially important for understanding both the vulnerability of women to poverty and the vulnerability of poor women, since many of their problems and the underlying causes are invisible from the perspective and assumptions of a conventional economist.¹⁸

International and regional human rights treaties have recognised that women must be empowered to overcome poverty, exploitation, social inferiority and dependence for the sake of justice and securing the human rights of half of the human race. Although women's lack of realisation of human rights is not reducible to an issue of poverty, there is a circular relationship between poverty and sexuality. Poverty drives women to activities where they become vulnerable to human rights abuses. Tackling poverty, therefore, improves the protection and realisation of the sexual rights of women.

4 Denial of sexual rights and poverty: What are the connections?

Few studies and reports examine the relationship between poverty and the denial of sexual rights. However, emerging literature by researchers, activists and organisations shows that, in many cases, poor people are more vulnerable to oppression around sexuality, and that the denial of sexual rights entrenches poverty.¹⁹

Taking a rights-based approach to sexuality is an important part of the struggle to achieve equality, to end violence and to achieve economic justice.²⁰ The principle of the integral nature and indivisibility of human rights implicates the interdependence of sexual rights with other rights, such as the rights to health, housing, food and employment, as enshrined under African human rights instruments. In the sub-sections below, this chapter explores the link between violations of sexual rights, as envisaged under different African human rights instruments, and poverty.

4.1 Discrimination based on sexual orientation and its link to poverty

The Universal Declaration of Human Rights (Universal Declaration) guarantees full and equal human rights for all, including the right of every

18 As above.

19 Swedish International Development Cooperation (SIDA) 'Poverty and sexuality: What are the connections? Overview and literature review' (2010) <http://www.globalequality.org/storage/documents/pdf/sida%20study%20of%20poverty%20and%20sexuality.pdf> (accessed 12 May 2014).

20 K. Sheill 'Sexual rights are human rights: But how can we convince the United Nation?' (2006) 37 *Institute of Development Studies Bulletin* 40 41.

person to protection against discrimination.²¹ Subsequent international human right instruments have guaranteed individuals' rights to non-discrimination and equal protection of the law.²² Although these instruments do not include 'sexual orientation' among the enumerated protected categories, it is accepted that the enumerated categories are intended to be illustrative and not exhaustive. The use of the phrase 'other status' means that the list of categories is open-ended. The United Nations (UN) Committee on Economic, Social and Cultural Rights (ESCR Committee) supports this approach.²³ The ESCR Committee has explained that the term 'other status' includes social groups that are not enumerated, but which are commonly recognised as vulnerable and marginalised social groups. Similarly, decisions of UN treaty bodies have made it clear that discrimination on the basis of sexual orientation is prohibited under international law and, furthermore, that the criminalisation of same-sex conduct is a form of prohibited discrimination.²⁴

The issue of discrimination based on sexual orientation is receiving more attention and support within the UN. On 17 June 2011, a resolution condemning discrimination based on a person's sexual orientation and gender identity was passed by the UN Human Rights Council – the first of its kind.²⁵ The resolution expresses 'grave concern at acts of violence and discrimination, in all regions of the world, committed against individuals because of their sexual orientation and gender identity'.²⁶

Under the African regional human rights system, the African Charter in its Preamble states that freedom, equality, justice and dignity are essential objectives for the achievement of the legitimate aspirations of African people.²⁷ More specifically, the African Charter guarantees the right to equality and entitlement to equal protection of the law to all individuals.²⁸ It provides that individuals are entitled to the rights under the African Charter 'without distinction of any kind such as race, ethnic group, colour, sex, language, religion, political or any other opinion, national or social origin, fortune, birth or other status'. The use of the phrases 'such as' and 'other status' clearly shows that the prohibited grounds for non-discrimination are not exhaustive. This provision implies

21 Universal Declaration of Human Rights arts 1 & 2.

22 International Covenant on Civil and Political rights arts 2(1) & 26; art 2(2) International Covenant on Economic, Social and Cultural Rights.

23 ESCR Committee General Comment 20 para 27.

24 See generally *Toonen v Australia*, Communication 488/1992, UN Doc CCPR/C/50/D/488/1992, 4 April 1994 para 8.7; *Edward Young v Australia*, Communication 941/2000, UN Doc CCPR/C/78/D/941/2000, 12 August 2003; *X v Colombia*, Communication 1361/2005, UN Doc CCPR/C/89/1361, 30 March 2007.

25 United Nations General Assembly, Human Rights Council 'Human rights, sexual orientation and gender identity' A/HRC/17/L.9/Rev1 15 June 2011.

26 As above.

27 African Charter Preamble, paras 3-4.

28 Art 2 African Charter.

that sexual minorities, by virtue of their status as equal human beings, are entitled to the same enjoyment of fundamental rights and freedoms as other human beings. On the basis of articles 60 and 61 of the African Charter, reliance is also placed on the General Comment of the ESCR Committee, which deals with article 2 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), the non-discrimination clause, including the proscription of discrimination based on sexual orientation.²⁹

Furthermore, the African Commission on Human and Peoples' Rights (African Commission) observed in *Zimbabwe Human Rights NGO Forum v Zimbabwe*:

Together with equality before the law and equal protection of the law, the principle of non-discrimination provided under article 2 of the Charter provides the foundation for the enjoyment of all human rights ... The aim of this principle is to ensure equality of treatment for individuals irrespective of nationality, sex, racial or ethnic origin, political opinion, religion or belief, disability, age or sexual orientation.³⁰

Despite such reaffirmation of equal legal protection and enjoyment of rights under different international and regional human right instruments, the protection from abuse remains elusive for sexual minorities in Africa. In many African countries, sex between two people of the same sex is still a crime, and public displays of affection between such people are considered indecent acts. The criminalisation of homosexuality in Africa is a colonial legacy. Most laws criminalising same-sex relationships were introduced by colonial powers during the twentieth century. At independence, virtually all African jurisdictions inherited statutes, mainly in the form of penal codes that proscribed and punished same-sex behaviour.³¹ The criminalisation of same-sex behaviour has grave consequences for sexual minorities, as it prevents them from exercising and enjoying the rights enshrined under international and regional human right laws. There are many documented incidences of unlawful arrest and abuse by the state of individuals in Africa on the basis of sexual orientation.³²

29 General Comment 20 (n 23 above) para 27.

30 (2006) AHRLR 128 (ACHPR 2006) para 169.

31 Ngwena (n 2 above) 84.

32 In Botswana in 1995, two men were arrested and convicted on sodomy charges stemming from a private sexual act. In Cameroon, 11 men spent more than a year in prison before seven of them were convicted on sodomy charges in 2006. In Senegal in February 2008, suspected homosexuals were attacked by mobs and ten people – nine men and one woman – were arrested after photographs taken at a private gay wedding reception were published in a magazine. There have been several trials in Northern Nigeria in the last five years in which the death penalty was the proposed punishment. See generally J Rukweza *Sexual orientation under the African Charter on Human and Peoples' Rights* (2006) <http://pambazuka.org/en/category/features/68953> (accessed 13 May 2014).

Instead of protecting the rights of lesbian, gay, bisexual and transsexual (LGBT) persons, politicians and religious leaders across Africa have actively condemned them and called for their persecution. Many political leaders have consistently and vehemently denied or overlooked the existence of same-sex relationships, persistently claiming that it is 'un-African' and fuelling hatred of homosexuals, and inciting violence. For instance, senior government officials from Zimbabwe,³³ Uganda,³⁴ Namibia³⁵ and Cameroon³⁶ have made statements condemning homosexuality.

The assertion of a public lesbian identity is particularly problematic in an African context. Commentators have emphasised that 'love between women is as natural to Africa as the soil itself, but that homophobia is a Western import'.³⁷ Lesbian unions have not been viewed as an alternative to heterosexual marriage, which is both a sexual and economic part of the predominant culture.³⁸ At a conference on Sexual Health and Rights in Nairobi in June 2006, openly lesbian and gay Africans presented a panel titled 'The big question: Is homosexuality un-African?' in which Fikile Vilakazi, from the Coalition of African Lesbians, underlined that 'lesbianism is as old as African history'.³⁹

South Africa stands apart when it comes to the legal status of LGBTs in Africa.⁴⁰ South Africa's Constitution is the first in the world to prohibit unfair discrimination on the grounds of sexual orientation.⁴¹ A number of decisions handed down by the South African Constitutional Court have confirmed that section 9 of the South African Constitution, which prohibits discrimination on the ground of sexual orientation, prohibits the state from unfairly discriminating against gays and lesbians. The Constitutional Court has confirmed that the prohibition of unfair

33 O Phillips '(Dis)continuities of custom in Zimbabwe and South Africa: The implication for gendered and sexual rights' (2004) 7 *Health and Human Rights* 84.

34 Rukweza (n 32 above).

35 As above.

36 As above.

37 J Cock 'Engendering gay and lesbian rights: The equality clause in the South African Constitution' (2003) 26 *Women's Studies International Forum* 39.

38 See generally O Phillips 'Constituting the global gay: Issues of individual subjectivity and sexuality in Southern Africa' in C Stychin & D Herman (eds) *Law and sexuality: The global arena* (2001) 17.

39 See the Conference Digest Newsletter for the 2nd Africa Conference on Sexual Health and Rights, 21 June 2006 <http://www.popcouncil.org/pdfs/SHRConferenceNewsletter3.pdf> (accessed 25 August 2013).

40 See Phillips (n 33 above) 19 for a discussion why the South African Constitution did not weaken the equality clause with any exemptions from customary law. See also E Cameron 'Sexual orientation and the Constitution: A test case for human rights' (1993) 110 *South African Law Journal* 451; C Undie & K Benaya 'The state of knowledge on sexuality in sub-Saharan Africa: A synthesis of literature' (2006) 8 *JENDA: A Journal of Culture and African Women Studies* 7.

41 Sec 9(3) of the South African Constitution states: 'The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.'

discrimination on the basis of sexual orientation requires states to respect and protect the human dignity of gay men, lesbians and other sexual minorities.⁴²

In the landmark case of *National Coalition for Gay and Lesbian Equality & Another v Minister of Justice & Others*, the South African Constitutional Court found that the common law offence of sodomy, which was aimed at prohibiting sexual intimacy between men, violated the right to equality in that it unfairly discriminated against gay men on the basis of sexual orientation.⁴³ Such discrimination is presumed to be unfair, since the Constitution expressly includes sexual orientation as one of the prohibited grounds for unfair discrimination. The Court therefore concluded that the common law offence of sodomy and its inclusion in certain statutory schedules and the Sexual Offences Act were not reasonable or justifiable limitations on the rights of gay men to equality, dignity and privacy.⁴⁴

However, notwithstanding the constitutional recognition of same-sex relationships, public perceptions towards such relationships remain negative.⁴⁵ For example, lesbian women who take attributes of masculinity in dress code, behaviour and appearance are often punished for this subversion with corrective rape. Corrective rape becomes a means of pushing lesbian women back into the traditional heterosexual perception of womanhood.⁴⁶ This shows that lesbians in South Africa continue to experience egregious violations of their human rights.

Putting matters to the extreme, in Somalia, lesbian couples were sentenced to death after being found guilty of 'exercising unnatural behaviour'.⁴⁷ This is so regardless of the fact that Somalia does not have specific laws governing homosexuality, and the conviction was loosely based on Shari'a. This case shows that there is often little connection

42 See the following decisions of the Constitutional Court of South Africa on issues involving gay and lesbians rights: *National Coalition for and Lesbian Equality & Another v Minister of Justice & Others* 1999 (1) SA 6 (CC); *Du Toit & Another v Minister of Welfare and Population Development & Others* 2002 10 BCLR 1006 (CC); *Satchwell v The President of the Republic of South Africa* 2002 (6) SA 1 (CC). See also *J & B v Director-General of Home Affairs & Others* 2003 (5) SA 621 (CC).

43 *National Coalition for and Lesbian Equality & Another v Minister of Justice & Others* (n 42 above) para 28.

44 As above.

45 See Human Rights Watch press release on violence against lesbians in South Africa following the murder of three lesbians by a mob on the Cape Flats on 6 July 2007, stating that, despite legal commitments to equality for all, lesbians in South African townships are still targeted for rape and murder. The press release urged the South African government to reaffirm equality before the law and to launch public education campaigns to eliminate homophobic prejudice in all walks of life, <http://www.hrw.org/english/docs/2006/03/02/safric12753.htm> -14k (accessed 25 August 2013).

46 L di Silvio 'Correcting corrective rape: Carmichele and developing South Africa's affirmative obligations to prevent violence against women' (2011) 99 *Georgetown Law Journal* 1485.

47 See International Lesbian and Gay Association 'The legal status of homosexuality in Africa' http://www.pcsproud.org.uk/rep_black_members_feature28.html (accessed 26 August 2013).

between the strict legal position and what obtains in practice. The Shari'a Court in Somalia appears to have based its findings and sentence on the need to appease the public that was outraged by the mere existence of homosexuality in Somalia.⁴⁸

The above discussion shows that many lesbians and gay men in Africa live in a climate of prejudice and hostility. Those who depart from the norm of heterosexuality face discrimination in their communities and workplaces, which can extend to an outright denial of their humanity. This has serious ramifications for lesbians and gay men, such as diminished employment opportunities, eviction from housing and other challenges. Many lesbians and gay men avoid discrimination by not disclosing their sexual orientation, but this may lead to significant social and psychological problems. People who hide their sexual orientation for fear of discrimination or alienation live less fulfilling lives. They may experience stress and find themselves in situations that are not conducive to safe sexual practices. As a consequence, sexual minorities face a high risk of social isolation and the loss of the social safety nets normally provided by family members and wider social groups.

4.2 Sexual violence against women and its link to poverty

The African Women's Protocol has defined violence against women as all acts perpetrated against women which cause or could cause them physical, sexual, psychological and economic harm.⁴⁹ This definition is consistent with the UN Declaration on the Elimination of Violence against Women (DEVAW) adopted in 1993.⁵⁰ The African Women's Protocol enjoins state parties to take appropriate and effective measures to enact and enforce laws to prohibit all forms of violence against women, including unwanted or forced sex, whether the violence takes place in private or in public. In addition, state parties have the obligation to adopt other legislative, administrative, social and economic measures as may be necessary to ensure the prevention, punishment and eradication of all forms of violence against women.⁵¹

The causes of sexual violence against women are related to the deeply-embedded structural inequalities and the dominant patriarchy that still

48 As above.

49 Art 1(j) African Women's Protocol.

50 The 1993 UN Declaration on the Elimination of Violence against Women defines violence against women as 'any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life'. See Declaration on the Elimination of Violence Against Women (DEVAW) art 2.

51 Art 4(2)(b) African Women's Protocol.

exist in African societies. Sexual violence against women takes many forms, including rape, sexual harassment, intimidation, teasing and threats. Rape within marriage is one form of sexual violence, usually perpetrated in the private sphere. Forced sex within marriage does not constitute an offence under the statutory laws of many African countries.⁵² As Banda has articulated, the non-recognition of the crime of marital rape in most legal systems is a major stumbling block to protecting women from sexual violence because one cannot be heard to complain about the violation of a non-existent right.⁵³

Another major challenge to the realisation of the sexual rights of women in Africa is sexual violence during armed conflict. There is increasing evidence linking violence against women to armed conflict in Africa.⁵⁴ Sexual violence may be systematic, carried out for the purpose of destabilising populations and destroying bonds within communities and families. In these instances, rape is often a public act, aimed at maximising humiliation and shame.

For instance, in the war-torn east of the Democratic Republic of the Congo (DRC), sexual violence has been used as a weapon of war to terrorise and subdue communities and as a form of punishment.⁵⁵ Rape and other forms of sexual violence against women and girls have been a prominent feature of the 'ethnic cleansing' campaign carried out by government forces and militia in Darfur.⁵⁶ Displaced women in refugee camps in Chad and Darfur have been subjected to sexual and gender-based violence.⁵⁷ Similar sexual violence and exploitation has also been experienced by women in countries such as Liberia,⁵⁸ Rwanda,⁵⁹

52 Ngwena (n 2 above) 129.

53 Banda (n 9 above) 176.

54 See generally J Giniifer *Armed violence and poverty in Sierra Leone* (2005) <http://www.researchgate.net/publication/2731287> (accessed 18 November 2012); Centre for International Co-operation and Security; Amnesty International *Rape as a tool of war: A fact sheet* (2005) <http://www.amnestyusa.org/women/pdf/rapeinwartime.pdf> (accessed 18 November 2012); E Wood 'Variation in sexual violence during war' (2006) 34 *Politics and Society* 307; Human Rights Watch *The war within the war: Sexual violence against women and girls in Eastern Congo* (2002) 8. See also Human Rights Watch *Seeking justice: The prosecution of sexual violence in the Congo war* (2005).

55 Human Rights Watch (n 54 above) 8.

56 Human Rights Watch *Sexual violence and its consequences among displaced persons in Darfur and Chad* (2005) 3.

57 See the 8th periodic report of the United Nations High Commissioner for Human Rights on the human rights situation in the Sudan for the statement on Women abducted, raped and kept as sex slaves following the December 2006 attacks on Deribat (Darfur) http://www.ohchr.org/english/press/docs/Deribat_report_20Aug07.pdf (accessed 27 August 2012).

58 United Nations Populations Fund 'Majority of Liberian women suffered sexual violence during war, says study' (2007) <http://reliefweb.int/report/Liberia/majority-liberain-women-suffered-violence-duing-war-says-new-study> (accessed 15 November 2013).

59 J Hubbard 'Breaking the silence: Women's narratives of sexual violence during the 1994 Rwandan genocide' unpublished MA dissertation, Virginia State University, 2007 17.

Angola⁶⁰ and Somalia⁶¹ during times of conflict.

There is a clear link between acts of sexual violence perpetrated against women and poverty. Sexual violence jeopardises the surviving victim's economic wellbeing, often leading to homelessness, unemployment, interrupted education, and ill physical and mental health. One of the social consequences of sexual violence is that most victims are stigmatised by society. Surviving victims may experience rejection and even divorce by their husbands. Such rejection or divorce may be based on fear of contracting HIV.⁶² For many African women, this is a nightmare scenario. They run the risk of losing their children, being ostracised and finding themselves at the margins of society.⁶³ Sexual violence against girls also manifests in the low enrolment of girls in schools, poor performance at school, high dropout rates, teenage pregnancy and increasing rates of HIV in the 15 to 24 years age group.⁶⁴

In turn, poverty increases the risk of sexual violence. According to WHO's report, poverty increases one's vulnerability to sexual violence.⁶⁵ It increases vulnerability to sexual exploitation in the workplace and at school. It also increases vulnerability to prostitution, trafficking in sex and trafficking in drugs. Poverty renders women more dependent on men for survival and, therefore, less able to control their sexuality.

Poverty and sexual violence in the African context constitute a vicious cycle. Poverty marginalises women, increasing their risk of victimisation, while sexual violence also isolates women, as the mental and physical effects grind away at women's sense of well-being, limiting their capability to escape poverty. The combined effects of poverty and sexual violence against women in Africa create a formidable barrier to women's equality, well-being and full participation in society.

4.3 Denial of women's reproductive rights and its link to poverty

One of the central points of discussion in the discourse of sexual rights is their conflation with reproductive rights. In an article, Miller discusses the different understandings of the relationship between sexual rights and

60 Human Rights Watch Report on Sexual Violence in Angola, http://www.hrw.org/doc/?t=women_sexualviolence&document_limit=40,20-40k (accessed 26 August 2013).

61 See *Plus* news report <http://www.plusnews.org/Report.aspx?ReportId=73769-58k> (accessed 25 August 2013).

62 Human Rights Watch (n 60 above) 64.

63 H Hynes 'On the battlefield of women's bodies: An overview of the harm of war to women' (2004) 27 *Women's Studies International Forum* 447.

64 Human Rights Watch *Scared at school: Sexual violence against girls in South African schools* (2001) 7 <http://www.hrw.org/reports/2001/safrica/> (accessed 26 August 2013).

65 EG Krug *et al* (eds) *World report on violence and health* (2002) 23.

reproductive rights.⁶⁶ Sexual and reproductive behaviour can be linked or can be disconnected.⁶⁷ Such an understanding of the relationship between sexuality and reproduction provides room to consider the broader set of rights which reflect the intersection between sexual and reproductive rights.

Reproductive rights include the rights of individuals to marry; the right to choose one's spouse; the right to decide how many children one wants to have and when to have them; the entitlement to family planning information and services; the right to benefit from scientific progress; and the right to privacy.⁶⁸ Women's rights to make reproductive decisions include both the right to choose, that is, recognising women as full moral agents capable of making decisions about their own lives, and the right to implement the choice.⁶⁹ The latter is particularly important, because it acknowledges that the abstract right to make a decision is meaningless if the conditions needed to carry it out do not exist. A few African countries have incorporated these rights in their constitutions.⁷⁰

In Africa, contraceptive use among women is much lower than that of other regions. The United Nations Population and Development (UNPD) estimates that in 2007, throughout the continent, there were over 30 million women with an 'unmet need' for modern contraceptives,⁷¹ meaning that they wanted to avoid pregnancy but were using traditional family planning methods (with a low efficacy) or no methods at all. Low contraceptive use means that more and more African women are at risk of unwanted pregnancy and unsafe abortion. The lack of access to contraception diminishes decision making about sexual activities. In the developing world, women's reasons for not using contraceptives commonly include concerns about possible side-effects, the belief that they

66 Miller (n 2 above) 71.

67 Miller (n 2 above) 88.

68 These are but some of the rights included in the International Planned Parenthood Federation (IPPF) *Charter on sexual and reproductive rights* (1998), CEDAW Committee General Recommendation 24 para 4. See also C Packer *The right to reproductive choice: A study in international law* (1996) 15.

69 L Freedman 'Censorship and manipulation of reproductive health information: An issue of human rights and women's health in Article 19' in S Coliver (ed) *The right to know human rights and reproductive health information* (1995) 5.

70 Eg, the Constitution of the Federal Democratic Republic of Ethiopia in art 35(9): '... women have the right of access to family planning education, information and capacity'. See also the South African and Kenyan Constitutions. In respect of the Constitution of the Republic of South Africa, 1996, sec 12(2)(a) guarantees everyone a right to bodily and psychological integrity, including the right to make decisions about reproduction. Sec 27 guarantees everyone a right of access to health services, including reproductive health care; and sec 28(1)(c), *inter alia*, guarantees a child a right to basic health care. Art 43(1)(a) of the Kenyan Constitution of 2010 guarantees everyone a right to the highest attainable standard of health, including the right to health care services, which in turn includes the right to reproductive health care services.

71 United Nations Population Division *World contraceptive use 2009* <http://www.un.org/esa/population/publications/WCU2009/Main.html> (accessed 28 August 2013).

are not at risk of getting pregnant, poor access to family planning, and their partners' opposition to contraception.⁷²

A recent report by WHO indicates that the abortion rate in Africa is 29 abortions per 1 000 women of childbearing age.⁷³ At 15 abortions per 1 000 women, the report shows that the Southern African region is the sub-region with the lowest abortion rates in Africa. East Africa has the highest rate, at 38 abortion per 1 000 women, followed by Central Africa, at 36 abortions per 1 000 women, West Africa, at 28 abortions per 1 000 women, and North Africa, at 18 abortions per 1 000 women.⁷⁴ The criminalisation of abortion impacts negatively on the sexual autonomy of women in Africa. The WHO report reveals that highly-restrictive abortion laws are not associated with lower abortion rates. For example, the abortion rate is 29 per 1 000 women of childbearing age in Africa and 32 per 1 000 women in Latin America. These are regions in which abortion is highly restricted in the majority of countries. This contrasts with Western Europe, where abortion is liberalised in the majority of countries, but the abortion rate is only 12 per 1 000 women.⁷⁵

The criminalisation of abortion also impacts on the health and lives of women. Highly-restrictive abortion laws are associated with significant levels of unsafe abortion-related mortality and morbidity. For example, in South Africa, the number of annual abortion-related deaths fell by 91 per cent after the liberalisation of the abortion laws.⁷⁶

The UN International Conference on Population and Development (ICPD), held in Cairo, Egypt, in 1994, articulated the need to address population and reproductive health issues to eradicate poverty and to improve the quality of life for all people within a human rights framework.⁷⁷ The ICPD Programme of Action set a number of goals and objectives to be attained by 2015. These include universal access to comprehensive reproductive and sexual health services, including family planning and sexual health; reduction in infant, child and maternal mortality; universal access to basic education, especially for girls; and gender equality and women's empowerment.⁷⁸ Poor reproductive health reduces productivity and earnings, constrains investment in children and leads to suffering.

72 WHO *Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008* (2011) http://whqlibdoc.who.int/publications/2007/9789241596121_eng.pdf (accessed 15 May 2014).

73 As above.

74 As above.

75 As above.

76 As above.

77 United Nations International Conference on Population and Development (ICPD) 1994 <http://www.unfpa.org/icpd/summary.cfm> (accessed 14 May 2014).

78 As above.

The failure to address the inextricable connections between the rights of women to control their own bodies and other fundamental human rights costs lives and deepens poverty. It undermines the capabilities of poor women to escape from poverty. Empowering women with the ability to regulate and control their sexuality is a basic requirement for well-being, quality of life and enjoyment of sex. Poverty perpetuates precarious health situations and rapid population growth. High fertility rates exacerbate and perpetuate poverty, both at individual and country levels.⁷⁹

5 Conclusion

Sexual rights embrace human rights that are already recognised in African human rights instruments. The realisation of sexual rights requires ensuring gender equality in society and confronting gender-conforming sexuality and social norms. Taking a rights-based approach to sexuality is an important part of the struggle to achieve equality and economic justice, and to bring an end to violence.

In this chapter, it was shown that women's rights to control their sexuality and to pursue sexual pleasure can be denied when women are unable to protect themselves from unwanted pregnancy, sexual violence, and when they are compelled to conform to dominant sexual norms. Taking violations of women's sexual rights seriously requires appreciating the consequences that such violations have on their well-being and livelihoods. Just as sexuality has repercussions related to poverty, marginalisation and death, it can also lead to empowerment, well-being, and the enhancement of shared intimacy. Without realising African women's sexual rights, there is little doubt that efforts to reduce poverty and to improve the security and well-being of women will fail to make a genuine and lasting difference on the continent.

79 ME Greene & T Merrick *Poverty reduction: Does reproductive health matter?* (2005) <http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/GreenePovertyReductionFinal.pdf> (accessed 26 August 2013).

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Before joining the Centre for Reproductive Rights in 2001, she managed projects on women's health in West African parliaments for Parliamentarians for Global Action, and worked at the Carnegie Corporation of New York focusing on funding projects on women's legal rights in sub-Saharan Africa. From 1996 to 1997 she was a visiting lecturer at four Russian university law faculties, Yale University and the Open Society Institute. She has lectured widely and made presentations before policy and academic institutions across the globe