ANALYSIS OF STATUS OF **ADOLESCENTS SEXUAL AND REPRODUCTIVE HEALTH** PROTECTION POLICIES FOR **KENYA, ZAMBIA, TANZANIA AND DEMOCRATIC REPUBLIC OF CONGO**

FINAL REPORT

Findings and Recommendations

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sharp
Solutions for Supporting Healthy Adolescents

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ABBREVIATIONS

ACERWC	-	The African Committee of Experts on the Rights and Welfare of the child.
ACHPR	-	African Charter on Human and People's Rights.
AIDS	-	Acquired Immuno Deficiency Syndrome.
AHRC	-	Africa Health Research Centres
ASRHR	-	Adolescent Sexual Reproductive Health and Rights.
AU	-	African Union.
CAC	-	Comprehensive Abortion Care.
CEDAW	-	Convention on Elimination of all Forms of Discrimination Against Women.
CHRAGG	-	The Commission for Human Rights and Good Governance.
COK 2010	-	Constitution of Kenya 2010.
CRC	-	Convention of the Rights of the Child.
CRR	-	Centre for Reproductive Rights.
CSE	-	Comprehensive Sexuality Education.
CSOs	-	Civil Society Organizations.
DRC	-	Democratic Republic of Congo.
EAC	-	East African Community.
FBOS	-	Faith Based Organizations.
FC	-	Female Cutting.
FGM	-	Female Genital Mutilation.
GBV	-	Gender Based Violence.
GDP	-	Gross Domestic Product.
HIV	-	Human Immunodeficiency Virus.
HRBA	-	Human Rights Based Approaches.
ICCPR	-	International Covenant on Civil and Political Rights.
ICESCR	-	International Covenant of Economic Social and Cultural Rights.
ICPD	-	International Conference on Population and Development Cairo 1994.
IDGLR	-	International Conference on the Great Lakes Region.
LGBTI	-	Lesbian, gay, bisexual, transgender and intersex.
MAPUTO PROTOCOL	-	The African Charter on Human and People's Rights on the Rights of Women in Africa.
MPOA	-	The Maputo Plan of Action.
NANHRI	-	The Network of African National Human Rights Institutions.
NGOs	-	Non-Governmental Organizations.
NHRI	-	National Human Rights Institution.
OHCHR	-	Office of the United Nations High Commissioner for Human Rights.
PAC	-	Post Abortion Care.
RM NCAH	-	Reproductive Maternal, Newborn, Child Adolescent Health.
SDGs	-	Sustainable Development Goals.
SGBV	-	Sexual Gender Based Violence.

SHARP	-	Solutions for supporting Healthy Adolescents and Rights Protection.
SOA	-	Sexual Offences Act.
SRH	-	Sexual Reproductive Health.
SRHR	-	Sexual Reproductive Health Rights.
STIs	-	Sexually Transmitted Infections.
TDHS-MIS	-	Tanzania Demographic and Health Survey and Malaria Indicator Survey.
UDHR	-	Universal Declaration of Human Rights.
UHC	-	Universal Health Coverage.
UN Women	-	United Nations Entity for Gender Equality and the Empowerment of women.
UNAIDS	-	The joint United Nations Programme on HIV and AIDS.
UNCEA	-	The United Nations Economic Commission for Africa.
UNFP	-	United Nations Population Fund.
UNICEF	-	United National Children Fund.
UPR	-	Universal Periodic Review.
URS	-	United Republic of Tanzania.
USAID	-	United States Agency for International Development.
WHO	-	World Health Organization.

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This report is an output of an assessment commissioned by the Network of National Human Rights Institutions (NANHRI) in collaboration with National Human Rights Institutions of (Kenya, Tanzania, Zambia and DRC) to track existing policies, regulations and budgets to inform strategic approaches of the SHARP Project and make recommendations towards improved and friendly Adolescent Sexual and Reproductive Health Services and Rights.

The aim of the study is to increase capacity of duty bearers in service delivery and for rights holders to hold duty bearers accountable for their obligations under relevant treaties ratified by States. To this end, NANHRI acknowledges the support and contributions of all Key Partners and Stakeholders who were identified as Key Informants in the Study. Further. NANHRI extends its appreciation to all the NHRIs in the four countries and especially the Focal Point persons identified for coordinating country teams in offering the responses that were invaluable in making the findings herein.

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CHAPTER 1: THE STUDY BACKGROUND

1.1 Introduction

Solutions for Supporting Healthy Adolescents and Rights Protection (SHARP) is a four-year, European Union funded programme implemented in Burundi, Democratic Republic of Congo, Kenya, Rwanda, Tanzania and Zambia, and at regional level (East African Community, International Conference on the Great Lakes Region). The programme's aim is to contribute to improved adolescents' sexual and reproductive health and rights (ASRHR) in the Great Lakes Region.

The analysis of status of Adolescent Sexual and Reproductive Health (ASRH) protection policies is a baseline survey for the SHARP project aimed at assessing and analyzing the policies, regulations and budgets existing in the four named countries to support, inform strategic plans and the development of policy recommendations towards ensuring compliance with human rights standards and principles as States' obligations.

1.2 Purpose of the Study

The Network of African National Human Rights Institutions (NANHRI) in collaboration with National Human Rights Institutions (NHRIs) undertook this study on Sexual Reproductive Health (SRH) policy analysis to track existing policies, regulations and budgets to inform strategic plans and the development of policy recommendations towards fulfilling one of the objectives of SHARP , which is that **duty-bearers adopt, develop, improve, and implement (sub) national and regional policies and budgets that advance ASRHR particularly for girls and other vulnerable adolescents.**

Further that the analysis of the current state of ASRHR policies will bring out the true picture of the policy and legal landscape as part of States obligation's upon ratifying international and regional treaties, to enable the NHRIs ensure ASRHR protection and implementation.

1.3 Scope of Work

The study mainly focused on four Africa countries namely Kenya, Zambia, United Republic of Tanzania and Democratic Republic of Congo. The assignment entailed the following analysis.

i. Evaluating statuses of selected NHRIs engagement with Government on ASRHR policy review and implementation.
ii. Determining the level of capacity/ institutionalization of SRHR within NHRI.
iii. Determining the effectiveness of existing SRHR platforms at national and regional level in holding governments accountable and policy influencing to advance access to SRH commodities and services for adolescents.
iv. Reviewing status of Government's regional commitments (Maputo Protocol on the Rights of Women in Africa, Abuja Declaration of 2001 (allocating at least 15 % of State Budgets on their annual budgets to the Health Sector), International Conference on Population and Development (ICPD) Cairo 1994) and other related treaties in the target countries on their provisions around ASRHR.

v. Determining youth involvement in decision making regarding ASRHR
vi. Identifying gaps that need to be addressed to ensure successful implementation of ASRHR policies
vii. Mapping out of ASRHR networks, platforms, partners in the target country/region and focal persons within the NHRI and networks that work on ASRHR.

1.4. The Role of National Human Rights Institutions (NHRI's) in Promoting Sexual and Reproductive Rights

Promoting rights of women and girl's health and Reproductive Rights has been strengthened by NHRIs institution through adoption of a Programme of Action that promotes these rights.[i] During the eleventh International Conference of the International Coordinating Committee of national Institutions for the Promotion and Protection of Human Rights Institutions that was held in Amman, Jordan from 5-7 November 2012, the Amman Declaration and Programme of Action was adopted. The NHRIs pledged to protect and promote reproductive rights without any discrimination and recognized the numerous rights associated with it as outlined in the International Conference on Population and Development (ICPD) Cairo 1994 and reiterated in the Beijing Platform of Action in 1995. This was because National Human Rights Institutions are a creation of Governments under the Paris Principles and are in a unique position to support the national governments to meet their human rights obligations and with the mandate to also work with Civil Society Organizations.

The key relevant action areas relevant to Sexual and Reproductive Health and Rights as pledged by NHRIs in the Amman Declaration and Programme of Action include the following:-

Paragraph 25: Protect and promote reproductive rights without any discrimination, recognizing reproductive rights include the right to the highest attainable standard of sexual and reproductive health, the right of all to decide freely and responsibly the number, spacing and timing of their children, and on matters related to their sexuality, and to have the information and means to do so free from discrimination, violence or coercion, as laid out in the Beijing Platform for Action and the Programme of Action of the ICPD.

Paragraph 26: Encourage and aid the compilation of an evidence base (e.g. data, inquiries, research) concerning the exercise of reproductive rights and the right to sexual and reproductive health, including but not limited to cases of *de jure* and *de facto* discrimination in access to sexual and reproductive health care information and services, forced sterilization, forced abortion, child marriage, forced marriage, female genital mutilation/ cutting, biased sex selection and other harmful practices;

Paragraph 27: Review national laws and administrative regulations relating to reproductive rights such as those governing family, sexual and reproductive health, including laws which are discriminatory or criminalize access to sexual and reproductive health services, and propose recommendations to assist States in meeting their human rights obligations; and

Paragraph 28: Promote measures to ensure access to comprehensive sexual and reproductive health information and services and to remove barriers, which hinder such access, and support the establishment of accountability mechanisms for the effective application of the laws and the provision of remedies when obligations have been breached.

Principally, NHRIs agreed to work in the broader area of SRHR. These would include undertaking relevant researches on legal and policy frameworks at national levels, commissioning studies including public inquiries, monitoring States obligations, prioritizing and promoting the rights of women and girls and gender equality, and engaging in the ICPD Global Reviews, among others.

1.5. About Network of African National Human Rights Institutions (NANHRI)

The Network of African National Human Rights Institution (NANHRI) is a regional umbrella non-profit organisation with a membership of 46 African National Human Rights Institutions in Africa, which endeavors to capacitate NHRIs with the necessary knowledge, skills, tools and techniques for them to undertake their mandate of human rights protection and promotion in line with the Paris Principles. The secretariat of NANHRI is based in Nairobi, achieves this through facilitating and coordinating efforts amongst NHRIs and linking them to other key human rights actors at the regional and international level.

In this study, NANHRI in collaboration with four National Human Rights Institutions (NHRIs), namely Kenya, Zambia, United Republic of Tanzania and Democratic Republic of Congo, commissioned the study to conduct Sexual Reproductive Health (SRH) policy analysis to track existing legal and policies, regulations, budgets to inform strategic plans and the development of policy recommendations to influence and advance access to SRH commodities and services for adolescents.

1.6 The Study Methodology

A combination of methods was used for the study in order to capture best practices. Both primary and secondary methods of data collection were employed. The legal and policy analysis was conducted by review of laws policies and through structured interviews by identified key stakeholders. In-depth interviews were conducted with select stakeholders (state and non-state) in Kenya, DRC, Tanzania and Zambia. Qualitative data was gathered from existing secondary sources available online. The NHRIs focal points identified in every country helped the researchers to identify country level key legal and policy documents (if not available online) and any other relevant reports.

The study mainly used Qualitative data gathered through sampled key informants' interviews, complimented with desk review. Two Focus Group Discussions were conducted with adolescents in Kenya and DRC (online) through partner organizations. CSOs enlisted were those involved in ASRHR programming at country levels. Information was collected from targeted public bodies through a questionnaire relevant to the ASRHR issue of focus. Desk reviews were undertaken. Relevant global, continental, sub regional and national documents were reviewed.

Available publications related to ASRHR within the framework of health and rights were reviewed.

The study findings were validated in organized Country Specific Workshops, whose objectives were to enhance the capacity of NHRIs and Partners on ASRHR in State Reporting mechanisms and providing a platform for learning between CSOs and NHRIs at country levels. Further, the platform was used to disseminate the findings from the study for each country participating in the SHARP project.

1.6.1 Sampling

Purposive and convenient sampling was used to identify the relevant respondents. This was premised on the fact that those who hold relevant information are a specific group of people with relevant expertise on SRHR at the country level.

1.6.2 The Research Design

Qualitative method of data collection was used in obtaining primary and was complemented with secondary data. Relevant national policy and legal documents were also reviewed.

1.6.3 Study Limitations

All the questionnaires were administered online. Online administration of questionnaires had challenges that included internet connectivity as well as getting as many Key Informants to participate including adolescents as had been anticipated. The study relied mostly on qualitative analysis of secondary data to overcome the challenge.

National Human Rights Institutions in every country played a key role in identifying key informants. This was limited to the officers assigned to participate. The study interacted with key select officers working on economic Social and Cultural rights that included ASRHR promotion and education. In some cases, the assigned officers did not have the capacity to respond to all the questions.

1.7. The Report Structure

This report provides findings of the study and is arranged in …. Chapters as below.

Chapter 1 includes the background of the study, thus, the introduction to the SHARP project, the purpose of the study and the scope of the study. It gives a snap shot of the role of National Human Rights Institutions (NHRIs) in promoting and protecting human rights. Further, it provides the methodology of the study and the structure of the report.

Chapter 2 provides the study literature review. It defines key terms in the study areas, provides the normative framework for ASRHR and the State obligations upon ratification.

Chapter 3 presents analysis and findings from the four countries, namely Kenya, Uganda, Zambia and Democratic Republic of Congo. The report is presented in four parts namely;

A. Demographic Health Indicators Relevant to ASRHR in Kenya
B. Legislative& Policy Content Analysis
C. Accountability: The Role of Country Specific NHRIs
D. Recommendations

Country specific analysis are presented in the following subheadings identified as key areas of focus for ASRHR. These are:-

1. Equality and non-discrimination Principles
2. Age of consent sexuality
3. Age of consent to marriage
4. Age of consent to health services-contraception information services
5. Criminalization of consensual sexual acts among adolescents
6. Criminalization of HIV and AIDS
7. Sexual and Reproductive Health Services for young people
8. Cultural and Religious and harmful cultural practices
9. Learner Pregnancy Retention and re-entry law and policy
10. Laws and policies on Comprehensive Sexuality Education (CSE)
11. Unsafe abortion
12. Freedom from Gender Based Violence (GBV)
13. Budgeting /Financing of Adolescent Sexual Reproductive Health and Rights

The chapter also presents the findings on the process at the East Africa Community, that is relevant to ASRHR programming.

Finally the report presents the Map of ASRH Networks/Platforms/Partners at Country level as annexes 1-4.

CHAPTER 2. LITERATURE REVIEW

2.1 Defining Key Terms

The International Conference on Population and Development (ICPD)[ii] and the World Health Organization (WHO) have defined the term reproductive health and sexual health, thus;

ICPD Cairo 1994 definition of reproductive health;

> The basic right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health.

> Reproductive health is a state of complete physical, mental, social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and freedom to decide if, when and how often to do so.[iii]

The WHO definition of sexual health[iv];

> *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 positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experience, free of coercion, discrimination, and violence.*

The World Health Organization has defined adolescence as:

> *The phase of life between childhood and adulthood, from ages 10 to 19. This is a unique stage of human development since it lays the foundation of good health. Young people are those between 10 and 24.*[v]

2.2. Vulnerability of Adolescents in the Context of Reproduction in Africa

Adolescent's Sexual and Reproductive Health and Rights (ASRHR) has taken center stage in the recent past years because of considerable challenges they face in accessing services, information, participation and providing their voice and agency. Adolescents and young people comprise almost half the world's population. Because of the variations in age, most government policies exclude adolescents from decision-making processes. At most times, they are considered as children (below age 18) and laws and policies are made without their meaningful participation.

Adolescents and young people aged 15 – 19 in Sub-Saharan Africa are at risk of early and unwanted pregnancy leading to unsafe abortion, sexually transmitted diseases including HIV

and AIDS, high rate of maternal and child mortality, high rates of school drop out by girls and sexual exploitation. Adolescents also experience low social status, lack of autonomy and physical vulnerability to access these rights.

Adolescents are also at risk and suffer human rights violations that include sexual coercion, sexual abuse, and violence, lack of education and information, high rates of teenage pregnancy, lack of access to health services including safe abortion, gender inequalities including being subjected to harmful cultural practices i.e. Female Genital Mutilation, child marriage among others.[vi] UNFPA notes that adolescence is a decisive age for girls around the world but in sub Saharan Africa, the girls experience highest challenges during their teenage years.

Adolescents globally suffer violations of their Sexual Reproductive Health and Rights (SRHR) that include lack of comprehensive sexuality education, lack of access to confidential health care services, sexual violence, being exposed to harmful cultural practices for example child marriages, practice of Female Genital Mutilation (FGM) among others. Young girls are subjected to harmful cultural practices like Female Genital Mutilation in some communities. Numbering about 226 million, adolescents in Sub-Saharan Africa make the largest population in the world with 23 percent of them aged 10-19 years.[vii] They have reproductive rights, just as adults, but their social status, lack of autonomy and physical vulnerability make it more difficult for them to exercise those rights.

There are known factors that predispose adolescents and young people to sexual health risks. These include gender socialization in different settings for young people and adolescents. Country specific contexts in terms of policy and legal frameworks i.e. schooling, promotion of rights to access information and the openness in access to health services contribute significantly and influence decisions by young people and adolescents. These decisions are occasionally socially construed and determines future decisions

The gender socialization process differs from one community to another. Communities play a critical key role in providing information to the Adolescents especially including mainstream and social media. Parents and Peers also contribute to the source of information adolescent's access and they are also key stakeholders in shaping how adolescents receive and utilize information on SRHR. Adolescent girls are very vulnerable, and those between the ages 15-19 years have twice the risk of pregnancy related complications compared to women in their twenties, while girls under the age of 15 have five times the risk of pregnancy related deaths worldwide.[viii]

A large group of adolescent and young persons in pre-reproductive group face challenges constantly transitioning into reproductive group. Some known barriers youth encounter in accessing comprehensive sexual and reproductive health services include[ix]-

i) Restrictive laws and policies based on age.
ii) Lack of comprehensive sexuality education.
iii) Lack of access to confidential health care information and services that compromise their physical and mental health.

iv) Denied autonomy and capacity in making decisions requiring parental consent.
v) Exposure to harmful cultural practices i.e. female genital mutilation, child marriages
vi) Frequent exposure to sexual violence.
vii) Lack of access to education for girls who drop out of schools when pregnant.
viii) Suffering stigma and discrimination associated to sexuality and discrimination because of age or marital status.

2.3. The SRHR Normative Framework: A Scan of Human Rights Commitments

Africa's Agenda 2063 recognizes that the future of the continent rests on the skills, knowledge, talents and commitments of the young people.[x] It further recognizes that development is people driven and also unleashing the potential of youth and women. It recognizes the important role women and youth play as drivers of change. One key objective of the African Youth Charter is to ensure constructive involvement of Youth in the development agenda of Africa and participation in debates, decision-making processes and development of all policies and programmes. The charter puts a set of responsibilities on the youth as well.

The Protocol to the African Charter on the Rights of Women in Africa (the Maputo protocol), adopted on 11th July 2003 by African Union (AU) Member States came into force on 25th November 2005[xi]. To date 43-member states have ratified it. The Maputo protocol makes explicit the protection of women's rights.

In 2014, the African Commission on Human and People's Rights adopted General comment No. 2 on Article 14 (1) (a), (b), (c), (d), & (f) and Article 14(2) (a) & (C).[xii] The essence of the general comment is to assist States in understanding the requirements under article 14 on legislative, policy and administrative steps taken to enhance drafting States reports and reporting accordingly. It provides interpretive guidance on overall specific obligations of State Parties towards promoting the effective domestication and implementation of Article 14. It is to be used when States draft periodic reports in expounding of implementation of Article 14.

The African Charter on the Rights and Welfare of the child[xiii] provides for the rights of the child, defined as anyone below 18 years. They have among others the rights to equality and non-discrimination (article 3), freedom from expression (article 7), education (article 11), health and health services (article 14), protection against harmful social and cultural practices (article 21) and protection against sexual exploitation(article 27).

The African Youth Decade (2009-2018) was a framework for multi-sectoral and multi-dimensional engagement of all stakeholders towards the achievement of the goals of the objectives of the African Youth Charter. Young people account for 40 per cent of the total labor force. When youth face an uncertain future without work and life skills, this impairs their ability to get good jobs in desirable occupations, resulting in low and unstable incomes while exposing them to potentially long periods of unemployment. This in turn leads to a vicious cycle of poverty. [xiv]

The 2017 analysis by United Nations Economic Commission for Africa (UNCEA), of the Africa youth agenda noted that the youth in Africa were alienated and marginalized. Many young people were jobless and were struggling to access public resources and quality social services. They are barely involved in policy formulation and programme design as their participation in policymaking and decision-making is ad hoc and often limited. The analysis suggests how young people should be meaningfully engaged in the implementation and tracking of the SDGs and Africa Agenda 2063.[xv] It recommends among others promoting investments that absorb the capacities of the youth in a variety of sectors including education, health, employment, governance and civic engagement.

At the African continental level, the Maputo Plan of Action Review Report (MPoA) of 2015 revised the Plan to Action from 2015 – 2030 to enable more effective implementation with a key focus on people centered development, especially focusing on potential offered by youth and women as part of the Agenda 2063.

The Continental Policy Framework has strategic focus on the following areas that are relevant for ASRHR promotion: -

i) Sexual and reproductive health.
ii) Integration of sexual and reproductive health services into primary health care.
iii) Sexual and reproductive health communication.
iv) Budgeting for sexual and reproductive health activities.
v) Mainstreaming gender in development programmes.
vi) Youth sexual and reproductive health.
vii) Midlife concerns of men & women.
viii) The fight against HIV/AIDS pandemic and other infectious diseases.
ix) Strengthening of the sexual and reproductive health programmes of the African Union.

Maputo Plan of Action 2016 – 2030 seeks to achieve Universal Access to Comprehensive Sexual and Reproductive Health Services in Africa. It operationalizes the Continental Policy Framework for Sexual and Reproductive Health and Rights. The Continental Policy Framework on SRHR was adopted in 2005 by the Minister and endorsed by AU Heads of State in January 2006 and remains the relevant framework for achieving universal access to SRH and SDGs. The Maputo Plan of Action (MPoA-2007-2010), and extended to 2015 to coincide with the end MDGs. The elements of SRHR in the Maputo plan include Adolescents SRHR, maternal health and newborn care, safe abortion care, family planning, prevention and management of sexually transmitted infections including HIV/AIDS, prevention and management of infertility, prevention and management of cancer of the reproductive systems, GBV, health education, etc.

A comprehensive review of MPoA was conducted to inform the continental SRHR Policy direction post 2015. The Maputo review gave rise to the Maputo Plan of Action 2016-2030 to

operationalize the Continental Policy Framework. The revised Maputo Plan of Action 2016-2030 on SRH remains consistent with Africa's agenda 2063, an integrated Continent, politically united based on Pan Africanism. It also aligns to SDGs agenda 2030. The Continental Policy Framework on SRHR has 10 strategic areas that are:

i) Sexual and Reproductive Health legislation into primary health care.
ii) Integration of SRH services.
iii) SRH communication.
iv) Budgeting for SRH activities.
v) Mainstreaming Gender into Development programmes.
vi) Youth Sexual and Reproductive Health.
vii) Mid-life concerns of both men and women.
viii) The fight against HIV/AIDS pandemic.
ix) Strengthening of SRH programmes of the AU.
x) Establishment of an African Maternal and infant mortality Advocacy day.

The SRH Continental Policy Framework (2016-2030) considers findings from Gaborone Declaration on the Roadmap towards Universal Access to prevention, treatment and care, the Brazzaville commitment on scaling up towards access to the Abuja call for Acceleration action towards Universal Access to STI/HV/AIDS, Tuberculosis and Malaria services in Africa and The Agenda 2063, and the SDGs and the Global Strategy for Women's, Children's and Adolescents Health.

States have obligations of reporting in terms of relevant treaties ratified that are relevant to promoting to the fullest extent the health and well-being and potential of all children, adolescents and youth. The key relevant treaties at the African level are the Protocol on the Rights of Women in Africa, otherwise known as the "Maputo protocol on Women", together with the international Convention on Elimination of All Forms of Discrimination against Women (CEDAW), the African Charter on Human and People Rights, The African Charter on the Rights of the Child. Further, countries continue to subject themselves to voluntary examination through reporting to various UN treaty bodies including the African Commission on Human and people's Rights, CEDAW Committee, the Universal Periodic Reviews (UPR), the ICPD Cairo 1994 implementation reviews, the Beijing platform of Action Reviews and the recent Sustainable Development Goals under Goal 5 country voluntary reviews.

At the global level, countries have signed voluntarily to implement the 2030 Agenda thus, the Sustainable Development Goals (SDGs). Recent review in 2021 of global progress on SDG 5 on gender equality and empowerment of women and girls by the office of the UN Secretary General has noted slow progress towards implementation, and as such, noted further that many African countries may be off-track in achieving gender equality by 2030.[xvi] Countries have made significant strides in the promotion of gender equality and women's empowerment and

putting in place large scale national programmes on adolescents and young people and adopting policies and enacting legislative frameworks to facilitate implementation of SRHR. However, there are notable gaps in putting accountability at the forefront of policy planning, implementation and budget allocations.

The Gender Snapshot 2022 in assessing SDG 5 data shows that the world is not on track to achieve gender equality by 2030 (UN Women digital library). There is a backlash against women's sexual and reproductive health and rights. This has been exacerbated by COVID 19, violence against women, climate change and humanitarian crisis.[xvii]

While focusing on financing health, the Abuja Declaration commitment on States' allocating at least 15% of its national budgets to health of 2001[xviii] is important reflection as countries focus on financing Universal Health Coverage (UHC) under the SDGs 2030 commitments. The Abuja declaration was and is still a significant political commitment that supports African countries to meet their international and regional obligations within the ratified treaties in promoting the right to health.

SDGs indicators in health programmes globally show 1.2 billion women and girls of reproductive ages (10-49) live in countries with some form of restriction on accessing safe abortion and 102 million live in countries where abortion is prohibited altogether. Adolescent birth rates remain high in the least developed countries at the rate of 94%. Thirdly, maternal mortality increased because of COVID19 with 62% in Uganda, 1% in South Africa and 9% in Kenya. Fourthly, for girls in school, pregnancy, gender-based violence and insecurity compounded learning losses.[xix]

A study in Kenya, Rwanda, Uganda and United Republic of Tanzania found that 56% of adolescent girls from hard to reach populations dropped out of school due to pregnancy. Adolescent girls in sub Saharan Africa were at greatest risk of sexual violence, exploitation, HIV infection and lower educational attainment. The pace of reform on women's legal rights is too slow. While constitutions and other enabling laws have provisions that discriminate against women, women continue to be subjected to harmful cultural practices. For example, in Sub-Saharan Africa, 24.7% of women and girls aged 15-49, have undergone Female Genital Mutilation, despite capital investments and adoption of policies that expand opportunities for young people.[xx]

The Global Strategy for women's, Children's and Adolescent's Health (2016-2030)[xxi] highlights the high return on investment in Women's, Children's and Adolescents health by ensuring access to essential intervention and supplies aimed at strengthening health systems to address all major determinants of health. The Global Strategy for the first time acknowledged the unique health challenges facing young people alongside women and children. By investing in the right policies and programmes for adolescents to realize their human rights to health, education and full participation in society, it helps to unleash the vast human potential to transform the world using the SDGs Generation. The strategy highlights the adolescent's health challenges. Globally, millions of adolescents die on or become sick from preventable causes. Too few adolescents access information and counselling and integrated, youth friendly services,

and especially to sexual and reproductive health services, without facing discrimination or other obstacles. In many settings, adolescent girls and boys face numerous policy, social and legal barriers that harm their physical, mental and emotional health and well-being. The barriers are greater among adolescents living with disabilities and / or in crises.

T**he Convention on Elimination of all forms of Discrimination against Women (CEDAW)**[xxii]**, adopted** in December 1979 and came into force in September 1981, guarantees women equal rights in freely and responsibly deciding on the number and spacing of their children, access to information, education and means to enable them exercise these rights. (Article 16). Women have the right to education that includes access to specific educational wellbeing of families, including information and advice. The CEDAW General Recommendation 24[xxiii] requires States to prioritize prevention of unwanted pregnancy through family planning. The committee affirmed the access to health care including reproductive health as basic rights. States are called upon to take appropriate legislative, judicial, administrative, budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realize their rights to health care.

T**he 1995 Beijing Platform for Action,** adopted during the fourth conference on women in 1995, [xxiv] clarified that human rights of women include the right to have control over and decide freely and responsibly on matters of sexuality including sexual and reproductive health free of coercion, discrimination and violence.

The Committee on Economic, Social and Cultural rights in General Comment 14 [xxv]on the Right to Health, explains the provisions of Article 12 of the UN Convention on Economic, Social and Cultural Rights. It provides that the maternal health services have core obligations that cannot be derogated from under any circumstances. Further, that the right to health has immediate obligations on State's to take deliberate, concrete and targeted steps towards fulfillment. Further, General comment 22 of the Committee recommends States to repeal or eliminate laws, policies, practices that criminalize, obstruct or undermine access by individuals or a particular group to sexual and reproductive health facilities, services, goods and information.

The United Nations Population Fund (UNFPA)[xxvi] is the United Nations entity charged with the responsibility on SRHR to which; overseeing implementation progress of the International Conference Population and Development (ICPD) 1994 commitments. Governments in 1994 in Cairo, adopted a landmark programme of action for advancement of sexual and reproductive health and rights (SRHR) known as the ICPD Programme of Action (POA)[xxvii]. The ICPD commitments and its periodic reviews is to achieve gender equality, promote equal and fulfil human rights and reproductive freedom for all.

The ICPD+25 Nairobi Summit (November 2019)[xxviii] in marking 25th Anniversary of ICPD made commitments to address GBV as fundamental obligation for realization of the ICPD POA. The commitments were categorized in (i) integration of gender equality and sexual and reproductive health and rights (SRHR), (ii) Universal Health Coverage, (iii) Comprehensive Sexuality Education. At the closure of the Nairobi Summit, countries showed overwhelming

commitments to supporting and empowering youth by providing them with tools and creating enabling environment necessary to harness the demographic dividends.

Youth commitments focused on Comprehensive Sexuality Education (CSE), HIV and pregnancy prevention programmes, gender-based violence prevention and programmes, policies related to access to youth friendly, sexual and reproductive health services, increasing access to decision-making, processing, spaces, and access to quality education and quality employment, gender equality and contraception. Further, the commitments are geared towards leveraging support for access to SRHR and access to youth-friendly SRH services and CSE programmes for out of school youth.

2.4. Domestication of Adolescents Sexual Reproductive Health and Rights (ASRHR)

Over the years, the UN treaty bodies have called for reforms in legal and policy frameworks across countries. Upon ratification of treaties and commitments, States are expected to domesticate the commitments. In the recent past, the United Nations has adopted a human rights-based approach to Development. The Human Rights Based Approaches (HRBA) is a conceptual framework for process of human development that is normatively based on international human rights standards and operationally directed to promoting and protecting human rights. States have been urged to adopt it in their policy development and programming. In relation to the right to health, HRBA aims to support better and more sustainable development outcomes by analyzing and addressing the inequalities, discriminatory practices (de jure & de facto) and unjust power relations which often is at the heart of development problems. Key elements of a HRBA to health specifically aims at realizing the right to health and other related human rights.[xxix]

General comment No. 14 on the right to the Highest Attainable Standard of Health (article 12) outlines the scope of international right to health drawing from existing standards and norms.

According to the first special rapporteur on the right to Health Prof. Paul Hunt, the two analytical frameworks or tools adopted by the right to health experts to facilitate understanding and implementation of the right to health including Sexual Reproductive health and Rights are (i) the ***obligations by the States to Respect, Protect and Fulfil human rights***, arising from the ratified treaties and commitments and in the context of policy making the health services ***available, accessible, acceptable and of good quality***.[xxx]

The State obligations are;
Respect: not to interfere directly or indirectly with the enjoyment of the right to health, e.g. refrain from limiting access to health-care services or marketing unsafe drugs.

Protect: prevent third parties from interfering with the right to health, e.g. ensure that private companies provide safe environmental conditions for their employees and surrounding communities, and

Fulfil: adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures to fully realize the right to health.

UNFPA has adopted the HRBA approach to programming and in its practical implementation manual and training materials has identified the rights relevant to SRH that include right to life, liberty and security, health, to access information, marry and start a family, decide freely the number and spacing of children, be free from torture and inhuman degrading treatment.[xxxi]

In order to meet the human rights standards and principles for adolescents to enjoy their SRHRs, the rights below must be promoted and protected using an HRBA approaches: -

a) **The right to autonomy** – individual has rights to autonomous decision making without interference by third parties.
b) **The right to non-discrimination and equality**. The international and regional human rights treaties prescribe discrimination on the basis of; inter alia, sex, race, ethnicity, language, religion, disability and economic status. Treaty monitoring bodies have recognized additional grounds of discrimination on the basis of age, (actual or perceived), sexual orientation, gender identity, parental duties, health statues, HIV status and pregnancy. States are asked to take appropriate measures including legislation to ensure full development and advancement of women to guarantee their equal rights with men.
c) **Accountability** – Accountability is necessary and ensures that policies and programmes must be implemented properly in terms of preventing human rights relations. The ICPD PoA recognizes that all population including the marginalized and vulnerable communities are included – the reproductive health programmes. States are called upon to enhance accountability through laws and policies and through budget allocations. The obligations of duty bearers and role of rights holders provided for. Access to justice for claiming of rights when violated must be enhanced.
d) **Participation and Empowerment** – To recognize and offer effective realization of sexual and reproductive health and reproductive rights, the active participation of women and girls must be secured. The vulnerable require to be empowered to demand their rights and accountability.
e) **International Cooperation –** The International Community have agreed on the need for increased commitment to International Cooperation and assistance. Donor States have responsibility to ensure that their resources are utilized for sexual and reproductive health programs that respect and advance human rights.

The provision of reproductive health services must conform to the International Human Rights Framework and Standards. The Committee on Economic, Social and Cultural Rights in the year 2000, adopted General comments 14.

It defined the elements of the right to health to include the following for key elements, namely:

i) **Availability** – States to ensure they have adequate number of functioning health care facilities, services, goods and programmes to serve the whole population including essential medicines such as contraception and emergency conception.
ii) **Accessibility** – States to ensure that health facilities are accessible to the whole population without discrimination. The most vulnerable, adolescents, people with disabilities, (PWDs), must be included. Information must be provided to all population.
iii) **Acceptability** – The Health Facilities, services and goods must be culturally appropriate, considering the needs and interests of minorities, indigenous population and different genders and age group.
iv) **Quality** – Reproductive health care must be of good quality, meaning that it is scientifically and medically appropriate and that the service providers must receive adequate training. The said Standards must apply to underlying determinants of health including access to sexuality education and information.

The Maputo Protocol on the rights of women in Africa affirms reproductive choices and autonomy as key human rights. It is known to be the first treaty to explicitly articulate human rights to abortion when pregnancy results from sexual assault, or incest or when continuation of the pregnancy endangers the life or health of the pregnant women, and further in cases of incompatible with life. Notably, Sub-Saharan Africa has the worst indicators of women's health. These include highest infant mortality and highest HIV related deaths. In brief, the Protocol requires States to ensure that the right to health of women, including sexual and reproductive health is respected and promoted. The States are called upon to: -

- Provide adequate, affordable and accessible health services to women.
- Establish and strengthen prenatal, delivery and post-natal health and nutritional services for women during pregnancy and while breast feeding.
- Prohibit all medical or scientific experiments on women without their informed consent.
- Guarantee women's rights to consent to marriage.
- Set the minimum age of marriage at 18 years.
- Ensure equal rights for women in marriage.
- Protect women against all forms of violence during armed conflict and consider such acts as war crimes.
- Enact and enforce laws prohibiting all forms of violence against women, including unwanted or forced sex and
- Reform laws and practices that discriminate against women specifically Article 14 of the Maputo Protocol states.
- Prohibition of harmful practices such as female circumcision/female genital mutilation – (FC/FGM).

CHAPTER 3: DISCUSSION OF KEY RESULTS -FINDINGS AND ANALYSIS

The findings are presented per country, thus Kenya, United Republic of Tanzania, Zambia and Democratic Republic of Congo (DRC). For every country, a snapshot of the baseline information touching on demographics and landscape of Sexual Reproductive Health and Rights is provided, drawn from the last county Demographic Survey or any identified credible national statistics including the unpacking of the legal and policy framework on adolescents based on the key areas identified at country level is presented. The analysis identifies gaps that need to be addressed to ensure successful implementation of ASRHR policies and laws. The study has reviewed the status of government's regional commitments (Maputo Protocol, Abuja Declaration, ICPD) and other related treaties in target countries on their provisions around ASRHR.

National Human Rights Institutions (NHRIs) are recognized at the regional level to play a critical role in accountability to human rights. The study has analyzed each country's National Human Rights Institution's engagement with accountability towards implementing ASRHR.
The assessment sought information on State's commitment to the Abuja 2001 declaration to allocate 15% of their total budget to health. Budget allocation to matters ASRH is critical in linking policy implementation to political good will.

The study has responded to the question of how existing legal and policy frameworks have influenced the access to SRH services and commodities by adolescents. The analysis on youth involvement in decision making is critical in testing and establishing if a country has adopted a Human Rights-Based Approach that includes respect of human rights, transparency and accountability, participation and empowerment and the sustainability in designing their interventions. Finally, the study presents a Map of ASRHR networks, platforms, partners in the target country/region and focal persons within the NHRI and networks that work on ASRHR for future engagement.

The findings are presented using the thematic areas identified in the UNFPA Guide in support of NHRI's Country Assessment and Inquiries on Human Rights in the context SRHR and well-being[xxxii] & UNFPA/WHO/OHCHR and the Danish Institute of Human Rights[xxxiii] themes on SRHR modified and adopted to suit reproductive health rights for adolescents in response to the Terms of Reference.

These are: -

i) Age of consent of sexually activity.
ii) Age of consent to marriage.
iii) Age of consent to health services.
iv) Criminalization of consensual sexual activity among adolescents.
v) Criminalization of HIV transmission.
vi) SRH services for young people.
vii) Cultural, religious and traditional practices that are harmful.

viii) Leaner re-entry in school / retention policies and
ix) Provision of comprehensive sexuality education.

COUNTY CASE STUDIES FINDINGS AND ANALYSIS

3.1 KENYA

A. Demographic Health Indicators Relevant to ASRHR in Kenya

The Kenya National Bureau of Statistics (KNBS) in collaboration with the Ministry of Health and other Stakeholders recently released the Kenya Demographic and Health Survey 2022. The demographic health data was collected from February 17th to July 19th 2022 and provides estimates of demographic, health and nutrition indicators. In respect to adolescents (15-19) years, the fertility level was found to be low (73 births per 1,000 women).
Generally, the Total Fertility Rate in Kenya has declined by 33 children from 6.7 & 3.4 previously between 1989 and 2022. In rural areas, the decline is from 7.1 children to 3.9 children and among urban women, the decline is from 45 children to 2.8 children.

Teenage pregnancy- 15% of women, aged 15-19 have ever been pregnant, 12% have had a live birth, 1% have had a pregnancy loss and 3% are currently pregnant. Further, the percentage of women who have been pregnant increases with age, from 3% among those age 15 to 31 and those aged 19. Further finding was that about 4 in 10 women age 15 – 19 who have no education have ever been pregnant, as compared with only 5% of women who have more than secondary education. Teenage women in the lowest wealth quintile were more likely to have even been pregnant than women in the highest wealth quintile. The percentage of women who have been pregnant decreases from 21% among those in the lowest wealth quintile to 8% among those in the highest wealth quintile.

In Kenya, both traditional and modern family planning methods are used. The total unmet need for Family Planning (for currently married women age 15-49) is at 14%, 6% are using traditional methods while 57% are currently using modern methods. Among sexually active unmarried women aged 15 – 49, 70% use contraceptive method, and 5% of those women use a modern method. The use of traditional methods is more common among sexually active unmarried women than among currently married women (11% and 5% respectively). 60% of currently married women are using contraceptives methods, with 57% using a modern method.

Among married women, male condoms are the most commonly used contraceptive method (20%) followed by injectable (16%) and implants (11%). There is a decline of the unmet need for Family Planning from 35% to 14%. The higher the education level, the lower the unmet need for Family Planning. For Maternal care, 98% of women reported receiving antenatal care from skilled provider in the last 2 years. The percentage was higher in urban areas (74%) as compared to rural areas (62%). The percentage of live births that were assisted by a skilled provider has markedly increased over the past two decades from 14% in 2003 to 89% in 2022. Almost all live births to mothers with more than a secondary education were delivered by a

skilled attendant (99%). The Counties below recorded lower percentage of births delivered by skilled providers – Turkana (53%), Mandera (55%), Wajir (57%) and Tana River (59%).

Younger people are at greater risk of HIV infection. The KDHS 2022 presents information of the Youth aged 15-24 years. The knowledge of HIV prevention by young people is high (women – 54%) and (men 55%). However, knowledge of prevention is lowest among ages 15-17 (44% of women and men, and among those who have never had sex). (47% of women and 48% of men). 51% of young women and 63% of young men in urban areas have knowledge about prevention as compared with 52% of young women and 51% of young men in rural areas. Knowledge of HIV prevention increases with education from 13% among young women with no education to 69% among those with more than Secondary Education and from 14% among young men with no education to 80% among those with more than a Secondary Education.

Sexual behavior puts adolescents and young people at risk. 15% of men and 4% of women reported having multiple sex partners. 24% women and 45% of men reported using a condom during last sexual intercourse. Average number of sexual partners are 2.3 among women and 7.4% among men. Women of ages 15 – 19 reported using a condom at last sexual intercourse with a person who was neither their spouse nor lived with them. 67% of youth ages 15-24 have ever tested for HIV; while 46.6% of those aged 15-19 have tested and received results.

Gender Based Violence (GBV) is acknowledged as a violation of basic human rights. This is violence that may cause physical, sexual, economic or psychological harm or suffering to women, girls, men and boys. It also includes threats to such acts, coercion or the arbitrary deprivation of liberty. 24% of women in Kenya have experienced physical violence since age 15, including 16% who experienced physical violence in 12 months prior to the survey. Slightly lower proportion of women have experienced physical violence. About 27% of men have experienced physical violence since age 15. The trends of women who experienced physical violence in 12 months preceding the survey declined from 20% in 2014 to 16% in 2022 as compared with men at slight decline from 12% to 10%. Experience of violence among women increases with age. 20% of women age 15-19 have experienced physical violence since age 15 compared to 42% of women age 45-49. Married women are likely to have experienced violence since age 15.

The most common perpetrators of physical violence among women who have ever been married or ever had an intimate partner was the current husband or intimate partner (54%) followed by a former husband/intimate partner (34%). The prevalence of sexual violence was also estimated in KDHS 2022. 13% of women reported that they had experienced sexual violence in the last 12 months. Slightly lower proportion of men reported experiencing sexual violence – 7%. The percentage of women who have experienced sexual violence increases with age; from 7% among those age 15-19 to 18% among those age 40-49. 3% of women who have never been married and never had an intimate partner report sexual violence as compared to 12% never married women who ever had an intimate partner, 13% of them currently married women and 27% of formerly married women.

The most reported perpetrators of sexual violence among women who have been married were currently husbands or intimate partners (71%) and former husbands or intimate partners (19%). Commonly reported perpetrators of sexual violence among men who have ever been married or had intimate partners were current wives or intimate partners (63% for former wives and intimate partners (32%). Harmful Cultural Practices impact on enjoyment of adolescent and women to their Sexual

Female genital mutilation / cutting FGM/C is widely recognized as a violation of human rights. By trends, the prevalence of FGM declined from 38% in 1998 to 15% in 2022. Since 2014, the percentage of circumcised women who were cut and flesh removed declined from 87% to 70% while percentage of women sewn closed increased from 9% to 12%. The percentage of FGM increases with age. 9% of women age 15-19 have been circumcised compared with 23% of women age 45-49.

Table: Summary of Kenya Selected Sexual and Reproductive Health–Related Statistics from KDHS 2014 & 2022

	Parameter	Detail	Value
1.	Under 5 mortality	# deaths Per 1,000 live births (2022 KDHS)	41
2.	Infant mortality	# deaths per 1,000 live births	32
3.	Neonatal mortality	% deaths per 1,000 live births % Neonatal deaths account for 66% of infant deaths and 5.1% of under-5 deaths	2.1% 5.1%
4.	Maternal mortality ratio	# per 100,000 live births (KDHS 2014) *(The 2022 estimates not yet released on this indicator)*	362
5.	Teenage Pregnancy	% Teenage (15–19) pregnancies increase with age, from 3% among those aged 15 to 31% among those aged 19	15%
6.	Adolescent seeking Contraceptives	% The total demand for family planning for ages 15-19 years % Unmet need (15-19 years)	65.5% 21.6%
7.	Births by skilled health personnel	% increase with the mother's education - 54.6% are mothers with no education, and 99.1% with more than secondary education	89.3%
8.	Health Budget	as % of gross domestic product (*Not yet released)*	-
9.	Contraceptive prevalence rate	%Modern methods (2022 KDHS) Sexually active Married women %Sexually active Unmarried women	 57% 59%
10.	Unmet needs for family planning	% of currently married women 15 to 49 years old (KDHS)	13.9%
11.	Female genital	% of prevalence (KDHS)	15%

	mutilation		
12.	Gender-based violence	% of Prevalence (KDHS) % Physical violence since age 15 % Sexual violence	34% of women & 27% of men 13% of women 7% of men
13.	Total Fertility Rate	# 3.9 children in a lifetime among women in rural areas and 2.8 in urban areas	3.4

B. The Legislative and Policy Content Analysis

In Kenya, SRHR issues are addressed within various legislative and policy frameworks. These include the Constitution of Kenya (2010), Sexual Offences Act (2006), Children Act (2022), Counter-Trafficking in Persons Act (2010), Prohibition of Female Genital Mutilation Act (2011), Protection Against Domestic Violence Act 2015, Basic Education Act 2013, Health Act 2017 and its 2019 Regulations, Persons with Disabilities Act (2003), HIV and AIDS Prevention and Control Act (2006), Marriage Act (2014) and the Protection of Traditional Knowledge and Cultural Expressions Act (2016).

The policies include the recently adopted National Reproductive Health Policy (2022-2032), the Kenya National Adolescent Sexual and Reproductive Health Policy 2015 (now under review) National Youth Policy (2007), Sessional Paper No. 3 on Population Policy for National Development (2012), Gender Policy in Education (2007), The National Gender policy (2019), Kenya Health Policy (2014-2030), Kenya Health Sector Strategic and Investment Plan (2013-2017), Education Sector Policy on HIV and AIDS (2013), National School Health Policy (2009), National Gender-Based Violence Policy (2014), and Kenya Vision 2030. Further the 2020 National Guidelines for School Re-entry in Early learning and Basic Education has been adopted.

Findings and analysis

1. Equality and non-discrimination Principles

Kenya's Health Policy 2014–2030 highlights the importance of equity, people-centeredness, and taking participatory multisectoral and social accountability approaches in health service delivery.[xxxiv] Drawn from the Kenya Vision 2030 (the country's long-term development agenda),[xxxv] with global commitment towards realizing fundamental human rights as enshrined in the Constitution of Kenya 2010 (CoK 2010),[xxxvi] It gives direction in management and operations in health care. The Health Policy further emphasizes key SRH priority areas, including the need to ensure proper access to comprehensive reproductive, maternal, newborn, child, and adolescent health (RMNCAH). Kenya took further steps in providing further guidance in the reproductive health specific policies. While the constitution 2010 promotes the right to reproductive health and rights, Kenya has not demonstrated how citizens including the adolescents need to access the services, especially with restrictions on accessing SRH services. Existing and subsequent policy guidelines continue to undermine the Constitution making SRH

services not accessible to all women of reproductive age. Services are not available and friendly to all adolescents including those from poor quintile, those marginalized and those with disabilities. In its reporting to the committee on the African Charter on the Rights and Welfare of the Child (2012-2017). Kenya admitted that children with disabilities were discriminated in access to health, education and access to justice because of the structural barriers, that make the environment not conducive.[xxxviixxxviii]

The National Reproductive Health Policy of 2022-2032 guides planning, standardization and implementation, and monitoring and evaluation of reproductive health services in the country. It provides access to SRH services for all. Nevertheless, it still restrains adolescents (under age 18) to only access certain SRH service, with consent of parent or guardian.

Parliament has more than once rejected or shelved a national reproductive health bill.[xxxix] Efforts have been made to draft the Reproductive health bill in 2019 and 2020 and presented to the Senate but efforts were not successful; the last bill was withdrawn in August 2021. It had sought to provide the right to reproductive health care, set standards of reproductive health, and provide the right to make decisions regarding reproductive care. It had, before its withdrawal, met with great opposition from some religious groups, politicians, civil society organizations (CSOs), and other lobby groups opposed to the proposals.[xl] This was a lost opportunity to define SRHR in a legal framework for ease of implementation.

The Kenya National Adolescents Sexual and Reproductive Health Policy 2015 (under review) acknowledges that adolescents should be provided with services that are responsive to their needs, specifically prevention, testing, treatment, and management services for STIs such as HIV/AIDS and HPV; and contraceptive services. It also calls for access to comprehensive and age-appropriate information and education on sexuality; education both in school programmes and in programmes for out-of-school adolescents. In a bid to ensure adolescent inclusion, the policy calls for promotion of adolescent participation in decision-making processes with regards to policy, advocacy, budgeting, planning, research, and implementation. In these aspects, the policy provides guidance to meet the emerging trends and needs of adolescents and to comply with global commitments. The policy promotes integrated approaches, strengthened leadership, and coordination with renewed political commitment to strengthen implementation and mobilize resources to ensure effective implementation and monitoring and evaluation. It is important to review the policy to allow compliance with emerging trends i.e. digitalization of SRH services among others.

The National Guidelines for Provision of Adolescent and Youth Friendly Services in Kenya (2016) also promote sexual and reproductive health services and information that should be provided to adolescents and young people. The policy recognizes that the need for third-party authorization (including parental and spousal consent) before accessing services is a barrier to access. Additionally, it envisions adolescents and young people having access to a wider range of SRH services and information. Its description of essential youth-friendly services includes counselling and information on sexual and reproductive health; pregnancy testing; counselling, screening, treatment, and management of STIs; testing for and treatment of urinary tract infections; counselling on contraception and access to the full range of contraceptive methods; counselling and treatment of irregular or painful menstruation; screening for anemia; post-

abortion care (PAC); antenatal and post-natal care; and screening services for both breast and cervical cancer. Implementation of the policy is limited through providing third party's consent, which is a violation of the rights of women and girls who mostly require the services.

The youth/adolescents who participated in this study indicated that the SRH services offered across the facilities are not adolescent friendly and occasionally expose them to unfriendly health providers who deny them the required services. One of the youths said thus;

> ***I feared going back for my check up after my first antenatal clinic since the nurse scolded me for getting involved with men when I was only 15 years old. She was so harsh……***

2. Age of consent to sexuality

The age of sexual intercourse consent in Kenya is 18 years. This is governed by the Sexual Offences Act 2006 and Penal Code and the Evidence Act. The Sexual Offences Act has had challenges in prosecuting boys under 18 years when they engage in consensual sex with girls who are under 18 years of age. While reporting and responding to the list of issues raised by the the committee on the African Charter on Human and Peoples Rights, Kenya indicated that the term consensus is not preferred for use domestically for children and instead opted to use the term non -violence sex, indicating that the sexual action was not forced.[xli]

The State in its report to the Committee Experts on the Rights of the Child, indicated that it does not discriminate the boy child. That Children found to be culpable of sexual offences are treated as children in need of care and protection. This is done by filling a protection and care form and opening a protection and care file for both instead of filing a charge sheet, as in other criminal prosecution.

The Judiciary in the case of ***POO (A minor) v Director of Public Prosecutions & another [2017] eKLR*** ruled that both children charged with sexual offence shall not be discriminated and shall be treated as children in need of care and protection. The court further stated that the two children should have counselling availed to them and/or any other non-custodial measures to ensure that the judicial officer with the support of all the justice actors instill in the children that sexual activity is prohibited until they are in a position to take full responsibility of the by-product of sexual activity meaning; pregnancy, sexually transmitted diseases and infections, reproductive health before and after bearing of a child and expenses related to the same. The Office of the Attorney General is currently reviewing the Policy and the Sexual Offences Act.

Kenya judges have found that the two minors (under 18) all need to be brought to court as children in need of care and support. The Constitution of Kenya 2010 and the Children's Act 2022 all provide for definition of a child as one below the age of 18 years. However, it is naïve for the State to burry its head in the sand to imagine that adolescents do not engage in sex until they are 18 years. There has been debate in the country as whether to amend the Sexual

Offences Act, to lower the age of Consent to sex to 16. That has been opposed by many including religious groups.

The challenge in limiting the age of consent to sexuality is in accessing SRH services. There are restrictions on when a person under the age of 18 can access the services. Young people also run into challenges when seeking HIV and AIDS services due to age. The National Adolescent Policy 2022 – 2023 has retained restrictions on Adolescents (below 18) accessing SRH information and Family Planning Services. This requires consent of parents and guardians. This is in total contradiction with the Adolescent National Policy 2015 (under review) that promotes access to age appropriate information to all adolescents.

3. Age of consent to marriage

In 2014, Kenya adopted a Consolidated Law on Marriage, the Marriage Act 2014. It defines marriage as a voluntary Union of a man and woman whether in monogamous or polygamous union. The legal age of marriage is 18 years. It is an offence to marry someone below the minimum age.

Despite the provisions of the law, child marriages are still reported across communities. The communities mainly practicing FGM tend to marry off girls once they attain the customary age of puberty, which sometimes is as low as 12 years. Once girls get married, they are denied numerous human rights including the right to education, the right to decide when to marry, who to marry and when to have children. Other communities experience child marriages arising from pregnancies in peer to peer relationships of those under 18 years.

4. Age of consent to health services-contraceptive information and services

Availability and accessibility of information and education that provides accurate, age-appropriate, comprehensive, and up-to-date information on physical, psychological, and social aspects of sexuality and reproduction is critical for the realization of adolescents' SRHR. In 2013, the Kenyan government signed the Ministerial Commitment on Comprehensive Sexuality Education and SRH Services for Adolescents and Young People in Eastern and Southern Africa, committing to scaling up comprehensive rights-based sexuality education beginning in primary school.[xlii] Kenya has further developed the Education Sector Policy on HIV/AIDS[xliii] (2013), the National Adolescent Sexual and Reproductive Health Policy[xliv] (2015) and the Kenya School Health Policy (2019), which provide for comprehensive sexuality education.

Despite these frameworks, Kenya has yet to implement the comprehensive sexuality curriculum due to numerous socio-educational challenges. Parents and some religious organizations are opposed to CSE, claiming that it would introduce children to immoral behaviors. The current life skills curriculum is not examinable and teachers are not trained to guide the pupils accordingly. The African Committee of Experts on the Rights and Welfare of the Child, in its concluding observations in 2020, called on Kenya to ensure that adolescents have access to comprehensive and scientifically accurate sexuality education by integrating the subject in national school's curriculum and having programmes to reach out to out of school adolescents.[xlv]

Upon expiry of the Ministerial Commitments on CSE, Kenya has not signed to renew the Commitment.

5. Criminalization of consensual sexual acts among adolescents

In Kenya, there are national laws and policies that criminalize, or prohibit, certain reproductive health services for adolescents. The pervasive use of criminal laws to regulate SRH services creates a climate where law-abiding health providers, individuals seeking services, and advocates face harassment, intimidation, arbitrary arrest, and detention. The Penal Code criminalizes same-sex relationships and prohibits sex work, making it difficult for sex workers and men having sex with men to access SRH services.

Adolescents are unable to comprehensively realize their SRHR, due in part to the criminalization of all sexual acts, including consensual, noncoercive, and non-exploitative sexual conduct between adolescents under the Sexual Offences Act (2006). The law therefore hinders access to comprehensive SRH services by driving stigma and myths surrounding adolescent sexuality.

Emerging evidence shows that Key Populations (sexual minorities) between ages 15 and 24 are not being optimally reached by programmes for either young people or adults, pointing to a big gap in the HIV response as high-priority, and high-risk young people are being missed out in response measures.[xlvi] The National Implementation Guidelines for HIV and STI Programming among Young Key Populations reports that members of young key populations who are victims of violence are reluctant to approach the police for fear of extortion, sexual abuse, or arrest. Moreover, service providers hesitate to provide services and commodities because this could be misconstrued as encouraging children to perform sexual acts or engage in drug use; Kenya's Sexual Offences Act criminalizes sexual offences with children and mandates their protection from harmful practices, sexual exploitation, and drug use. Furthermore, minors require parental consent to access sexual and reproductive health–related services and to participate in research. These factors hinder access to services, especially when individuals' medical issues require them to disclose their sexuality or the nature of their work.[xlvii]

6. Criminalization of HIV and AIDS

The HIV and AIDS Prevention and Control Act[xlviii] provides measures for the prevention, management, and control of HIV and AIDS; for the protection and promotion of public health; and for the appropriate treatment, counselling, support, and care of persons infected with or at risk of HIV and AIDS infection. It makes it an offence for a person who is aware of being infected with HIV or who is carrying and is aware of carrying HIV to knowingly and recklessly place another person at risk of becoming infected with HIV, unless that other person knew that fact and voluntarily accepted the risk of being infected.

S.24 of the Kenya's HIV and AIDS prevention and Control Act No. 14 of 2006 criminalized the failure by a person living with HIV and take all reasonable measures and precautions to prevent HIV transmission and the failure to inform 'sexual contacts' of their HIV status. The courts have made pronouncements on the matter when called upon. In the decided case of **AIDS Law Project v AG & 13 others**,[xlix] the High Court found that the provision was unconstitutional and

invalid and violated the privacy of people living with HIV and AIDS. The legislature is yet to review the law to remove the offending section.
Secondly, S.26 of the Sexual Offences Act 3 of 2006, also criminalizes doing anything or permitting anything to be done which the person could reasonably know is likely to transmit HIV. It creates the offence of 'deliberate transmission' of HIV.

The Constitutionality of S.26 of the Sexual Offences Act was challenged in court by the Kenya Legal and Ethical Issues Network on HIV/AIDS (KELIN), a CSOs engaged in promotion of human rights through public Interest litigation. The High court did not find merit in the case by KELIN and therefore criminalization of HIV transmission remains an offence in in the Sexual Offences Act. The Sexual Offences Act (SOA) amended the Penal Code and sets up various offences. S. 43 (3) (c) of SOA further classifies sex as rape if a sexual partner fails to disclose their HIV status. The Sexual Offences Act provides for Offences including rape, sexual assault, defilement, gang rape, indecent acts, promotion of a sexual offence with a child, and child trafficking.[I]

Kenya needs to reform the above legislations to conform with the International Human Rights standards, whereupon prevention of HIV transmission, access to information and services, avoiding stigma and discrimination and promoting confidentiality and the right to make informed decisions is promoted as opposed to criminalization of HIV.

7. Sexual and Reproductive Health services for young people

The Constitution of Kenya (CoK) (2010) provides the overarching framework for a rights-based approach to health. Under Article 43(1) (a), it grants all citizens the right to the highest attainable standard of healthcare, including reproductive health care. Kenya's Sexual Offences Act 2006, criminalizes sexual offences with children and mandates their protection from harmful practices, sexual exploitation, and drug use. Furthermore, minors require parental consent to access sexual and reproductive health–related services and to participate in research. These factors hinder access to services, especially when individuals' medical issues require them to disclose their sexuality or the nature of their work.[Ii]

The newly adopted Reproductive Health Policy (2022 – 2032) seeks to guarantee Universal Reproductive Health Coverage to all persons in response to SDGs 3, 5 and 10, through quality and comprehensive reproductive health interventions. The policy adopts the WHOs definition of adolescent (ages 10-19) and refers to young adults (18-19). It defines adolescent friendly services to be those delivered responsively and to the specific needs of adolescents. The policy challenges are on clarifying age of consent, improved capacity of adolescents, to make decisions because of numerous variations in policy documents. The Policy is not clear in its implementation framework how it will reconcile providing services to all and dealing with the restriction on adolescents requiring parental and guardian consent for some SRH services. The policy needs a quick review to remove the requirement of parent consent to adolescent (under 18) to access SRH services.

Other issues identified that may require better execution by the Ministry of Health working in collaboration with the Ministry of Education include programming for both in school and out of

school adolescents, provision of free sanitary towels, and access to justice for those who suffer SGBV. The Ministry of Education is responsible for curriculum development and implementation. The Ministry of Education will need to engage all key stakeholders to have an all-inclusive participatory approach in the curriculum development.

Kenya adopted the Menstrual Hygiene Management Policy 2019-2030.[lii] The policy seeks to ensure that myths, taboos and stigma around menstruation is addressed by providing information on menstruation to men and women, boys and girls alike. The provision of knowledge is aimed at breaking the silence. The policy objectives are to have an enabling legal and regulatory framework, to address the myths and taboos on menstruation, ensure women and girls have access to safe and hygienic menstrual products, services and facilities, ensure clean and healthy environment for menstrual waste and to establish an effective monitoring and evaluation, research and learning framework in Kenya on menstrual hygiene. To this end there have been attempts to provide free menstrual sanitary towels.

Provision of sanitary towels role is shared between the Ministry of Education, the Ministry of Public Service and Gender and Affirmative Action and the County Members of Parliament representing women (Women Representatives) offices. These policy providers require greater and better coordinated collaboration and partnerships to ensure that no girl is left behind in accessing sanitary pads especially those from vulnerable and marginalized communities. There are notable challenges in implementing the Menstrual hygiene policy. These include low level of education on menstrual cycles, non-availability of sanitary towels to all the adolescents that require them monthly, cultural taboos and practices that limit discussions on the subject matter and the culture of silence that limits open discussions on the subject matter. CSOs/NGOs in Kenya are also engaged in free sanitary distribution programmes mainly for school going adolescents and youth, and have also reported challenges during implementation especially the previous lack of a policy regulatory framework.

The Assisted Reproductive Technology Bill 2022,[liii] has been re-introduced in parliament. First attempt to legislate on this in Kenya was in 2014, introduced by Hon. Millie Odhiambo. It has been presented previously without success. The first bill restricted surrogacy to married couples only. The 2022 bill is nor more elaborate and aims at providing assisted reproductive technology to prohibit certain practices and to establish an authority to regulate and provide provision for children born of assisted reproductive technology processes. The wording of the draft bill indicates that surrogate mothers are proposed to be adult women. Surrogacy means assisted reproductive technology, of a woman carrying and giving birth to a baby for commissioning parent or couple. The object of the bill is to create an enabling environment for reduction of infertility, to provide a framework for protection and advancement of assisted reproductive technology and to ensure access to quality and comprehensive assisted reproductive technology services in line with article 43(1) of the CoK 2010. The proposed bill prohibits obtaining a sperm or ovum from a donor under 18 years of age or use of sperm or ovum from a donor under 18 years except for future human procreation by the minor and with consent of the parent or legal guardian of the minor (see section 17 of the draft bill).

The Africa committee of experts on rights and welfare of the child, in the 2020 concluding observations on Kenya, recommended that there should be strengthened collaboration between national government, county governments, Faith Based Organizations (FBOs), private sector and other stakeholders to facilitate the improvement of service delivery in the health sector. By extension this include all policies adopted.

8. Cultural Religious and Harmful Traditional Practices

Harmful Cultural Practices impact on enjoyment of adolescent and women to their Sexual Reproductive Health and Rights. Female genital mutilation / cutting FGM/C is widely recognized as a violation of human rights. Studies have revealed substantial gender inequities in power relations in sexuality and reproductive issues that illustrate the role of gender as a determinant of sexuality and risky behaviour in society.[liv] Women and adolescents encounter social and cultural barriers in accessing SRH services and information. They are subjected to harmful cultural practices, such as female genital mutilation or cutting (FGM/C) and early and forced marriages.

There are deep social norms that uphold these harmful practices, such as the consolidation of family interests of maintaining honor, enhancing fidelity within marriage, and preserving virginity before marriage, the social integration of the girl and family, and financial security in situations of poverty.[lv]

FGM/C is a deeply rooted cultural practice that remains prevalent in Kenya despite being outlawed in 2001 by the Children Act 2022 and Prohibition of FGM Act 2011.[lvi] Some of the adverse health outcomes of FGM/C include its association with HIV, infertility, fistula, and early/child marriage.[lvii] Studies have shown that girls who have undergone FGM/C as a rite of passage are likely to drop out of school and experience child marriage and early childbearing.[lviii] Further, child marriage is associated with termination of education, low labor force participation, increased risk of HIV infection, heightened risk of gender-based violence (GBV), and early childbearing, as well as high fertility rates. There is also a risk of high infant mortality, as well as maternal morbidity and mortality.[lix] From the last statistics by the KDHS, 2022, there is a decline of the practice recorded at 15% from 38% in 1998. Kenya did not meet its goal of eliminating FGM by the year 2022. (See the ICPD +25 Kenya commitments).

The Protection of Traditional Knowledge and Cultural Expressions Act 2016 provides for a Framework for the protection and promotion of traditional knowledge and cultural expressions. This newly adopted law is not known among most actors in the sector. It defines Customary Laws and Practices to mean Customary Laws, norms and practices of local and traditional Communities that are legally recognized in Kenya. It promotes traditional knowledge guided by Article 10 of the Constitution that promotes National Values and Principles of Governance. It is the obligation of the State to undertake dissemination and implementation of the law. This needs to be immediately disseminated to promote the protection of positive culture and outlaw harmful cultural practices, still prevalent among certain communities.

9. Learner Pregnancy Retention and Re-entry law and policy

Estimated 13,000 girls drop out of school annually in Kenya due to early and unintended pregnancy. Kenya recently adopted the **National Guidelines for School Re-entry in Early Learning and Basic Education 2020.** The policy recognizes that early/teenage pregnancy compromises access, retention, transition and completion of education for girls. The Basic Education Act requires that children of school going age to be in school and education has continued to be free for primary schools and subsidized for secondary schools. Every child has a right to education (CoK Art. 53).

The guidelines focus on learners who drop out of school for various reasons including teenage pregnancy, HIV and AIDS, Drug and Substance abuse, GBV, inhibitive cultural practice, child labor, special needs and disabilities. The Policy appreciates the menace of teenage pregnancy with some counties i.e. Homabay registering approximately 60% of out of schoolgirls aged 13-19 who have dropped out of school due to pregnancy (undue et al 2016). Among the proposed steps to be taken, include to keep the girls in school as long as possible and provide guiding and counselling, explain the school re-entry programme. Such learners shall be allowed to sit for National Examinations if their condition permits.

The school in collaboration with parents / guardians are to take reasonable steps to accommodate the learners learning, health and maternal needs. The learners are assisted through re-entry, the many times she gets pregnant notwithstanding. Learners who are beyond 18 years are to be advised to enroll in adult education and continue education. The Policy while it seeks to provide support to the girls, and boys (under 18) involved, it restricts itself to only providing practical guidance and counseling and fails to provide policy direction in terms of SRHR needs especially for girls to access the services as per the National Adolescent SRH Policy 2015. Policy makers continue to make assumptions that adolescents below 18 years do not engage in sexual activities and to do not require to access SRH services. This is contrary to the statistics indicating higher levels of child pregnancies and child marriages. The policy guidelines will require to be made available in other communication i.e. braille to ensure adolescents with disabilities are not left behind.

Guiding and counselling procedures alone cannot prevent pregnancy. The school policy needs to be alive to the reality of adolescents who are sexually active or already mothers and require help to avoid getting pregnant. The implementation of the policy, occasionally gets girls to suffer stigma and discrimination, lack social support mechanism of childcare to enable them to go back to school. There are huge gaps between what the policy provides and the actual implementation. Most teenage mothers are not aware of the policy and some get forced into child marriages, unsafe abortions while others have no resources to go back to school, since parents and guardians abandon them on learning of their situation.

There is need for the Government to have programmes to end teenage pregnancy through provision of SRHR and services. The Government must review the policy to include social protection to the girls and provide psycho-social support for the girls and care of the baby as a special category.

10. Laws and policies on Comprehensive Sexuality Education (CSE)

In 2013, the Kenyan government signed the Ministerial Commitment on Comprehensive Sexuality Education and SRH Services for Adolescents and Young People in Eastern and Southern Africa, committing to scaling up comprehensive rights-based sexuality education beginning in primary school.[lx] Kenya has further developed the Education Sector Policy on HIV/AIDS[lxi] (2013), the National Adolescent Sexual and Reproductive Health Policy[lxii] (2015) and the Kenya School Health Policy (2019), which provide for comprehensive sexuality education. Despite these frameworks, Kenya has yet to implement a comprehensive sexuality curriculum due to numerous socio-educational challenges.

A study conducted in 78 secondary schools in Kenya found that only 2% of the students received information on all the topics that should be covered under comprehensive sexuality education.[lxiii] Fewer than half of teachers (46%) reported having received any training on teaching sexuality education, and most of the teachers held misconceptions about a range of issues related to adolescent sexuality, including the belief that making contraceptives available encourages young people to have sex (62%).[lxiv] As such, most teachers were found to focus on abstinence as the best or only method of preventing pregnancy and sexually transmitted infections.[lxv] Numerous studies have shown that programmes that exclusively promote abstinence while withholding information about contraception are not effective at improving adolescents' sexual and reproductive health.[lxvi]

These findings are consistent with the findings of yet another research conducted by the Center for Reproductive Rights in 2021 on access to SRH information by women and girls in Kenya.[lxvii] The study, conducted in five of the most populous counties in Kenya, found that 62% of women and girls understand what reproductive rights are but that a majority of women do not have a comprehensive understanding of what sexual and reproductive health entails outside family planning and STI reduction and management. Furthermore, a majority of women and girls were unaware that reproductive health rights are enshrined in the constitution.

The lowest levels of understanding on CSE, were found among young women, unmarried women, and women with limited education. The lack of knowledge on SRH was not uniform across the different facets of SRH services. The restrictions through teachings by religious leaders has contributed to the negative attitudes toward CSE across the country. The fear especially from the Catholic Bishops is that the curriculum would introduce LGBTQ that will destroy the youth and the country at large. They have been organized groups of individuals, religious leaders, parents and CSOs that have engaged in high level social media advocacy against CSE and have called on Kenya to withdraw its signature to the Ministerial commitment on CSE. Indeed, Kenya has not yet re committed itself to the initiative whose aim is to scale up and deliver CSE and sexual reproductive health services for young people.

CSOs made a call to the Kenya Government to re -commit to the Ministerial Commitment on Comprehensive Sexuality Education and SRH Services for Adolescents and Young People in Eastern and Southern Africa, beyond 2020. The commitments herein have not been realized since 2013. Draft guidelines on age appropriate CSE have not been finalized. Religious leaders have opposed the introduction of CSE in schools, despite available evidence that the CSE

increases knowledge on HIV and other sexual and reproductive health issues. Kenya has adopted the teaching of Life Skills model that is less controversial. However, it was evident that teachers and trainers have limited capacity to handle the life skills proposed topics. On the other hand, parents have not effectively played their role of complementing the teaching of the age appropriate information on sexuality.

11. Unsafe abortion

Article 26(4) of the constitution permits abortion if, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger or if permitted by any other written law.[lxviiilxix] Despite the adoption of the 2010 constitution, no single law consolidates the legal provisions on abortion. The law on abortion in Kenya must therefore be pieced together from various laws including the Sexual Offences Act (No. 3 of 2006) which allows for the formation of guidelines on provision of health care services to victims of sexual violence.[lxx]

The Penal Code, in sections 158 to 160, criminalizes unlawful abortion. These sections of the Penal Code operate as a blanket ban on abortion, which is inconsistent with the constitution and the other laws discussed above.[lxxi] The upshot is a contradictory legal framework in the country on the question of abortion, providing legal barriers to implementation of abortion as part of SRHR. Post-abortion care, on the other hand, is unconditionally legal in Kenya. It is considered emergency medical treatment, which is a right for all under Article 43(2) of the Constitution of Kenya[lxxii]. The Kenya Maternal and Newborn Health model recognizes post-abortion care (PAC) services as one of its pillars and one of the strategies for improving maternal survival. To this effect, the Ministry of Health has developed two documents: i) The National Post Abortion Care Training Curriculum for Health Service Providers (Ministry of Health, 2012) and ii) The National Post Abortion Care Reference Manual (MoH, 2013). These two documents were developed out of the need to equip reproductive health service providers with the necessary knowledge and skills to provide timely, high-quality PAC services to reduce morbidity and mortality associated with complications of unsafe abortion. There has been a skills transfer in Kenya whereby nurse midwives and clinical officers are trained to provide post-abortion care.[lxxiii]

In 2018, the Ministry of Health in collaboration with African Population and Health Research Centre (APHRC) undertook a study on the costs of treating unsafe Abortion complications in Public Health facilities in Kenya. [lxxiv]The findings were that as the cost of managing complications of unsafe abortions in public facilities in Kenya were substantial and the treatment consumes considerable financial resources. Further, that treatment of one case of unsafe abortion complication in Kenya's Public Health family uses average of 7.4% hours of health personal time. (Nurses and Clinical Officers). The study recommended among other strategic interventions promoting women's access quality post abortion care, including post abortion family planning, counseling and improved provision and education on family planning. It called on Kenya to rethink its structure of sexual and reproductive health care delivery to ensure both access to and the availability of quality providers at all levels of care.

The Government must forthwith reinstate the withdrawn standards and guidelines and national training curriculum for the management of unintended, risky and unplanned pregnancies. This will ensure health care providers are trained and well-coordinated to provide the services as per the constitutional provisions in article 26(4).

In the landmark case of Federation of Women Lawyers (FIDA – Kenya) & 3 others v Attorney General & 2 others; East Africa Center for Law & Justice & 6 others (Interested Party) & Women's Link Worldwide & 2 others (Friend of the court) [2019] eKLR[lxxv] In the case of FIDA-Kenya and 3 Others versus Attorney General and 2 Others, (referred to as the JMM case), the High Court of Kenya has clarified on provision of article 26(4) of the Constitution of Kenya. CRR brought the case to claim violations of the rights of a young Kenyan aged 14 years (JMM) who died from complications that resulted from unsafe abortion. She became pregnant as a result of rape (defilement).

The case was filed against the Attorney General, Director of Medical Services and the Ministry of Health. She was unable to access safe abortion and had her pregnancy terminated by unqualified provider and did not also receive post-abortion care required. The guidelines were a very key policy document adopted to guide healthcare providers in providing the services.

The High Court found that the 2014 Ministry of Health withdrawal of "The Standards and Guidelines for Reducing Morbidity and Mortality from unsafe abortion violated the rights to Abortion in Kenya and its subsequent ban on abortion trainings for health care professionals was arbitrary and unlawful. The court reiterated that the right to health includes complete physical, mental and social wellbeing and that victims of sexual violence in Kenya have the Constitution right to abortion. Article 26(4) is the incidence where the constitution permits abortion in Kenya, for purposes of emergency treatment or where the trained health care provider concludes the life of the mother or the foetus is in danger. The Court has clarified that emergency treatment refers to the necessary immediate health care that can be administered to prevent death or worsening of a medial situation.

The Court ordered the following: -

a) Declared that women and girls have the right to the highest attainable standards of health.
b) Ordered reparations to JMM's mother.
c) Declared the memo withdrawing the guidelines to have violated and threatened the rights of health workers and the memo and letter were unlawful.
d) Declared that abortion is permitted for victims of sexual violence.

12. Freedom from Gender Based violence

Pursuant to the Sexual Offences Act, the National Guidelines on Management of Sexual Violence in Kenya (2009) [lxxvi]were developed. Under these guidelines, survivors of sexual violence have a right to access termination of pregnancy and post-abortion care. The guidelines also stipulate that the core components of a comprehensive response to sexual violence includes clinical evaluation, examination, and documentation; HIV testing; HIV prevention through the use of post-exposure prophylaxis; pregnancy prevention through the provision of emergency contraception (EC); management of sexually transmitted infections (STIs); counselling for trauma; and referral for the well-being of survivors.

Despite the constitution's right to be free from violence and the criminalization of sexual violence in Kenya, rates of sexual violence remain high. SGBV disproportionately affects women and girls, who represent a vast majority of reported cases of sexual violence in Kenya,[lxxvii] with one in five women and girls reporting having experienced sexual violence in their lifetime.[lxxviii] One-third of girls report having experienced sexual violence before the age of 18.[lxxix] Although sexual violence occurs both inside and outside the home in Kenya, almost all perpetrators are known to the victim, with most perpetrators being current or former husbands, partners, or boyfriends.[lxxx] Rural women are more likely to have experienced sexual violence than women in urban setting,[lxxxi] while women in some rural communities are accorded much lower social status than men, a status that is perpetuated and reinforced by violence or the threat of violence. Low-income women and those with less than a secondary education is also more likely to experience sexual violence.[lxxxii]

Victims of sexual violence in Kenya often remain silent about their experiences because being a victim of sexual violence is stigmatized. Victims may be blamed for the rape,[lxxxiii] and victims have spoken about their own community shunning them by stating they are "useless" to the community. As a result, 60% of women and girls in Kenya who have been subjected to violence do not report that violence to authorities,[lxxxiv] and 45% never seek help or tell anyone about the violence.[lxxxv] Gender-based violence, including sexual violence, has a significant impact on the physical and mental health of women and girls in Kenya and on the health and well-being of society. Victims of violence will often have long-term physical health problems, including chronic pain, associated with injuries.[lxxxvi] Women and girls who are the victims of gender-based violence may also suffer short- and long-term mental health problems, including negative behaviours, alcoholism, anxiety, depression, post-traumatic stress disorder, low self-esteem, and suicidal tendencies. These physical and mental health issues negatively affect their productivity, their work, and the ways in which they engage with their families and communities.

Survivors of SGBV may also experience poor SRH outcomes, such as unplanned pregnancies, risk of HIV infection, obstetric and perinatal complications, and even death. Inadequate friendly SRH services for women, girls, and children affect their access to health, education, and economic opportunities.[lxxxvii] The National Gender and Equality Commission (NGEC) reports that the commitment to addressing SGBV in Kenya has advanced more quickly in policy documents than in practice. It further states that there are wide gaps between actual legislation and the experience of victims of SGBV emanating from implementation process, and there is a

considerable amount of operational confusion at multiple levels.[lxxxviii] The NGEC calls for multifaceted approaches contextualized to the specific counties to curb SGBV at the county level since the counties are closer to the people.[lxxxix]

13. Budgeting /Financing ASRHR

In the year 2001, AU member States adopted the Abuja declaration where they pledged to commit at least annual allocate 15 % of its Budget to the Ministry of Health. At the same time, they urged the Donor community to increase their support to improve the health sector. In a study undertaken by World Health Organization 10 years after the commitments, only three countries were on track, namely Mauritius, Seychelles and Eritrea. Kenya was rated among those that has made insufficient progress. Thereafter international commitments were made in the MDGs and now SDGs, and countries have made significant progress in budget allocation.

According to a 2015 study on inequity in costs of seeking SRH services in Kenya, lower-income households spent a higher percentage of their income on care than higher-income households spent. In Kenya, spending on SRH as a percentage of household income ranged from 0.03% to 7.5%. Further, the poorest households spent 10 times more on care than the least poor households. The said study concluded that highly regressive spending on SRH services highlights the heavier burden borne by the poorest when seeking care in resource-constrained settings such as Kenya.[xc] The Ministry of Health budget for family planning is extensively funded by development partners. Kenya in the devolved functions sees health managed at the county level. The budget allocations are varied, but are huge on infrastructure. The data available on budget is not disaggregated to enable the study make conclusive estimates on the actual expenditure on ASRH.

A study by KNCHR found that the Health Budget in Kenya has stagnated between 5% - 7% and Kenya has not met the 15% as adopted in Abuja Declaration. The Study revealed a worrying trend that the National Health Insurance Coverage only reached 19% of the Population, despite the same being the government flagship project toward Universal Health Coverage. The SHARP partners will require to work closely with the Ministry of Health, Department of Adolescents to access the budgetary allocations and undertake disaggregated analysis. Further, since health services is a devolved function, sub national contacts at various counties of interest will need to be done by SHARP partners to assess the budget allocations at the county levels on ASRH services.

C. Accountability: The Role of the Kenya National Commission on Human Rights (KNCHR)

The KNCHR has embraced work on promoting economic, social and cultural rights since its inception. KNCHR was among the first NHRI's in Africa and globally to use the human rights accountability framework to seek implementation of SRHR. In its April 2012 report of "a Public Inquiry into violations of SRHR in Kenya", the Commission investigated issues of Access availability, affordability and quality of SRHR Services generally including Adolescent SRHR as a vulnerable group. It included a section on vulnerable groups, including adolescents. The Commission has continued to engage more on SRHR. In its 2020 State of Human Rights Post

2010 Constitution Study, the Commission made findings that the health services in Kenya were increasingly inaccessible and failed to meet the human rights standards.

Further, the Commission has continued to receive complaints on violations of the right to health including SRHR. The Commission investigated the pain of Covid19 to the Public using a Human Rights Framework. It has also participated in the Strategic Public Interest Litigation on matters that challenged the freedom of movement. Kenya has ratified most treaties relevant to promoting ASRHR. These are the CEDAW, ICESCR, the Maputo Protocol and the African Charter on the Rights and Welfare of the Child. Kenya has effectively and timely reported it progress to the relevant committees. The KNCHR has seized the moment drawing from its mandate and has actively engaged with the human Rights treaty bodies, internationally and regionally to shape the outcomes of reporting.

The Commission has effectively utilized shadow reporting as a Mechanism of accountability and the African Union level. Specifically, in September 2021, the commission presented a Shadow Report on Maputo Protocol. The Commission brought to the attention of the African commission that, Kenya's continuous violation of the right to safe abortion, as provided in article 14 (2) of the Maputo protocol. The commission in its shadow reporting raised concerns with the State Party withdrawal of Standards and Guidelines and the National Training Curriculum for the management of unintended, risky and unplanned pregnancies that has led to confusion in women and girls seeking services that are guaranteed in the constitution (article 26(4).[xci]

KNCHR recommended that Kenya considers removal of Article 14(2) (c) of the Maputo Protocol and reinstate. Indeed, the reservation is an abuse of the Kenya constitution 2010 that authorizes certain incidences when abortion is allowed. This study finds KNCHR has the capacity to work on all aspects of ASRHR, as it has over many years conducted inquiries, studies on SRHR under its *ECOSOC programme*. Further it has received and processed complaints of SRHR violations.
However, KNCHR may require further capacity on deeper understanding on how to engage with ASRHR specific interventions and to continuously hold the state accountable for realization of SRHR including ASRHR. KNCHR continues to be strong in its promotional and protective mandate and works well with CSOs and public bodies alike.

D. KEY RECOMMENDATIONS

For NANRI

1. To disseminate the findings from the study to the NHRIs involved and promote understanding of the legal and policy frameworks on ASRHR in each country, to ensure rights of all adolescents are promoted, protected and fulfilled.

2. To engage in continuous capacity building and understanding of each country's policy and legal framework on ASRHR and work toward achievement of Universal Adolescents Sexual

and Reproductive Health and Rights in conformity with the Maputo protocol and SDGs 3 and 5, calling for full implementation of all regional commitments.

3. To establish a broader and strong political advocacy movement at the African Union level comprising of NHRIs, CSOs and Partners to advocate and lobby for implementation of Resolution 275 and to hold governments accountable towards full domestication and implementation.

For NHRIs (KNCHR)

1. Kenya has ratified the Maputo protocol but has not put in place mechanisms to implement the same. It still has made reservation on Article 14(2) (c). KNCHR to consider lobbying and continuous advocacy for Kenya to lift the reservation and fulfill its obligations through implementation of legal, policy and administrative frameworks that complies with the protocol to make SRH services available to adolescents across all facilities in the country.

2. Working with CSOs, networks and partners, KNCHR should sustain continuous high-level political advocacy calling on the State to reinstate and implement the Standards and Guidelines on Safe Abortion that were withdrawn and reinstated by the court.

3. Work with the Ministry of Justice and Parliament to harmonize the legal and policy frameworks that are divisive for example the Sexual Offences Act, HIV Prevention and Control Act among others. In the same line advocate for passage of the Reproductive health Bill pending in the Senate.

4. To invest in its own capacity to create more awareness on all legal and policy frameworks in the country, regionally and internationally on ASRH and advocate for review of legal and policy frameworks identified herein as being contradictory and limiting access to ASRHR and services i.e. the new adopted National Reproductive Health Policy 2022-2032.
   To coordinate all partners, Networks and CSOs working on ASRHR to develop a strong accountability mechanism that would deliver Adolescents' SRH information and services that meet the threshold of the right to health, being available, affordable accessible and of good quality.

5. To Join hands with duty bearers to develop a human rights-based framework towards implementing legal and policy framework on ASRHR, including allocating adequate budgets, setting up youth friendly services, review of the age appropriate comprehensive sexuality education curriculum, and review of all legal and policy framework to guarantee quality SRH services to adolescents.

6. Promote full and meaningful participation of Adolescent in Policy decision making including review of existing laws and policies that are discriminatory.

7. Advocate with Parliament for increased budgets in health and further seek that budget implementation be disaggregated to know component spent on Adolescent SRH Service for better understanding and planning and implementation for their needs.

8. To develop a Training Manual and give continuous capacity to health practitioners, Ministry of Education employees and other public and private actors in relation to the issues on issues of Adolescents and SRHR.

9. Review the findings herein and Identify areas in the health sector where there are barriers for adolescents in accessing SRH information and services and make appropriate recommendations for adolescents to meaningfully participate and engage in policy making in order to enjoy their rights.

10. Conduct regular inspections at various health services to ensure the services meet the AAAQ using human rights framework.
    - Availability
    - Accessibility
    - Acceptability
    - Quality
11. Disseminate the concluding observations from the recent reporting by Kenya on the Maputo protocol and the African Charter on the Rights and Welfare of the child.

CSOs and Other Non-State Actors

1. Increase accountability platforms to demand that duty bearers adopt policies/regulations and where they exist, implement ASRHR and services as per the WHO guidelines and recommendations, and advocate for review of restrictive laws/policies that act as a barrier for adolescents in accessing SRH services.

2. Engage in targeted advocacy at domestic level to lobby for increased Budget allocations to Health as well as mobilize external resources toward implementation of State's set priorities on ASRHR and advocate for States to adopt, develop and implement commitments existing at the international, regional and sub regional levels that advance ASRHR, i.e. CEDAW, ICPD Cairo, Maputo Protocol, etc.

3. Advocate for inclusive joint programming approaches through partnerships and collaboration that will empower communities and integrate sustainability frameworks, and avoid duplication.

4. Form and/or join existing networks to engage with policy makers and advocate for inclusive policies to invest more in ASRHR to guarantee the availability, accessibility, affordability and quality SRH for all adolescents respecting intersectionality.

5. Form alliances to undertake targeted public education and awareness creation on Sexual and Reproductive Health Rights of adolescents and young people using a multi-sectoral approach that brings on board different actors involved in ASRHR programming, thus religious, women organizations and youth, private and adolescent specific actors).

6. Engage in continuous dialogue with policy makers including National Parliaments and provide them with available sex disaggregated data to make a case for the need to adopt and or review existing policies and or legal framework that hinder adolescents seeking SRH services and advocate for local allocation of more resources to meet the demands by the adolescents for quality services.

7. Partner with KNCHR and report complaints of ASRHR violations and participate in monitoring human rights violations, undertaken by the Commission.

8. Link with regional organizations working at African Union Level (ECOSOC accreditation) to use regional mechanisms, for example writing Shadow and alternative Reports and filing complaints after exhausting domestic remedies on ASRHR.

9. To strengthen partnership and collaboration to understand and build their own capacity address the legal, policy and administrative barriers on Adolescent SRHR.

10. Advocate and put in place programmes for adolescents in and out of school adolescents to bolster their participation and understanding of SRHR and the available accountability mechanisms when the rights are violated.

3. 2. UNITED REPUBLIC OF TANZANIA

A. Demographic Health Indicators Relevant to ASRHR in Tanzania

The 7th Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS) was released of 2022. 20% of the female respondents and one quarter of male respondents were adolescents (age 15-19). The total Fertility rate is higher in rural areas than in urban areas. The average fertility is 4.8 children in a woman's lifetime. A rural woman in the mainland is estimated at 5.5 children in rural while in urban setting it is at 3.6 children. Fertility was found to be lower among adolescents ages 15-19, estimated at 112 births per 1000 women as compared to 222 births per 1000 among those aged 25-29.

The past 2015-16 TDHS-MIS, estimated the median age at first marriage for women and men to be 19.2 and 24.3 years respectively. 18% of married women have co-wives compared to 9% of married men who have more than one wife. Averagely men tend to initiate sexual activity one year later than women. Further, the median age at first intercourse for men aged 25-49 was 18.2 years while median age for women of same age is 17.2 years. The marriage and sexual activity help determine the extent to which women are exposed to risk of pregnancy. 36% of women aged 25-49 marry before their 18th birthday and 59% marry before their 20th birthday. However, for men the same age, percentage 45% and 15%. A large majority of women (85%) are married by age 25. The median age for first marriage was 18.8% for women and 24.3 years for men. Educated women and men tend to wait longer before having sex.

Young people who initiate sex at an early age are typically at a higher risk of becoming pregnant or contracting sexually transmitted infections than younger people who initiate sex later. 12% of young women and 13% of young men age 15-24% had sex before they were 15. About 60% of women and 51% of men age 18-24 reported having sex before reaching the age of 18. The level of education contributes the decrease of age at first sex.

Youth in Tanzania are at a greater risk of contracting sexually transmitted infections (STIs) including HIV/AIDS and of having unwanted pregnancies in the period between first sexual intercourse and marriage. Knowledge of HIV transmission id crucial to enabling people to avoid HIV infection, and especially for youth people. 42% and 32% of women and men respectively of age 15-24 have thorough knowledge of HIV prevention. 65% (Two third) of women 15-24 know that using condoms every time they have sexual intercourse is an HIV prevention strategy. 72% of men age 15-24 know that limiting sexual intercourse to one uninfected partner can reduce the chance of acquiring HIV.

Sexual behavior is important in designing and monitoring intervention programmes to control the spread of STIs and HIV. Among women and men of age 15-49, who had sexual intercourse with a person who was neither their spouse nor lived with them in the last 12 months before the survey, 22% of women and 43% of men used a condom the last time they had sex with such a partner. There was likelihood of having shorter relationships with more partners. The 2015-16 TDHS-MIS found that 35% of young women and 47% of young men had sex during the 12 months preceding the survey. While condom use during pre-marital sex is not that high in Tanzania only 37% of women and 41% of men reported that, they used condom the last time they had sex. Condom use and premarital sex are higher among younger men and women in urban areas as compared to rural areas.

The 2015-16 TDHS-MIS, estimated that each year, in Tanzania, approximately 80,000 girls drop out of school due to pregnancy. This could fuel HIV infections, sexual, physical and psychological violence are the most common forms of violence affecting adolescents. 11.2% of girls and 5.9% of boys have experienced one form of sexual violence. Adolescent girls are disproportionally affected. Teenage pregnancy is a major health and social concern for Tanzania since it is associated with higher morbidity and mortality for both the mother and the child, and girls drop out from school that contributes to early marriages. Child bearing during teenage years has adverse consequences for educational attainment. In assessing Teenage pregnancy, the TDHS-MIS found that 22% of women age 15-19 have ever been pregnant, 16% of the same age have had a live birth, 2 % had had a pregnancy loss while 6 % were pregnant at the time of the assessment. The rural setting presented higher rate at 18.3 as compared to 16.6 for the rural.

The trends among currently married women-age 15-49 using of modern method of contraception roughly remained the same as in the 2015-16 TDHS-MIS, which was slightly over 20%. The 2022 TDHS found that the need of family planning among married women dropped to 21% from 22% in 2015-26 and 24% since 1999. Further the 2022 TDHS found that 32% of sexually active, unmarried women have unmet need for family planning. 76 % of sexually active, unmarried women have demand for family planning, while 59% is satisfied, with 48% of modern methods.

In 2015-16 TDHS-MIS, Knowledge of contraceptive methods was quite high at 99% of then married women age 15-49 and 100% of married men age 15-49. The contraceptive prevalence rate among married women in Tanzania was 38%. Urban married women were slightly more likely to use modern contraceptives than rural married women. (35% versus 31%).

The under 5 mortality rates for the 5year period preceding the 2022 TDHS is 43 deaths per 1,000 live births, a great decrease from 147 in the 1999. Infant mortality rate, thus the measure of deaths in the first year is estimated at 33, per 1,000 live births. Antenatal case (ANC) from a skilled provider is considered very important in order to monitor pregnancy and to reduce morbidity and mortality arising from pregnancy risks. Nearly 9 women out of 10 received ANC from a skilled provider for their last live birth in the 2 years before the survey. 65% of women received 4 or more ANC visits during pregnancy that resulted in a live birth in 2 years before the

survey. 81% of live births 2 years preceding the survey were born in a health facility as compared to 93% still births. 85% were delivered by a skilled birth attendant, in the same period, 2 years preceding the survey as compared to 96% still births. There was a great increase in the percentage of births assisted by a skilled birth attendant, from 66% in 2015-16 TDHS-MIS.

The maternal mortality ratio in Tanzania in 2015-16 was estimated at 556 maternal deaths per 100,000 live births. Mortality rates were marked higher among women than men in the younger age groups between ages 15 and 34. While reporting during the Universal Periodic Report in 2021. Tanzania indicated that the maternal mortality ratio had sharply decreased from 556 to 197 per 100,000 in 2020. This had been achieved through the successful implementation of the National RoadMap Strategic Plan to improve Reproductive, Maternal Newborn Child and Adolescent Health in Tanzania (2016-2020). Tanzania is also committed to the Global Strategy for Women, Children and Adolescents of 2016-20130, by providing services and ensuring that no one is left behind.

The 2015-16 TDHS-MIS provided estimates on Female Genital Cutting / Mutilation and sexual violence. The 2022 estimates have not released the new findings on the two key gender issues. 10% of women aged 15-49 had been circumcised, a decline from 18% in 1996. FGM is more prevalent in rural areas than urban. The highest percentage of circumcised women are in Manyara and Dodoma regions (58% and 47% respectively). 35% of circumcised women age 15-49 were circumcised before age 1 and 28% were circumcised at age 13 or older. Girls are likely to be circumcised if their mothers were circumcised. 86% of women who have heard of FGM, 95% believe that the practice is not required by their religion and should be discontinued. 40% of women age 5-49 have experienced physical violence. 17% had experienced sexual violence. Mainly husbands / partners were the main perpetrators of violence (37%). 15% of married women, reported to have ever experienced physical, sexual or emotional violence.

Table 1: Summary of Selected Sexual and Reproductive Health–Related Statistics from TDHS

	Parameter	Details	Value
1.	Under 5 mortality	# deaths Per 1,000 live births (TDHS-MIS 2022)	43
2.	Infant mortality	# deaths per 1,000 live births (TDHS-MIS 2022)	33
3.	Maternal mortality ratio	#maternal deaths per 100,000 live births in 2015-2016 **197** maternal death per 100,00 live births (TDHS-MIS 2022)	556
4.	Teenage Pregnancy	% women aged 15-19 years have begun childbearing (TDHS 2022)	22%
5.	Adolescent seeking Contraceptives	% accessing services (15-19) (TDHS 2015-16) young women young Men	 37% 41%
6.	Health Budget	% of gross domestic product (2020 Budget estimates)	7%
7.	Contraceptive prevalence rate	% Modern methods (TDHS 2022) Sexually active Married women Sexually active Unmarried women using contraceptives	 38% 45 %

8.	Unmet needs for family planning	% of currently married women 15 to 49 years old (TDHS-2022) % of sexually active unmarried women with unmet need for family planning % of sexually active unmarried women who have demand for family planning	21% 32% 76%
9.	Female genital mutilation	Prevalence among women aged 15-49 (2015-16-TDHS)	10%
10.	Gender-based violence	Prevalence (20115-16 TDHS) % Prevalence of Physical, sexual, or emotional violence among women age 5 -49 % Prevalence of physical violence in women of age 5-49 % Prevalence of sexual violence in women aged 5-49 Sexual violence among adolescent girls Sexual violence among adolescent boys	 15% 40% 17% 11.2% 5.9%
11.	Total Fertility Rate	# of children per woman	4.8

B. The Legal and Policy Content Analysis

Findings and Analysis

1. Equality and non-discrimination Principles

The United Republic of Tanzania prohibits discrimination based on gender (Art. 13(15) of and amended by article 12(15) of the Constitution of Zanzibar 1984. The constitution promotes the right to life, privacy, dignity and right to equality (article 12 & 16). Further, it protects the right to equal protection of the law. The constitution is supreme and prevails against any other law.

The Constitutions does not conform to the definition of discrimination, (direct or indirect) as provided by CEDAW. The constitution has not harmonized statutory law and customary and religious law. The Tanzania adolescent health and development strategy recognizes that very little information is available on the status, implementation and impact of policies related to adolescent health in Tanzania.

The government has strategies in place to expand adolescent friendly sexual and reproductive health services. This approach has increased uptake of HIV Testing Services. (HTS). The 2016-2020 National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child and Adolescent Health[xcii] recognizes that only 30% of service delivery points meet the standards of adolescent friendly sexual and reproductive services. The health sector HIV and AIDS strategic plan (2015-2020)[xciii]identifies critical components of adolescent friendly services for scaling up. Adolescent girls and young women are noted to be at risk of HIV infections and the plan outlines how they will receive adequate services and care. The Tanzania Vision 2025, identifies health as a priority sector and key among the strategies identified include ensuring access to quality reproductive health services for all appropriate ages and gender equality and empowerment of women.

The new National Five-year Development Plan 2021/2022-2025/2026 [xciv]has prioritized ensuring increased coverage of health insurance scheme and is in the process of amending the insurance law to provide one single insurance fund. The proposed key interventions seek to construct more health facilities and to improve health services responses. However, there is no direct mention of SRH services. Nevertheless, there is proposal to improve the indicators related to SRHR. These include reduction of maternal mortality from current 36 per 1000 live births to 30 in 2026, maternal mortality from 220 to 180 per 100,000, live births, national HIV prevalence from 4.7% to 3.1% and health expenditure from current 10% to 12.2%.

The National Adolescent Health Development Strategy 2018-2022[xcv]was premised on the fact that adolescent account for a fourth of the population and therefore the need to pursue positive development especially the health and well-being of adolescents with focus of sexual and reproductive health. The strategy noted that the greatest risk factors for adolescent health in Tanzania included poor sexual and reproductive health including sexual transmitted infections, malnutrition, anaemia, substance abuse, mental health concerns and violence including gender based violence. The proposed strategic action included engaging adolescents to strengthen their capacity to be involved in decision making and to demand their rights, ensuring the youth friendly services are available, strengthening policy and legal framework to deliver on the commitments, investing more in accurate data and access to information, increasing budgetary allocations to continuous service delivery and strengthening coordination and cooperation amongst organizations working on matters adolescents.

The National Accelerated Investment Agenda for Adolescent Health & Well-being –(NAIA) (2019-2022),[xcvi] noted that adolescents have been ignored and not much attention has been paid to them. Evidence showed that investment in adolescents health and particularly reproductive health can triple dividends. The investment strategy was developed with support of Gates Foundation. The vision for this Agenda is to accelerate the improvement of adolescent health and well-being to support transition of an educated, health, and empowered adolescent into adulthood. The six pillars selected to address core issues identified are: preventing HIV, preventing teenage pregnancies, preventing physical, sexual and emotional violence, improving nutrition, keeping boys and girls in school and developing skills for meaningful economic opportunities .

The report of United Tanzania's analysis of education sector in 2021 found that the State has put in measures that promote equality in access to education. Further the Integrated programme for out of school adolescents served as a pathway for out of school adolescents and it was now being piloted in 72 centres in 8 regions namely Mbeya, Iringa, Njombe, Songwe, Kigomo, Tabora,, Dodoma and Dar es Salam).[xcvii]

2. Age of consent to sexuality

The Education Act (1978) provides that the best interests of the child are of paramount consideration and that every teacher, craftsman and trainer execute it as a duty. It is an offence in the Education Act for a teacher, craftsman or trainer to impregnate a pupil of

primary or secondary school. The United Republic of Tanzania has made progress to define the child as one up to the age of 18.

The laws that have domesticated the Convention of the Rights of the Child (CRC) principles are: -

i) The Law of the Child Act (2009)-Applicable in Tanzania Mainland and
ii) Children's Act 2011 applicable in Zanzibar.

The age of consent for sexuality in Tanzania is 18 years, without exception. The law does not allow anyone under the age of 18 years to have sex with another of similar age. The penal code (section 135) states that where a sexual assault relates to a person under i8 years, there shall be no defense that the child consented to the act constituting the assault.
Further, the Sexual Offences (Special provisions) Act 1998, any person who commits an act of sexual exploitation of a child shall be imprisoned for 5-20 years. A child shall not be engaged in any work that exposes them to sexual activities. (section 83 of the law of the child Act). It is an offence to impregnate a schoolgirl as per the education Act. However, the Education and Expulsion and Exclusion from school's regulation of 2002 makes it unlawful to expel a child from school for being pregnant. In Zanzibar, the age of sexual consent for boys and girls is 18 years. However, a male adult is exempted from criminal prosecution if he has sexual intercourse with a child below 18 years if such child is his wife.

For purposes of HIV testing, the statutory age to consent for testing is 18 years as per the Tanzania HIV/AIDS (Prevention and Control Act). The age of majority in Tanzania is 18 years. However, the policies in support of the HIV programming allow mature minors who are already sexually exposed to provide their own consent as an exception to the rule. The HIV/AIDS Act however exposes children by providing that a child or a person with inability to comprehend the results may undergo testing after a written consent of a parent or recognized guardian. Further, the results of a child's HIV test may be disclosed to the child's parent/guardian, or spouse or sexual partner. This limitation exposes adolescents and young people to unnecessary fear and discomfort in seeking HIV testing and treatment.

The law contravenes the WHO guidelines that proposes that age of consent for HIV testing must be set lower than the age of majority. This is a barrier for adolescent seeking HIV Testing and Counseling services. This presents conflict in law and policy on the age of adolescents seeking such services. Children and adolescents definitely do not want to expose their sexual lives to their parents and or guardian. UNPFA has guided that the age of consent, does not need to be the same for sexual reproduction, marriage and HIV testing.

3. Age of consent to marriage

The Law of Marriage Act (1971) in Tanzania permits marriage after the age of 18 years for boys and 15 for girls (section 13(1). However, the law allows parents or guardians or by order of the court to allow girls younger than 15 years to get married. The Maputo protocol provides 18 as the age of marriage that must happen with consent of the marrying parties alone. The

Tanzanian marriage laws. The legal age of marriage for a long time was between 14-18 years. However, in 2016, the high court pronounced itself on the matter and made it legal for marriage to be for girls and boys who have attained the age of 18 year.[xcviii]

The court of appeal in 2019 affirmed the high court decision. Indeed, Tanzania has conflict in laws that allows younger girls to get married. This contributes to the higher numbers of teenage pregnancy that impact on high maternal mortality level rates for such pregnancies and deliveries. Persistence of early forced marriages of girls before even reaching puberty is also reported among n poor communities. These policies and laws are generally supportive of the health and development of adolescents in Tanzania.
However, there are some challenges in their operationalization to effectively promote delivery of sexual and reproductive health information, education and services to adolescents. For example, Tanzania Marriage Act of 1971 states that sexual relations and pregnancy become legally acceptable only if they occur within marriage. Further, a boy can get married at the age of 17 years or older while a girl can get married at the age of 15 years if parents/guardians give consent.

Customary law also allow adolescent below 18 years to get married. But the Sexual Offences Special Provisions Act of 1998 makes it an offence of rape for a male person to have sexual intercourse with a girl who is below 18 years with or without her consent.

There is urgent need to have these laws and policies harmonized.

4. Age of consent to health services-Contraceptive information and services

As indicated above, the Republic of Tanzania has conflicting laws and policies on adolescent seeking sexual and reproductive health services (either in marriage or out of marriage). The Tanzania National Family planning Guidelines of 2013 are very explicit on paper.

The eligibility to access family planning services for the young and adolescents (10-24) is open to all irrespective of their parity and marital status. Young people have a right to access accurate and complete family planning information, education and services. To this end, Youth friendly services have been established at all levels of seeking family planning services i.e. community and health facility. However as indicated earlier, in 2019, only 30% met the National Standards on Youth friendly services.

5. Criminalization of consensual sexual acts among adolescents

The Tanzanian Constitution of 1977 guarantees the right to equality and prohibits discrimination based on gender and sex. The constitution protects the LGBTI. They are treated equally but they feel unsafe and abused. The LGBTI community operates undercover because of the restrictions put in place by the Government. While the HIV and AIDS policy recognize the vulnerability of men who have sex with men to HIV transmission, the health policies do not adequately provide for them to access health services including sexual and reproductive health information and services. The Government has prohibited CSOs offering any community

support programmes to the LGTBI groups and has continued to threaten them with arrests. Activities of CSOs has been curtailed for promoting homosexuality since 2016.

The penal code of Tanzania prohibits same sex relationship by prohibiting carnal knowledge against the order of nature with the offence of unnatural offences (section 154) and gross indecency (s. 138A) introduced through section 12 of the sexual offences Special provisions Act in 1998. The penal code of Zanzibar also recognizes the offence of unnatural offences and indecency.
Criminalization fails to protect the vulnerable men, boy's women and girls despite the adoption of Resolution 275, calling on States to end violence and discrimination on the basis of sexual orientation, Tanzania has not offered any policy or legal protection to the sexual minorities who still suffer violations of numerous rights

6. Criminalization of HIV /AIDS

The Tanzania's HIV/AIDS Prevention and Control Act creates two specific offences on intentional transmission. Globally, it is now an agreed fact that criminalizing HIV transmission is a barrier to the HIV prevention. Section 47 of the HIV/AIDS Act of 2008 criminalizes intentional transmission punishable by 5 years imprisonment. Further, the section criminalizes the breach of any of the Acts provision relating to safe procedures and practices leading to spread of HIV. The Penal Code in Section 179 creates a general misdemeanor of unlawfully or negligently doing an act, which the person knows or believes to be likely to spread the infection of any disease dangerous to life. The UN Human rights bodies have found that the criminalization of HIV transmission undermines application of human rights standards.

Adolescents living with HIV are likely to have been infected at birth or get it through unprotected sex. Criminalization causes stigma and discrimination that should be avoided. Adolescents require more information on accessing SRHR Services, which they need most than worrying on getting to be prosecuted. The Adolescents living with HIV are more in need of health care services and are already vulnerable and should not be marginalized further.[xcix]

7. Sexual and Reproductive Health services for young people

The Health Act provides for structures and management of matters health. Over a time, studies undertaken in Tanzania have continued to show that teenage mothers are a higher risk of dying of pregnancy related causes. Increasing knowledge of young people on sexual and reproductive health is found to be critical. The government has noted that efforts must be given to the burden of morbidity and mortality among youth to facilitate them access SRH services.

The Health Policy is the framework that among other things creates structures to provide quality health care to all, children and adolescents included. The youth population in Tanzania is reaching unprecedented levels and their behavioral interventions, gender and social norms, poverty and vulnerability need to be attended to. A lot more investment is required to keep the youth in schools, take measures to prohibit and eliminate harmful cultural practices i.e. FGM.

The Tanzania National Family Planning Guidelines and Standards (2013) proposed to have youth friendly services offering right to privacy and confidentially in line with WHO guidelines. These services are to be incorporated in all service provisions. Young people and adolescents are provided with services on family planning without seeking consent of parents or guardians. The guidelines call of providers to give all young people sexual and reproductive health information, advice and services as required. The information and services include preventive, rehabilitative, and curative as appropriate. The guidelines however recognize the importance pf community and parental support in the adolescent's service provisions.

In 2017, Tanzania made a commitment to Family Planning 2020, to increase the number of youth friendly services from 30% to 80% . In the 2019 evaluation, the State made only 63%, a great improvement although only 30% met the National Standards on Youth Friendly Services.[c]

8. Cultural Religious and harmful traditional practices

Harmful cultural practices are still prevalent in Tanzania and include child/forced marriages, female genital mutilation (FGM) in some communities, polygamy, widow cleansing, widow inheritance, initiation rites, ceremonies for girls that lead to abuse, killing of older women accused of witchcraft, ritual killing attacks on albinism including women and girls as a cure for HIV performed on girls under 18 years of age.

At the policy, level there is established a national secretariat is to coordinate programmes and actions to eliminate FGM. However, the study found that there is weak enforcement of Sexual Offences Special Provision Act that prohibits FGM of girls (the Anti-FGM Law). Reports and informants indicated that young girls continue to be circumcised, with most cases unreported or where reported, they are not promptly investigated and perpetrators prosecuted. There is need to promptly investigate cases of FGM reported. Further, there is urgent need to engage with traditional leaders to denounce FGM practice, among the communities that practice it.

The state has strengthened measures regarding FGM that includes the Sexual Offences Special Provision Act that prohibits FGM of girls under 18 years. The two Children's laws (mainland and Zanzibar) forbid harmful traditional practices to children. The State has organized several awareness campaigns on dangers of FGM. It introduced Zero tolerance to FGM and adopted the National Plan of Action to combat FGM (2001 – 2015) that has continued to support elimination of FGM.

CSOs have formed an Anti-FGM Coalitions to accelerate elimination of FGM. CSOs have been engaged in numerous awareness campaigns, but they are still high incidence of practice of FGM and child marriages.

9. Learner Pregnancy Retention and Re-entry law

The United Republic of Tanzania Constitution (1977 and the Constitution of Zanzibar 1984) provide for equality and non-discrimination. The Education Act promotes the right to education. In Zanzibar, the Spinsters, widows, and Female Divorce Protection Act was repealed and replaced with Spinsters and Single Parent Children Protection Act of 2005, which allows

pregnant girls to return to school after giving birth. The girl is given an opportunity to choose the school where she can resume studies. Previously, it was an offence for the girl to be pregnant while in school and she would be expelled.

Tanzania has an unclear policy on adolescent girl's pregnancy testing and expulsion from secondary schools when they test positive. The application of the policy is misguided from the Education Act and its regulations of 2002 that permit expulsion of students who commit the offence against morality or students who have entered wedlock. The regulations are not explicit on teenage pregnancy. However, the ministry of education officers and teachers interpreted it over a time to include pregnancy in the definition of offences against morality. This is an ambiguity in the policy. This has followed a practice over decades that has subjected girls to dehumanizing practice of testing them for pregnancy and expelling them from schools.

In 2013, the Centre for Reproductive Rights in its study on pregnancy-based expulsion in Tanzania mainland[ci] found that adolescent girls had been subjected to the humiliating practice and over a decade about 55,000 girls had been excluded from school suffering huge human rights violations including the right to education, rights to dignity, discrimination among others. The study found many rights of the girls violated included, the right to education, health, privacy, dignity, life, gender-based violence among others.

The CRR study report found out that mandatory pregnancy testing and expulsion of pregnant Students in Tanzania, demonstrates how the education system is punishing pregnancy, through expulsion, forced drop out and exclusion of pregnant students. Further it found out that administrators have been expelling pregnant students in mainland Tanzania from schools when they test positive to pregnancy test. Pregnant girls (students) expelled from schools or forced to drop out are permanently excluded from government schools. There are rarely repercussions for boys involved. Ministry of Education seemed to condone the practice.

The Study further revealed that thousands of girls have been excluded over a period of years. Moreover, schools do not keep updated data, for certainty on the numbers. Such expulsions are often justified, by the administration. It causes the pregnant girls' high stigma, they are discriminated coupled with a lot of mockery the other students and the community. The punitive measures make pregnant adolescent girls vulnerable.

While the *Child Act* has penalties for men and boys who impregnate pupils in primary or secondary schools, yet, there are very few prosecutions recorded. Needless to say, the harsh rules on pregnancy force some of the concerned adolescents to undergo unsafe abortions, while others are forced into marriage. Community often shuns the girls referring to them as prostitutes. Pregnant girls have been known to commit suicide in some incidences. Though no written policy exists, Heads of Government schools and officials silently refuse to re-admit the pregnant girls once they deliver. In 2017, the practice was enforced and accelerated by the

then President John Magufuli, who put a ban to pregnant girls being re-admitted in school after delivery. This in itself was very discriminatory and against human rights standards.

The study found more adolescents and young people (girls) continue to drop out of school, for various reasons including ignorance of the existence of the policy or poor implementation of the policy that causes them stigma and discrimination or poor economic situations that makes motherhood and school resumption challenging because of the logistics of not being able to access child care services.

In 2021 with Her Excellency President Hon. Samia Suluhu, the first female President's regime, the Minister of Education has through a circular indicated that girls who get pregnant can be re admitted in school two years after delivery. While this is a positive more, Tanzania needs to draft and adopt a comprehensive policy for re-entry of girls into school after pregnancy and delivery. Further, the policy should address the underlying issues that has led to high levels of teenage pregnancies, including comprehensive sexuality education and access to SRHR information and service that respects human rights standards.

There is urgent need in the meantime to have clear girl's re-entry guidelines/policy to enable pregnant pupils to continue schooling and to address stigma and discrimination they face.
Lack of explicit provision in education legislation to prohibit the expulsion of pregnant girls from school and the continued prevalence of the practice of mandatory pregnancy testing of girls as a pre-condition for admission to school and their expulsion if found to be pregnant. The prohibition of girls who deliver to return to school is prevalent.

The Centre for Reproductive Rights, an international NGO in collaboration with a local partner the Legal and Human Rights Centre, a CSO have successfully used the treaty body communication mechanism at the African regional level (the African Committee of Experts to find that Tanzanian policies violate the right of adolescent girls, when they fall pregnant while in school.

The communication - The Legal and Human Rights Centre & CRR V. The Republic of Tanzania Communication No. 0012/Com/001/201/Decision No. 002/2022.

Tanzania had for years forced girls in public schools to undergo mandatory pregnancy testing and expelled permanently those found pregnant. These denied the girls the opportunity to access the right to education. The communication was brought to the experts challenging the actions of expelling girls from school as a violation of several rights including the right to health and education.

The African Committee of Experts on the Rights and Welfare of the Child (ACERWC) found that the practice of expelling pregnant students from school violated adolescent girls' human rights.

It recommended that Tanzania reforms its education policies. The case had argued that the expulsion of the girls from school violated the rights within the African Charter on Human and People's Rights, on the right of the child, particularly the obligation by non-discrimination, best interest of the child, protection of privacy, education, health and health services, protection against child abuse and torture and protection against harmful cultural practices. Tanzania was called upon to do the following: -

i) Immediately prohibit mandatory pregnancy testing in schools, health facilities and publicly announce the prohibition.
ii) Undertaken concrete steps to prevent expulsion of pregnant, married girls from school by providing applicable laws and policies.
iii) Investigate cases of detention of pregnant girls and immediately release those detained.
iv) Immediately stop the arbitrary and illegal arrests of pregnant girls.
v) Immediately re-admit schoolgirls who have been expelled due to pregnancy and wedlock.
vi) Provide special support programmes to ensure better learning outcomes for the returned girls.
vii) Provide adolescent sexuality education and friendly Sexual Reproductive Health (SRH) services.

As indicated earlier the Tanzanian Constitution protects many of the rights outlined as violated, including the right to life, privacy and personal security, equality, nondiscrimination, dignity and freedom from torture or inhuman or degrading punishment or treatment. In addition, the Child Act law passed in 2009 and domesticating the Convention of the Rights of the Child and the African Charter on the Rights and Welfare of the child provides many protections for children's rights. The law guarantees a child's right to non-discrimination, including on the basis of gender, age, health status, socioeconomic status and other status. Further the Act prohibits any a person from depriving a child access to education nor subjecting a child to torture, or other cruel, inhuman punishment or degrading treatment including any cultural practice which dehumanizes.

In this context, "degrading treatment" refers to "an act done to a child with the intention of humiliating or lowering his dignity. Needless the say the conditions the pregnant girls are subjected to violates all their constitutional and statutory rights. In addition, the Law of the Child Act introduces critical amendments to the Education Act, including a requirement that "no child of the age of seven or above shall be refused enrolment in a school.

The Education Act, states that any person who "impregnates a pupil of primary or secondary school" commits an offence and is liable to a fine and imprisonment upon conviction. Finally, it provides for increased criminal liability for sexual violence perpetrated in schools. The report by CRR confirms that there are very limited prosecutions in cases where school girls are

impregnated. All indications from the study point to the fact that the law, policy and administrative actions in Tanzania are in conflict and in need to harmonization.

Tanzania urgently needs to implement the recommendations from the African Committee of experts on the right and welfare of the child arising from the communications filed and heard. The services to safe legal abortion must be made available, accessible, affordable and of good quality.

10. Laws and policies on Comprehensive Sexuality Education (CSE)

Comprehensive Sexuality Education (CSE) is not fully incorporated in the education syllabus in Tanzania. The Government has instead opted for Life skills-based curriculum for primary and secondary education. Since CSE does not exist as a stand-alone curriculum, the country has opted to include CSE in the broader HIV and AIDS policy through adoption of Guidelines for Implementing HIV and AIDS and Life Skills Education Programmes. The approach takes an integrated approach by inclusion in subjects like biology, Christian Religious Education and Civics. The guidelines seek to provide information about transmission and prevention of HIV and AIDS and to promote responsible sexual behaviors including delaying sex and having protected sex.

There are persistence structural and other barriers to girl's access to high quality education owing to inadequate policy on CSE. Those who drop out of school due to pregnancy miss the learning opportunity because there is no programme for out of school. The teachers are not trained to offer CSE and therefore are unable to get into the in-depth of sensitive topics on sexuality. The teaching avails very limited education on sexuality since it is not comprehensive. The school's education offers a great opportunity of reaching out to a number of younger people with knowledge and skills.

The county needs to design both in and out of school CSE programme and provide capacity to teachers to offer the training accordingly. Community health volunteers can also be trained to offer the training to out of school adolescents and young people. The adolescents and youth will need to be provided with continuous capacity on the policy issues once determined.

11. Unsafe abortion

Tanzania ratified CEDAW in 2006 and the Maputo Protocol in 2007. Tanzania has one of the highest maternal mortality at 556 per 100,000 live births, with unsafe abortion as one of the leading causes of death.[cii] Unsafe abortion account for more than one third of hospitalization for pregnancy related complications. [ciii]While the Maputo Protocol promotes reproductive rights of women and authorizes medical abortion in cases of assault, rape, incest and where the continued pregnancy endangers the mental and physical health of the mother or life of the fetus, laws in Tanzania are still very restrictive and discriminate against women and girls or reproductive age.

Adolescents and young people in Tanzania face many risks as they navigate their lives – unemployment and economic exclusion, unintended pregnancies, maternal death, STIs, unsafe abortions and gender-based violence.[civ] The Penal Code provisions on termination of pregnancy are frequently misunderstood as a total prohibition on abortion. Sections 150–152 of the Tanzanian Penal Code criminalizes "unlawful" acts related to termination of pregnancy.

Further, the law criminalizes attempting to procure, or knowingly supplying things to procure, an "unlawful" abortion or miscarriage. These sections refer to the criminal liability of the provider/procurer, the pregnant woman, and the supplier of drugs or equipment for abortion, respectively. Tanzania has ratified the Maputo protocol without any reservations to article 14. The State continues to deny its citizens the right to safe termination of pregnancy. There are indications in the law above giving incidences where pregnancies can be lawfully terminated. The lawful termination of pregnancy includes one performed to preserve the life of the mother or her mental or physical health. (section 230). Trained mid-level providers such as nurses, midwives, and clinical officers to provide the service, are authorized to undertake the termination in addition to qualified medical practitioners.

Tanzania may have to consider amending S. 230 of the Penal code to enlarge incidences when medical abortion could be authorized by way of fully domesticating the Maputo protocol that allows medical abortion in certain incidences including rape and defilement.

12. Freedom from Gender Based violence

Corporal punishment is still justifiable in law, with high levels of child abuse, low participation of youth in policy making, high cases of sexual violence targeting children is reported. Sexual exploitation of girls especially in mining areas is reported. Sexual violence and abuse carried out by teachers and lack of disciplinary criminal investigation for teachers for professional misconduct.

Reports show limited access to psycho-social services for child victims of sexual abuse and reluctance of girl victims of sexual violence to report abuse and violence to the police because of stigma surrounding child survivors of gender-based violence. There are reports of cases of sexual, physical and emotional abuse by the police against girl victims of sexual exploitation under their protection. Most cases go unreported and uninvestigated. Practice of FGM constitute subjecting the girls to cruel, inhuman degrading treatment.

13. Budgeting /Financing ASRHR

Budgets have been allocated to Ministries. However, it was not clear how much of the budgets go on issues of adolescents SRHR. Tanzania has not been able to meet the 15% budget allocation to health as recommended by Abuja Declaration in 2001. The 2020 budget estimates stand at 7% of total budget is allocated to health. However, it is challenging to apportion a percentage that is specifically earmarked for adolescent health and well-being.

C. Accountability Measures by Commission for Human Rights and Good Governance (CHRAGG)

The CHRAGG, is the Republic of Tanzania's national human rights institution with the mandate to serve as the human rights commission and the ombudsman as well. It is an oversight institution for the protection and promotion of human rights and good governance. The Commission works closely with adolescents and young persons through established human rights in primary, secondary and higher learning institutions. CHRAGG uses these platforms to discuss various issues specifically SRHR. The commission has continued to receive and investigate human rights complaints including those violating SRHR od adolescents. The Commission has investigated various complaints and conducted public inquiries on teenage pregnancy and child marriages in three regions of Tanzania Mainland CHRAGG has continued to issue recommendations to the government about amending laws, issuing statements on violations of the rights and calling for implementation of ASRH issues.

The commission has noted the challenges below in interacting with adolescents SRHR.

i. Challenges in ASRHR policy review and implementation.
ii. Low Level of capacity/ institutionalization of SRHR within NHRI.
iii. Effectiveness of existing SRHR platforms at national and regional level in holding governments accountable and policy influencing to advance access to SRH commodities and services for adolescents.
iv. Inadequate budget allocation to matters children and the NHRI.
v. Non- recognition and involvement in the policy framework on adolescents by the ministry of Health.

The monitoring role on children's rights is undertaken by the Commission. The Commission has set up Gender and children's desks in every police station in the country. In Zanzibar, they have established the National Gender Based Violence Committee (GBV Committee). The Ministry of Community Development and Gender and Children (MCDGC) coordinates children matters in Tanzania Mainland, while the Ministry of Social Welfare Youth and Women and Children Development (MSWYWCD) coordinates in Zanzibar.

Treaty Ratification Status: Tanzania is a State Party to a number of international treaties promoting the rights of children and the sexual reproductive health rights including the protocol to the African Charter on Human and People's Rights, the International Covenant on Economic, Social and Cultural Rights (ICESCR), the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention Against Torture and other cruel inhuman or Degrading Treatment and Punishment. It has also signed the Universal Declaration of Human Rights (UDHR) and ratified the ICCPR, but has not signed onto its 2nd Optional Protocol. the African Charter on Human and Peoples' Rights (ACHPR), the Convention on the Rights of persons with disabilities (2008), the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). Tanzania has subjected itself to the UPR voluntary assessment and filed its last report in.

At the African regional level, Tanzania has also ratified key treaties namely the African Charter on Human and People's Right in 1984, the African Youth Charter in 2012, the African Charter on the Rights and Welfare of the Child in 2003 and the Maputo protocol in 2006. Tanzania is not

up to date with reporting. It has only submitted the initial and 1st periodic report under the African charter on the Rights and Welfare of the Child. It has 7 reports pending for the African Charter on Human and People's rights where upon part B of the report should be the status of the Maputo protocol. The last report submitted was the 2nd to 10 periodic report for the period 1992-2006. The commission heard and issues it concluding observations in 2008.[cv]

The State report to the African Commission, focused on the African charter on human and people's rights and did not make any mention of the Maputo protocol ratified in 2006. Tanzanian ratified the protocol without any reservation but has not fully domesticated the treaty not submitted the initial report as per the reporting guidelines of the Maputo Protocol[cvi]. The ratification has not translated in meaningful enjoyment by women and girls in Tanzania.

Notably, Tanzania has not submitted any report after ratification of the Maputo Protocol that guarantees women's rights specifically including ASRHRs. The CHRAGG has a responsibility to work with the Government to comply with the Reporting obligations under the Maputo Protocol.

D. RECOMMENDATIONS

For NANHRI

1. To disseminate the findings from the study to the NHRIs involved and promote understanding of the legal and policy frameworks on ASRHR in each country, to ensure rights of all adolescents are promoted, protected and fulfilled.

2. To engage in continuous capacity building and understanding of each country's policy and legal framework on ASRHR and work toward achievement of Universal Adolescents Sexual and Reproductive Health and Rights in conformity with the Maputo protocol and SDGs 3 and 5, calling for full implementation of all regional commitments.

3. To establish a broader and strong political advocacy movement at the African Union level comprising of NHRIs, CSOs and Partners to advocate and lobby for implementation of Resolution 275 and to hold governments accountable towards full domestication and implementation.

4. Provide to the NHRI both technical knowledge and capacity to address ASRHR using the HRBA framework in order to address issues of analysis of Sexual and Reproductive Health and Maternal Health and under 5 child health and Infuse human rights principals in SRHR Country Plans and implementation.

For Commission for Human Right and Good Governance (CHRAGG)

1. Build institutional capacity of CHRGG to deal with monitoring and accountability on State Responsibility for implementing the ECOSOC rights and specifically the ratified treaties especially the Maputo protocol and others promoting ASRHR.

2. Widely disseminate the report findings to relevant stakeholders and advocate for the review of conflicting legal and policy frameworks promoting ASRHR for example decriminalizing abortion and homosexuality.

3. Raise public awareness on ASRHR and especially the rights of pregnant girls and advocate for development and adoption of policy and guidelines framework for school re-entry programme for girls who get pregnant and drop off the school.
4. Working with Partners advocate for increased funding toward meeting the Abuja declaration committing of 15% of the budget to Health in order to meet the needs of adolescents to SRHR and services.

5. Investigate reported cases on ASRHR violations and undertake public inquiry as appropriate in line with its mandate.

6. **Laws and Policy Review:** Play a role in review of existing legislations, as well as National Plans and Policies, that have limitations and affecting ASRHR as identified and work with the relevant ministries, departments and parliament top review the same.

7. **Compliance with International Standards;** Identify non- reporting bottlenecks that may be preventing full realization of human rights including the right to health and that of ASRH.

8. **Review Laws and Policies** that constrain the advancement of Sexual and Reproductive Health and Maternal Health. Review the Legal restrictions on access to Sexual and Reproductive Health Services such as requiring spousal or parental permission to access services.

9. Conduct regular visits to the facilities and monitor to see whether they meet AAAQ. Ensure facilities have
    a. Adequate budgets.
    b. essential infrastructure.
    c. Provide adolescent friendly services.
    d. Treat adolescents especially girls with respect.
    e. Guarantee privacy and confidentiality of adolescents.
    f. Uphold dignity of health worker.
    g. Not charge fees.
    h. Address barriers related to harmful cultural practices.

For CSOs and Other Partners

1. Increase accountability platforms to demand that duty bearers adopt policies/regulations and where they exist, implement ASRHR and services as per the WHO guidelines and recommendations, and advocate for review of restrictive laws/policies that act as a barrier for adolescents in accessing SRH services.

2. Engage in targeted advocacy at domestic level to lobby for increased Budget allocations to Health as well as mobilize external resources toward implementation of State's set priorities on ASRHR and advocate for States to adopt, develop and implement commitments existing at the international, regional and sub regional levels that advance ASRHR, i.e. CEDAW, ICPD Cairo, Maputo Protocol, etc.

3. Advocate for inclusive joint programming approaches through partnerships and collaboration that will empower communities and integrate sustainability frameworks, and avoid duplication.

4. Form and/or join existing networks to engage with policy makers and advocate for inclusive policies to invest more in ASRHR to guarantee the availability, accessibility, affordability and quality SRH for all adolescents respecting intersectionality.

5. Form alliances to undertake targeted public education and awareness creation on Sexual and Reproductive Health Rights of adolescents and young people using a multi sectoral approach that brings on board different actors involved in ASRHR programming, thus religious, women organizations and youth, private and adolescent specific actors).

6. Engage in continuous dialogue with policy makers including National Parliaments and provide them with available sex disaggregated data to make a case for the need to adopt and or review existing policies and or legal framework that hinder adolescents seeking SRH services and advocate for local allocation of more resources to meet the demands by the adolescents for quality services.

7. Partner with **CHRAGG** and report complaints of ASRHR violations and participate in monitoring human rights violations, undertaken by the Commission.

8. Link with regional organizations working at African Union Level (ECOSOC accreditation) to use regional mechanisms, for example writing Shadow and alternative Reports and filing complaints after exhausting domestic remedies on ASRHR.

9. To strengthen partnership and collaboration to understand and build their own capacity address the legal, policy and administrative barriers on Adolescent SRHR.

10. Advocate and put in place programmes for adolescents in and out of school adolescents to bolster their participation and understanding of SRHR and the available accountability mechanisms when the rights are violated.

3.3. THE REPUBLIC OF ZAMBIA

A. Demographic Health Indicators Relevant to ASRHR in Zambia

The Zambia 6th Demographic and Health survey of 2018 provides estimates of demographics and health indicators and includes estimates in fertility preference, family planning, mothers' nutrition, childhood and maternal and child health, domestic violence and HIV /AIDS prevalence. The average household in Zambia stands at 5.0 persons.27% of households are headed by women. 48% of the population is under age 15 years.

According to the Zambia Demographic Health Survey 2018, the total fertility rate average is 4.7 children. However, women in rural areas have an average of 5.8 children compared with 3.4 children among urban women. Fertility also varies with education levels and household wealth. Women with higher education had an average of 2.4 children compared with 6.4 children among women with no education. Women living in poorest households have an average of 6.7 children compared to 3.0 children among women living in wealthiest households.

The median age of first sexual intercourse for women, aged 25-49 is 16.6 years. Women with higher education tend to begin sexual activity 4.2 years later than women with no education. 17% of women were reported to have begun sexual activity before the age of 15, while 16% began sexual activity before the age of 18 years. The Medium age of marriage of women age 24-49 years was 19.1 years as per the ZDHS 2018. Women from rural areas marry 2 years earlier than women from urban areas (18.3) years versus 20.3 years. It was estimated that the medium age of first birth for women age 25-49 is 19.2 years. 34% of women give birth by age 18.

Teenage fertility is estimated that 29% of young women age 15-19 who are already mothers or pregnant with the first child. Rural young women age 15-19 are twice likely to have begun child bearing than urban young women (37% versus 19% respectively). n assessing access to family planning, half of married women age 15-49 use some method of family planning while 48% use

modern method, 2% use traditional methods. The most popular method among sexually active, unmarried women was found to be injectable (2%), implants (9%) and male condom (7%). The use of family planning had increased from 15% - 1992 to 50% in 2018. The unmet need of family planning among women age 15-49 was found to be 20%.

Greater improvement was seen in terms of facility-based deliveries. 85% of deliveries were reported to be in health facilities. 80% births are through skilled birth attendants. However, 15% of deliveries were reported to still occur at home. The maternal mortality ratio for Zambia in 2019 was estimated at 252 per 100,000 live births being an assessment taken from seven-year period before the survey.

HIV prevalence among the youth 15-24 who had had sexual intercourse in the past one year prior to the survey was 38%. HIV prevalence was higher in urban areas (5.35) than rural areas (2.6%). HIV was more prevalence among young women than young men (5.6% versus 1.8%). 36% of women had experienced physical violence since age 15 years. The most common perpetrators for married women were current husbands / partners (65%). 80% of women and 84% of men age 15 – 49 knew the risk of getting HIV while risks of having multiple partners were also known. 2% of women and 15% of men age 15-49 had two or more sexual partners in 12 months prior to the survey.

Teenagers who had early exposure to sexual intercourse were at risk of pregnancy and child bearing. Teenage child bearing declined from 34% in 1992 to 29% - 2018. The percentage of women age 15-19 who had begun child bearing increased with age, from 6% among those aged 15 to 56% among those age 19. The teenagers who begun child bearing was higher in rural areas (37%) than urban areas (19%). However, the percentage of women age 15-19 who began child bearing declined with increasing education. 42% of young women, with no education had begun child bearing. Among women and men, age 15-19, 13% of women and 16% of men had sexual intercourse by age 15. Only 2% of women and less than 1% of men age 15-19 were married by age 15. 2% of women age 15-19 gave birth before age 15 and less than 1% of men in that age fathered a child before age 15. 2% of women age 15-19 years who had sexual intercourse in 12 months prior to the survey had sex with a man 10 or more years older. Teenage / Adolescent pregnancy is a great challenge in the country and undermines girl's human rights, including the right to education among others.

Table 1: Summary of Zambia Selected Sexual and Reproductive Health–Related Statistics from ZDHS

	Parameter	Detail	Value
1.	Infant mortality	deaths Per 1,000 live births (ZDHS 2018)	45
2.	Maternal mortality ratio	per 100,000 live births for the seven-year period before the survey (ZDHS 2018)	257

3.	Teenage Pregnancy	37% of women aged 15-19 are already mothers or pregnant with their first child in rural areas as compared to 19% in urban areas Teenage childbearing declined from 34% in 1992 to 29% - in 2018 (ZDHS 2018)	29%
4.	Births by skilled health personnel	85% of deliveries are in health facilities while 15% of births are at home (ZDHS 2018)	80%
5.	Health Budget	as % of gross domestic product for 2022 and projected to increase to 10.4% in 2023 (From the 22 Zambia UPR Report to the Human Rights Council	8%
6.	Contraceptive prevalence rate	Modern methods Sexually active Married women aged 15-49 (ZDHS 2018)	48%
7.	Unmet needs for family planning	% of currently married women age 15-49 (ZDHS 2018)	20%
8.	Proportion of women who have begun childbearing	% among 15- to 19-year-olds increased with age, from 6% among those aged 15 to 56% among those age 19 (ZDHS 2018)	20%
9.	HIV & AIDS	% of adults overall age 15-49 are HIV positive. With higher prevalence among women (ZDHS 2018) % Prevalence among women (age 15-49) % prevalence among men (age 15-49)	11.1% 14.4 7.5
10.	Young people's HIV Prevalence rate	%Youths 15-24 who have had sexual intercourse in the past year prior to the survey. % is higher in urban areas % in rural areas % higher in young women versus % young men	3.8% 5.3% 2.6% 5.6 1.8
11.	Gender-based violence	Physical violence since age 15 among women Women in Sexual violence Women spousal violence (ZDHS 2018)	36% 14% 47%
12.	Total Fertility Rate	Average of # of children	4.7

		Average # children in a lifetime among women in rural areas and 3.4 in urban areas (ZDHS 2018) Average # in Urban setting	5.8 3.4

B. Legal and Policy Content Analysis

Laws and policies have a significant bearing on guaranteeing the enjoyment of sexual and reproductive health rights. Zambia has put in place numerous legal and policy frameworks to guarantee Adolescents SRHR directly or indirectly. Some of the laws are restrictive and have become a barrier to adolescents accessing SRHR.

1. Equality and non-discrimination in provision of youth friendly services

The Constitution of Zambia as amended in 2016 provides for equality and non-discrimination (article 23)[cvii]. This affords children and youth the rights not to be discriminated nor exploited (article 24). Further, in article 11 the constitution provides that every person in Zambia is entitled to the fundamental rights and freedoms regardless of race, place of origin, political opinions, colour, creed, sex or marital status. As per Article 23(1), the constitution prohibits formulation of laws that are discriminatory. It states "…a law shall not make any provision that is discriminatory either of itself or in its effect" and in article 23(2) it prohibits discrimination by institutional behavior stating "…a person shall not be treated in a discriminatory manner by any person acting by virtue of any written law or in the performance of the functions of any public office or any public authority." The Constitution of Zambia is the supreme law . However it acknowledges the practice of customary law. (see constitution article 23(4).

Article 266 of the constitution defines a child as a person who has attained the age of 18 years and below. Other laws that promote equality and non -discrimination include the Education Act of 2011, persons with disabilities Act 2012, the Anti-Human Trafficking Act of 2008, the Gender Equity and Equality Act 0f 2015. The Industrial and Labour relations Act, in Section 108 prohibits discrimination in places of work on the grounds of sex, status, race, culture, and religious practices. The Persons with disabilities Act, prohibits discrimination on grounds of a person being with a disability.

The adoption of the National Youth policy framework has provided an enabling environment for the youth, in terms of programming. Zambia developed the 2015 National Youth Policy[cviii] and an Adolescent Health Strategy (2017-2021)[cix] to guide provision of reproductive health services to adolescents. One of the objectives of the 2015 Youth Policy is to strengthen commitment to and support the adolescents and youth to access sexual and reproductive health and rights services including commodities. The policy proposes establishment of youth friendly services that need to reach the most vulnerable including youth with disabilities, female youth especially in rural areas and well as male youth, in and out of school youth among others. The policy calls for meaningful engagement of youth.

Zambia adopted the National standards and Guidelines for the provision of Adolescent -Friendly Health Services (AFHS)[cx] that addresses the special needs of adolescents that include confidentiality, privacy, accessibility, affordability and of god quality. The aim of the guidelines is to strengthen services delivery through a response measure that is well coordinated. By extension this seeks to promote equality and inclusion of adolescents in accessing quality and age appropriate SRH services. The Government has established adolescent's health spaces in 53% of the facilities in order to increase access to SRH services for adolescents.[cxi] The country has established an Adolescent Health Unit in the department of Health whose mandate is specifically to strengthen the provision of SRH services for adolescents. The department reported success is having the adolescent safe spaces established and has continuously trained the health care provides to improve service delivery including for adolescents with disabilities.

The study finds barriers and or limitations and gaps in implementation of the youth friendly policies and guidelines herein. Where limitations are noted, youth have to access the services from the mainstream health facilities that are unfriendly. A shadow report by CSOs working on adolescent issues in their report in response to the Universal Periodic Report by Zambia in 2022[cxii], indicated that the following impediments to adolescents accessing the required friendly SRH services included the following centralization of the adolescent friendly services that are inaccessible by youth and adolescents in the rural setting and further challenges of engaging adolescents in key decision-making processes, including in policy formulation.

There is urgent need to advocate to the review of the Bill of Rights in the constitution to harmonize the plural law, thus statutory and customary, and to harmonize the different age limits to conform to age 18 as per the constitution and the recent child code law.

Youth and adolescent health friendly services should be made available, acceptable, affordable and of good quality and to encourage youth to participate in their design and advocating among fellow adolescent to access the services.

2. Age of consent to sexuality

The age of consent to sexuality in Zambia is 16 years. Individuals aged below 16 years are not able to consent to sexual activity. Such activities lead to prosecution for statutory rape.
The Penal Code Chapter 87- Section 132 and section 138 criminalizes rape and defilement. A person committing the offence of rape is liable to imprisonment for life. The law also criminalizes attempted rape (section 134 of the penal code). Any adduction of women for purposes of marriage is also an offence. (section 135 of the penal code).

The law also creates the offence of defilement. This is defined as having unlawful carnal knowledge with a child. (see section 138 of the penal code). This protects both boys and girls from sexual abuse. The offender cannot in defense say that he had reasonable cause to believe and he indeed believed that the child was above the age of 16. Consent of the child to sex is immaterial and cannot be used as defense. The Zambia law is silent on how to deal with consensual sexual activity when both parties are below the age of 16 years. In such cases, both

male and female below age of 16 should be prosecuted. However, the study finds that such prosecutions are very rare.
The penal code outlaws' assault. Section 247 prohibits common assault, section 248 prohibits assault occasioning actual bodily harm while section 248A prohibits battery including battery of children.

The Zambia Police Act No.14 of 1999- Section 53 of the Act establishes the Victim Support Unit. Section 53(2) provides that the functions of a Victim Support Unit shall be-

a) To provide professional counselling to victims of crime and to offenders; and to
b) Protect citizens from various forms of abuse.

The newly adopted Child Code Act 2022 defines a child to conform with the Zambian constitution-18 years. There is need to review the criminal code to comply with the child code and the constitution.

3. Age of consent to marriage

Article 24(4) of the constitution protects young persons from exploitation in relation to employment, trafficking, physical and mental ill-treatment, cruelty, neglect or exploitation – where "young person" is defined as "any person under the age of fifteen.[cxiii] The newly adopted Child Code Act 2022 defines a child to conform with the Zambian constitution as one aged 18 years and below.
The Zambia Marriage Act sets the minimum age of marriage **at 21 years**. However, a child can marry from the age of 16 years by consent of a legal guardian. The Education Act No. 23 of 2011 in Section 18 provides that subject to the constitution and any other written law, a learner who is a child shall not contract any form of marriage. Section 2 (a) and section 2(b) of the education Act, outlaws marrying off children of school going age.

> Section 2(a) states "a person shall not marry or marry off a learner who is a child" while section 2 (b) states "a person shall not prevent or stop a learner who is a child from attending school for the purposes of marrying or marrying off the learner who is a child."
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> Section 3 criminalizes the act of marrying a child who is a learner. It states, "a person who contravenes this section commits an offence and is liable, upon conviction, to imprisonment for a period of not less than fifteen years and may be liable to imprisonment for life."

The recognition of customary law in the constitution has compounded the problem. Under customary law, definition of a child is not by the number of years the child has attained, but by biological and sociological circumstances. Hence, a child who has come of age (started menstruating for example) is considered to be ready for marriage.

The constitution allows customary marriages. Under customary law, consent of the parents is more important than consent of the parties intending to marry.[cxiv] In the case of *Sibande V the People,* the court held that:

> in Zambia it is not generally unlawful for a man to have carnal knowledge of a girl under the prescribed age if he is lawfully married to her, lawfully here means that both the parents or guardians of the girl have consented to the marriage, but unfortunately, consent of the girl alone cannot be raised as a defense to a charge."[cxv] A child can therefore be married as long as the parents have agreed and she has reached puberty according to that child's culture. The High Court ruling in the case of R *V Chinjamba* (cited above) illustrates this. In that case, a headman was aware that one of the men in his village was having carnal knowledge with a minor (below 16) and did not report the case. He was arrested for being an accessory after the fact. The headman argued that the girl was married to the man in question under customary law. The Court held that a man who is married to a girl under customary law cannot be guilty of having unlawful carnal knowledge of a girl below the age of 16.

The Penal Code Amended in 2005 under Section 165 prohibits fraudulent pretense of marriage. Any person who willfully and by fraud causes any woman who is not lawfully married to him to believe that she is lawfully married to him and to cohabit or have sexual intercourse with him in that belief, is guilty of a felony and is liable to imprisonment for ten years." Section 166 prohibits polygamy creating an offence called bigamy. Therefore, under statute law, polygamy is not allowed, but it is allowed under customary law.

National Policies on marriage and age for marriage have been put in place including programmes to end child marriages. UNFPA jointly with UNICEF are implementing a global programme to end child marriage in Zambia since 2016. The programme mainly addresses the complex socio-cultural and structural factors that underpin practice of child marriage. It seeks to promote delayed age of marriage using community-based case management.

Anti-Child marriage campaign have been launched since then to educate the communities on the law seeking to end child marriages. Its vision is "a Zambia free from child marriage by 2030" with an objective of reducing child marriage by 30% by the end of 2020. The campaign against child marriage has engaged traditional leaders to be champions against child marriage. Since the campaign began, there is anecdotal evidence that traditional leadership is changing customary law on child marriage. The National Reproductive Health Policy sets to discourage early marriages and institute measures to reduce the rate of pregnancies among girls below 18 years of age.[cxvi]

Despite the existence of a robust legal and policy framework that is very progressive, child marriage is still a serious challenge in Zambia. In the years 2019 and 2020, COVID 19 exacerbated the risk of child marriages due to interruption of schooling and the support programmes for adolescents that had engaged them through schools to delay engagement in early sexual activities and early and forced marriages.

This study finds that the laws and policies under this subheading need to be harmonized. The communities require to be continuously engaged through awareness creation platforms and advocacy strategic interventions including targeted campaigns to understand the essence of the laws and policies that exist to end child marriages, including peer to peer child marriages.

4. Age of consent to health services-Contraceptive information and services

The law and policy on age to consent to health service is unclear. This emanates from the definition of a child. Studies undertaken by UNFPA in Zambia on SRHR show that majority of girls who become pregnant while in school (86%) are in primary school and aged (10–14 years).[cxvii] This suggests that CSE and SRH services are not reaching that large section of adolescents—a problem requiring immediate remedial action. The Education Act provides for education for all, without discrimination.

The Health Policy of 2012[cxviii] and the National Health Strategic Framework 2017-2021[cxix] are comprehensive and overarching national policy framework to provide for appropriate and evidence-based policy framework to guide the health sector toward attainment of national, regional and global health objectives. The overall purpose of the Health Policy is "to reduce the burden of disease, maternal and infant mortality and increase life expectancy through provision of a continuum of quality effective health care services as close to the family as possible in a clean and caring manner," and obligations on ensuring that, reproductive health services are available, accessible, and acceptable and are of good quality.

The Reproductive Health Policy 2000[cxx] has a vision "to bring the highest possible level of quality and affordable integrated reproductive health services to all Zambians as close to the family as possible." It has fourteen policy guidelines that cover population (to ensure that the Zambian population grows at a rate that is commensurate with the country's resources). One of the thematic areas of focus is adolescent sexuality and reproductive health (empowering adolescents with adequate information and education regarding reproductive health).

The study finds a gap and lack of clarity as to the legal age for adolescents to independently access contraceptives from the providers. The health policy and the reproductive health policy have frameworks for adolescents seeking and accessing sexual and reproductive health services. However, the restriction and requirement that adolescents who wish to access to SRH services need to obtain legal consent from parents and guardians is very limiting and discriminatory and a barrier to adolescent access to available, accessible, affordable and quality health care service.

5. Criminalization of consensual sexual acts among adolescents

Same sex relationships are prohibited in Zambian law. Homosexuality is an offence in Zambia penal code. This means that consensual sexual relationship among male adolescents is prohibited. From the statistics, the median age of sexual engagement is 16.5 years, an indication that adolescent below 16 years are engaging in sexual activities.

The penal code in Sections 155 – 158 criminalized the actions known as with "Unnatural Offences," which is applicable to homosexuality having sexual conduct. The penal code criminalizes what is termed as "*carnal knowledge against the order of nature".* It attracts a penalty of not less than fifteen years with the possibility of imprisonment for life. Section 158 criminalizes "indecent practices" between people of the same sex whether they be male or female as well as whether it's done in public or private. Open public advocacy on homosexuality illicit emotional reactions and stringent moral judgements from the public attract risk of prosecution by the courts of law.

> In 2013, Paul Kasonkoma was arrested and prosecuted after appearing on a local TV show. He was calling on government to decriminalize most at risk populations (sex workers, men who have sex with men) to more effectively target its responses to HIV. He was charged under section 178(g) of the Penal Code with the idle and disorderly offence of soliciting in a public place for immoral purposes. The subordinate court found him not guilty. Government appealed the judgement of the subordinate court to the high court. The High Court also acquitted him.[cxxi]
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> In 2014, two men Philip Mubiana and James Mwape were prosecuted on accusation of being homosexuals. This was because a neighbor suspected that the two lived as if they are husband and wife. On the day, the two men had a domestic dispute; they were picked by the public and taken to the police where they were both charged with homosexual offences. The court acquitted both of them for lack of evidence.[cxxii]

The Zambia government has not set in motion any implementation framework on sexual minorities arising from Resolution 275 of the African Commission on Human and People's Rights, to protect Human Rights violations against persons on the basis of their real imputed sexual orientation or gender identity. Zambia has criminalized same sex relationships. The same sex relationship is frowned upon by the society in the county. The environment is very hostile for any programme intervention protecting the rights of LGBTQ.

The Zambia Human Rights Commission works on promoting the rights of key population, promoted as human rights in efforts to facilitate access to health and other services without discrimination. The LGBT operations in the country remain undercover. The LGBTI individuals, adults or adolescents are afraid to advocate for their rights and declare their statuses for fear of stigma and discrimination and also fear of reprisals -thus being arrested and prosecuted. There have been no adolescents declaring openly to being sexual minorities for fear of being discriminated and rejected by society and subjected to violence, harassment and ridicule among other human rights violations. CSOs working to defend the rights of sexual minorities also suffer harassment, violence and ridicule. Criminalization of same sex relationship leads to increase in the spread of HIV.[cxxiii]

The study finds that there is need to review the legal and policy framework on sexual minorities in the country with possibility of decriminalization of same sex relationships to facilitate

adolescents and adults alike to seek SRH services to know their HIV and AIDS status and seek treatment.

6. Criminalization of HIV and AIDS

Criminalization of HIV transmission drives HIV under and causes stigma and discrimination. Adolescents and young people are at high risk of exposure and reaching to them is critical to HIV management. Young women aged 15-24 years are particularly high risk of new HIV infection. Adolescents living with HIV require access to information and health services. Criminalization poses negative impact to PLWHA. There is need to protect the dignity and sexual rights of everyone. Criminalization of sex work contributes to increased stigma and discrimination against sex workers in Zambia. In the stigma index conducted by Network of Zambian People Living with HIV, it was established that female sex workers are among the populations that are discriminated against both in health service provision as well as in society in general.[cxxiv]

Although the law does not directly prohibit sex work, it is illegal in Zambia to live on the proceeds of sex work. The Penal Code Chapter 304 of the Laws of Zambia in Section 146 (1) (a) says "A person who- (a) knowingly lives wholly or in part on the earnings of prostitution; or (b) in any public place, persistently solicits or importunes for immoral purposes, commits a felony and is liable, upon conviction, to imprisonment for a term not exceeding fifteen years." Section 149 – prohibits brothels and their ownership.

The Public Health Act Chapter 295 of the Laws of Zambia does not directly deal with availability of reproductive health services. It however provides for the protection of the right to health by regulating various public health issues that include sanitation and housing; how to deal with epidemics, suppression of infectious diseases and infection control. In Part III it focuses on sexually transmitted infections. Sections 58(1) and 58(2) criminalize willful infection of another person with a venereal disease.[cxxv]

In health facilities, sex workers are often afraid to disclose their sexual orientation statuses. This leads to false history and limited physical examinations, which may lead to misdiagnosis and ineffective or even harmful treatment.[cxxvi] There is silence of adolescents who are sex workers and how such category benefits from the SRH services.

There is a need to create more awareness and promote knowledge on HIV prevention and management and promote voluntary HIV testing to increase the levels of adolescents who know their HIV status and are able to freely access required treatment and therapy to protect themselves and their sexual partners. This is important especially for adolescents who are sex workers and continue to endanger themselves and their multiple sexual partners.

7. Sexual and Reproductive Health services for young people-Pregnancy and Child Birth

The Zambian Constitution in Article 11(a) protects the right to life. The constitution states; "It is recognized and declared that every person in Zambia has been and shall continue to be entitled to the fundamental rights and freedoms of the individual, that is to say, the right….to life,

liberty and security of the person and the protection of the law." Article 12(1) further prohibits intentional taking of life of someone by any means stating that "A person shall not be deprived of his life intentionally except in execution of the sentence of a court in respect of a criminal offence under the law in force in Zambia of which he has been convicted." A death sentence, however, cannot be carried out on a pregnant woman.[cxxvii]

The constitution does not have any specific reference to provision of SRH services aimed at prevention of maternal mortality or to guaranteeing reproductive health rights for adults or adolescents. The Directive Principles relevant to SRHR in Article 112 (d) which states that "the State shall endeavor to provide clean and safe water, adequate medical and health facilities and decent shelter for all persons, and take measures to constantly improve such facilities and amenities."[cxxviii]

The government is to develop policies that ensure health facilities through which SRH services are provided not only to be adequate in numbers and equipment, but also that they are constantly being upgraded to meet the demand for health and SRH services and to increase innovations that are aimed at preventing maternal deaths. The directive principles however are not justiciable. Article 111 of the constitution states that the "Directive Principles of State Policy…shall not be justiciable and shall not thereby, by themselves, despite being referred to as rights in certain instances, be legally enforceable in any court, tribunal or administrative institution or entity." Zambians can therefore not demand through judicial systems for the improvement of SRHR services.

The protection of life of pregnant women is provided for in the Health Professionals Act, which in section 3 establishes the Medical Council of Zambia that regulates conduct of medical practitioners through the propagation of a Code of Ethics. Section 60 of the Health Professionals Act, provides that a health professional commits professional misconduct if the health practitioner breaches the code of ethics or encourages another health practitioner to break or disregard the principles of the code of ethics (Sec 61(f)). Health care providers have a duty to provide available, affordable, acceptable and quality services to adolescents.

8. Cultural, Religious and harmful traditional practices

Zambia practices a dual legal system thus practice of customary law is recognized. The constitution in article 23 (4) (d), recognizes the value of customary law. Although there is no single definition of what customary law is in the constitution neither is there a place where there is a clear codification of what constitutes customary law, people have a right to practice their customs as defined by their culture. Customary law is based on what the community has practiced over time and that which has been passed on from generation to generation. Customary law is therefore contextual and localized to particular groups of people in Zambia.

In rural areas, some of the customary law practices have contributed to maternal mortality. Customs that restrict eating nutritional food during pregnancy and those that focus on the sexuality of a pregnant woman have contributed to morbidity and mortality of mothers. There

is need to harmonize customary and statute laws in order to increase protection of sexual and reproductive health rights vis-à-vis cultural and traditional practices

Although the constitution under article 11 guarantee the equal status of everyone, article 23 (4) recognizes customary law in Zambia. In its application, customary law is often discriminatory, particularly against women, "in such areas as bride price (lobola), guardianship, inheritance, appointment to traditional offices, exercise of traditional authority and age of maturity. It tends to see women as adjuncts to the group to which they belong such as a clan or tribe, rather than equals."[cxxix]
Customary law also discriminates when it allows the practice of polygamy. Women are not allowed to marry more than one man while men are allowed to marry more than one woman. The other discriminatory law is the Marriage Act Chapter 50 of the laws of Zambia. Section 17, the marriage law provides that a person can only marry if they are 21 years old. If they have to marry below that age, consent must come from the father not the mother unless the father "be dead, or of unsound mind or absent from Zambia…" the act completely disregards the opinion of the mother in consenting to marriage of her child. The courts in Zambia have dealt with the issue of discrimination based on traditional customary practices and found it unconstitutional.

The study recommends that the law reform process commences to harmonize the statutory and customary laws as discussed herein.

9. Learner Pregnancy Retention and re-entry law and policy

In 1997, Zambia adopted the Learner Re-entry policy whose objective is to provide opportunities to girls, who drop out of school as a result of pregnancy, to be able to go back to school after delivery and continue access to education unlike in the past when they were expelled from school. This enables girls not only to acquire further education, but also to have access to comprehensive sexuality education that may contribute to preventing further teenage or early pregnancy and child marriages. Over the year, the implementation of this policy has faced numerous challenges. Schools have not embraced the policy and data on girls dropping out and making the re-entry is not readily available. The policy puts much emphasize of guiding and counseling as opposed to providing right information and education on CSE and issues of prevention and access to SRH services.

All schools in Zambia are required to grant girls maternity leave for a specified period. The letter of maternity -template reviewed assumes that a girl who becomes a mother automatically gets to be separated from the child to resume school. The policy fails to address the socio-economic barriers that such girls face, i.e. not able to get a caregiver to take care of the child when they resume school. Respondents also indicated that some faith-based schools prefer the girls to transfer to other schools. The girls too, face a lot of stigma and would prefer not to resume learning at the same school but go to alternative one. While the policy is good, structural measures have not been put in place towards its successful implementation. The policy has no implementation and monitoring framework for its success.

The government needs to acknowledge that girls who fall pregnant and drop out of school require more support in accessing SRH information and services and continuous counseling to address the barriers in their lives including poverty, harmful cultural practices and lack of community support mechanisms to mentor them and childcare support services.

The retention programme must address other social issues prevailing to enable the young adolescent mother to resume school, for example, child support, food and shelter among others.

10. Laws and policies on Comprehensive Sexuality Education (CSE)

The Zambian Constitution provides for the right to education-under Part IX at Article 112(e), that is part of the Directive Principles for policy. Although recognized as a right, the right to education is not justiciable and can only be implemented if and when government is capable to do so. Article 112(e) states that "the state shall endeavor to provide equal and adequate educational opportunities in all fields and at all levels for all." This implies that education should include sexual and reproductive health among other fields of education.

The Education Act No.23 of 2011 empowers the Minister to issue a statutory instrument to make regulations for changing the curriculum. In section 108(1)(i), the Education Act states "the Minister may, by statutory instrument, make regulations…. providing for the development and adoption of guidelines to promote education on sexuality, reproductive health, HIV and AIDS and personal relationships in any educational institution."

The Juvenile Act Sec 75 and 76 – provides for the right to education and information for juveniles that come into conflict with the law. The Persons with Disabilities Act No.6 of 2012 protects the right to education of persons living with a disability. Under section 4(b) is the principle of non-discrimination while in sections 22 to 26, the Act directs that persons with disability must attend school and acquire an education like anyone else.

Zambia has made policies to promote CSE through -

a) School curricula include comprehensive, evidence-based, and non-discriminatory sexuality education including safe sex practices and contraception.
b) Ensure accurate public education and awareness campaigns on the prevention of HIV transmission, child marriage, sexual and reproductive health and gender-based violence.

In 2014, Zambia developed and rolled out a comprehensive in-school sexuality education curriculum that is consistent with the UNESCO guidelines on comprehensive sexuality education. The curriculum targets children 10 to 24 years old and caters for grades 5 to 12.

The comprehensive sexuality education is not a standalone subject. It has been integrated in other subjects such as science, biology and civic education. Teachers are therefore expected to teach various CSE in these different subjects. This is positive in the sense that it contributes to reducing overcrowding of the curriculum with a lot of subjects but it also ensures that CSE topics are part of the examinable subjects.

In 2014, the Ministry of Education began conducting in-service training for teachers to ensure that teachers are equipped with skills on how to delivery CSE curriculum. In order to ensure that all teachers are competent in CSE, the diploma teachers training curriculum has also been revised. In 2014 the Zambia Primary Teachers' Diploma Syllabus was revised to include CSE."[cxxx] Although significant progress has been made in developing and rolling out an in-school comprehensive education curriculum, this is not the case with out of school youth. Currently there is no curriculum that targets them and there is no mechanism of how the in-school youth CSE can be used at community level to reach out to out of school youth.

The Zambia Education Policy has one of the specific objectives to ensure that education "foster healthy living, physical coordination and growth. The policy is silent on CSE provisions. The National Youth Policy of 2015 aims to ensure reproductive health education for youths. In policy directive number 4.3, it is the objective of the policy "to increase access to comprehensive, youth-friendly, gender-sensitive sexuality (family life) education." The policy commits to "Promote the provision of Comprehensive Sexuality Education (CSE) and Sexual Reproductive Health (SRH) services that meet the specific needs of youth."

There is no specific law that compels government to ensure public education and communication strategies on HIV, child marriage and GBV. However, several policies have included public sensitization and communication as a central strategy to promote public awareness on these issues. Over the years several campaigns on HIV, sexual and reproductive health, GBV have been launched and implemented nationally. Programmes such as "Health Matters", "One Love Kwasila campaign", Child Health Week, and so on, have been instrumental in raising awareness on various sexual and reproductive and rights matters.

The challenge has been that most of these campaigns are sponsored by CSOs with direct donor funding.

11. Unsafe abortion and post abortion care

There are three laws that deal with abortion; the Zambian Constitution, The Penal Code Chapter 87 of the laws of Zambia and the Termination of Pregnancy Act Chapter 304 of the laws of Zambia.

The Constitution of Zambia prohibits unsafe abortion. In article 12(2), it states, "a person shall not deprive an unborn child of life by termination of pregnancy except in accordance with the conditions laid down by an Act of Parliament for that purpose." The Penal Code in section 151 and 152 prohibits abortion by a pregnant woman herself or assisted by any other person to procure an abortion.

Article 151 states "any person who, with intent to procure miscarriage of a woman, whether she is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing or uses any force of any kind, or uses any other means whatever, is guilty of a felony and is liable to imprisonment for fourteen years."

Article 152 of the penal code on the other hand prohibits a pregnant woman to choose to carry out an unsafe abortion on her own.

Safe abortion is legal in Zambia. It is prescribed under the Termination of Pregnancy Act of 1972 Chapter 304 of the laws of Zambia. In section 3(1), it provides for the conditions under which safe abortion can legally be performed. Safe abortion can only take place in a hospital (Section 3(3)), unless if the termination of pregnancy is deemed to be an emergency immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman (Section 3(4). In 2005, the penal code was amended to allow abortion to be carried out if the child below the age of 16 was raped and became pregnant as a result of that rape. Section 152 (2) of the amended Act states "Any female child being pregnant who, with intent to procure her own miscarriage, unlawfully administers to herself any poison or other noxious thing or uses any force of any kind commits an offence and is liable to such community service or counseling as the court may determine, in the best interests of the child: Provided that where a female child is raped or defiled and becomes pregnant, the pregnancy may be terminated in accordance with the Termination of Pregnancy Act."

Although safe abortion is legal in Zambia, the actual burden is seen due to varied conditions that are prohibitive rendering it inaccessible to many women and girls. The requirements that **three** doctors, one of which is a specialist in the area of concern the woman is presenting, and that abortion should take place in a hospital are not realistic especially for rural women. In rural areas, it is almost impossible to find three doctors and most health facilities are either rural health centers or clinics manned by medical officers or midwives. To reduce unsafe abortion, Zambia has put in place various policies that address abortion. These are:

a) National Standards and Guidelines on Safe Abortion in Zambia

In 2009, Zambia developed comprehensive standards and guidelines on safe abortion. The purpose of "this standards and guidelines document is to ensure that women prevent unwanted pregnancies and those with unwanted/unintended/risky pregnancies get appropriate services to prevent the occurrence of unsafe abortion and associated morbidity and mortality."[cxxxi]

b) The National Reproductive Health Policy

Published in 2005, the National Reproductive Health Policy provides guidance on reproductive health issues including safe motherhood, family planning, adolescent health and abortion. The abortion-specific objective is "to reduce the rate of abortion through enhanced public awareness of available reproductive health resources."

There is no policy directive on the provision of safe and legal abortion services as one of the policy measures to reverse recourse to unsafe abortion. The policy however puts emphasis on the provision of post-abortal care services, prevention of unwanted pregnancies through family planning and reproductive health education.

The Zambia law and standards and guidelines provides for safe termination of pregnancy. The public has been ignorant of the procedure. There is need to create awareness and sensitize communities and train health care providers to make the services available to the women and girls who require it in a safe environment.

12. Freedom from Gender Based violence

In Article 15 of the Zambian Constitution, the protection from inhuman treatment is guaranteed. It states that "a person shall not be subjected to torture or to inhuman or degrading punishment or other like treatment." This outlaw all forms of gender-based violence.

The Anti-GBV Act No. 1 of 2011: Is aimed at domesticating the CEDAW and Maputo Protocol the Anti-GBV Act comprehensively defines various aspects of GBV. These include but not limited to harassment, intimidation; physical, mental, social or economic abuse; emotional, verbal or psychological abuse; stalking, forced marriage, child marriage and sexual cleansing. The Act also establishes the Anti-Gender Based Violence Committee whose role among others is to monitor the activities of all the relevant institutions on matters connected with gender-based violence and make recommendations for a national plan of action against GBV. In addition, the Act provides for the establishment of shelters where victims of GBV can go to seek protection from the perpetrators of violence. To ensure the popularization of the GBV Act, government has translated the simplified version of the Act into seven local languages.

The National Referral Mechanism on Gender Based Violence and Violence against Children – Practical Handbook**. -** Published in 2014, the handbook provides clear explanations of what GBV is and how the community can deal with it. It simplifies the Anti-GBV Act and provides interpretations for the general public and practitioners to understand the Anti-GBV Act.
It then provides a list of various service providers of GBV services and their contact details for referrals.

13. Budgeting /Financing ASRHR

The Government has not demonstrated its commitment to its International and Regional obligations through allocation of budgets to implement SRHR programmes including those targeting Adolescents. The Zambian Human Rights Commission was not able to ascertain how much resources, if any, has been committed by the government to ASRHR.

Despite previous studies that had shown Zambia, relying more on external partners to fund matters of health in the past, in 2022 and 2023, the new government formed by the United Party of National Development is reported to have allocated 8% for 2022 budget and 10.4% for 2023 respectively.[cxxxii] This is good progress towards meeting Abuja declaration on Financing HIV/AIDS, Tuberculosis and Malaria.

However, the budget allocations are not disaggregated to ascertain the percentage that goes to ASRH.

C. Accountability Framework -Zambia Human Rights Commission Sexual Reproductive Health and Rights

The Zambia Human Rights Commission reported working on Sexual Reproductive Health and Rights generally but has not done any work on ASRHR. The commission has not demonstrated working specifically on ASRHR. There is no known Action Plan to implement recommendations from Treaty Monitoring bodies on relevant provisions of ASRH in Zambia. The Commission reported that it has commenced working on reproductive health and rights. However they could not measure the countries' progress of commitment and implementation of Economic, Social and Cultural Rights (ECOSOC Rights), despite numerous recommendations from CEDAW, and Universal Periodic Reporting which they have actively been engaged.

The commission has not actively engaged with the reporting mechanism under the Maputo Protocol and the African regional level. In line with their statutory mandate, the commission has continued receiving and processing complaints that touch on ASRHRs. They have worked closely with the National HIV &AIDS Council, promoting the human rights based approaches in programming. They undertook a baseline survey on SRHR jointly with UNFPA, but the findings are yet to be made public. They have an opportunity to include ASRHR issues in their annual state of human rights reports, and to include key issues promoting adolescent SRHR in their sensitization programmes.

Domestication of International and Regional Treaties: In 2016, the Parliament of Zambia adopted the Ratification of International Agreement Act. NO. 34 that provides for the process of domestication of the ratified treaties.[cxxxiii]

Zambia is not up to date with international and Regional reporting to Human Rights bodies. Under CEDAW reporting, Zambia last reported through its combined 5-6 report submitted on 5th January 2010. Numerous reports are pending submission. Zambia submitted its initial report to the ACHPR but has not submitted any further reports especially complying with the reporting guidelines that require separate reporting on to Maputo Protocol as part B, having ratified it on 2nd May 2006. It reported (initial report) under the African charter on the Rights and Welfare of the Child in 2008, and has not submitted the first periodic report for consideration.

Zambia has not put in place any monitoring and /or tacking efforts to assess how treaties relevant to ASRHR have been domesticated. The Commission was unable to ascertain if the process of domestication and implementation was on track. Further, the commission has not worked directly with the youth to promote their participation and meaningful engagement in matters SRHR. Further, the Commission has not identified the role CSOs have played in implementing the national development plans on ASRH.

D. RECOMMENDATIONS

For NANHRI

1. Provide capacity to the Zambia Human Rights commission on their promotional role of ensuring that the Government is up to date with the reporting international and regionally on treaties they have ratified, especially those that have a bearing on ASRHR, i.e. Maputo protocol and CEDAW.
2. Work with the NHRI to engage more in shadow and alternative report writing on matters of ASRHR
3. To disseminate the findings from the study to the NHRIs involved and promote understanding of the legal and policy frameworks on ASRHR in each country, to ensure rights of all adolescents are promoted, protected and fulfilled.

4. To engage in continuous capacity building and understanding of each country's policy and legal framework on ASRHR and work toward achievement of Universal Adolescents Sexual and Reproductive Health and Rights in conformity with the Maputo protocol and SDGs 3 and 5, calling for full implementation of all regional commitments.

5. To establish a broader and strong political advocacy movement at the African Union level comprising of NHRIs, CSOs and Partners to advocate and lobby for implementation of Resolution 275 and to hold governments accountable towards full domestication and implementation.

For Zambia Human Rights Commission

The Zambia Human Rights Commission needs:

1. To establish a treaty monitoring and accountability Framework with clear criteria on evaluating availability, accessibility, acceptability and quality of ASRHR for Zambia. This will help fast track reporting process for the country, which is not update with treaty monitoring reports both at the international and regional level, promoting reporting under the Maputo protocol.

2. Advocate for implementation of international and regional commitments especially obligations to meet the treaty reporting mandates timely.

3. To consider engaging with the government to call for accountability in disseminating the study findings and propose to review and harmonize the legal and policy framework on ASRHR addressing the identified gaps identified.
4. To build its own capacity to institutionalize ASRHR and that of partners, CSOs and private actors to better understand and programme on ASRHR within the human rights framework.

5. To call on the Ministry responsible for Health and Gender to use the Human Rights Based Approaches to implement policies and programmes to reduce and eliminate preventable mortality and morbidity of children.

6. To call on Government and Parliament to enhance budget allocation towards matters ASRHR.

7. **Social Accountability** – Work with traditional leaders infusing a HRBA to interventions that calls for citizens to participate at all levels of decision making regarding. Convene multi stakeholder's dialogue among government representatives, the health sector, CSOs, the media and other stakeholders to discuss issues of concern on ASRHR in the findings.

8. Conduct regular visits to the facilities and monitor to see whether they meet AAAQ. Ensure facilities are
    a. Adequate budgets.
    b. Have essential infrastructure.
    c. Provide adolescent friendly services.
    d. Treat adolescents especially girls with respect.
    e. Guarantee privacy and confidentiality of adolescents.
    f. Uphold dignity of health worker.
    g. Not charge fees.
    h. Address barriers related to harmful cultural practices.

CSOs and Partners

1. Increase accountability platforms to demand that duty bearers adopt policies/regulations and where they exist, implement ASRHR and services as per the WHO guidelines and recommendations, and advocate for review of restrictive laws/policies that act as a barrier for adolescents in accessing SRH services.

2. Engage in targeted advocacy at domestic level to lobby for increased Budget allocations to Health as well as mobilize external resources toward implementation of State's set priorities on ASRHR and advocate for States to adopt, develop and implement commitments existing at the international, regional and sub regional levels that advance ASRHR, i.e. CEDAW, ICPD Cairo, Maputo Protocol, etc.

3. Advocate for inclusive joint programming approaches through partnerships and collaboration that will empower communities and integrate sustainability frameworks, and avoid duplication.

4. Form and/or join existing networks to engage with policy makers and advocate for inclusive policies to invest more in ASRHR to guarantee the availability, accessibility, affordability and quality SRH for all adolescents respecting intersectionality.

5. Form alliances to undertake targeted public education and awareness creation on Sexual and Reproductive Health Rights of adolescents and young people using a multi sectoral approach that brings on board different actors involved in ASRHR programming, thus religious, women organizations and youth, private and adolescent specific actors).

6. Engage in continuous dialogue with policy makers including National Parliaments and provide them with available sex disaggregated data to make a case for the need to adopt and or review existing policies and or legal framework that hinder adolescents seeking SRH services and advocate for local allocation of more resources to meet the demands by the adolescents for quality services.

7. Partner with Zambia Human Rights Commission (ZHRC) and report complaints of ASRHR violations and participate in monitoring human rights violations, undertaken by the Commission.

8. Link with regional organizations working at African Union Level (ECOSOC accreditation) to use regional mechanisms, for example writing Shadow and alternative Reports and filing complaints after exhausting domestic remedies on ASRHR.

9. To strengthen partnership and collaboration to understand and build their own capacity address the legal, policy and administrative barriers on Adolescent SRHR.

10. Advocate and put in place programmes for adolescents in and out of school adolescents to bolster their participation and understanding of SRHR and the available accountability mechanisms when the rights are violated.

3.4 DEMOCRATIC REPUBLIC OF CONGO

The Democratic Republic of Congo (DRC) has constantly experienced ongoing humanitarian crisis that has led to forced displacement of communities. The World Bank reports that DRC is among five poorest nations in the world. In 2021, nearly 64% of Congolese slightly under 60 million people lived on less than 2 dollars a day. About one out of six people in DRC lives in extreme poverty.[cxxxiv]

A. Demographic Health Indicators Relevant to ASRHR in DRC

Democratic Republic of Congo (DRC) has a very young population – 58.9% of its total population is under 20 years old. According to the second Demographic and Health Survey of the *DRC, 2013-2014* findings,[cxxxv] it showed that the Congolese household consist of average of 5.3 members. Overall 25% % of households are headed by women. More than half (52%) of the

household population was children under age 15. Adolescent. The Total Fertility Rate is averagely 5.4 children per woman in urban and 7.3 in rural areas. Women with more secondary education have average 2.9 children compared to 7.4 among women with no education.

The Multiple Indication Cluster Survey with Malaria Component (***MICS-Palu, DRC, 2017-2018),*** [cxxxvi]that provides more recent statistics was conducted in 2017 and 2018 by the National Institute of Statistics of the Ministry of Planning of the DRC, in collaboration with the UNICEF, as part of the global program of MICS surveys. Technical support was provided by the United Nations Children's Fund (UNICEF). Additional technical assistance was provided by ICF for the part of the survey relating to blood tests for the study of malaria parasitemia. UNICEF, the Global Fund and USAID provided financial support.

The survey provides statistically reliable and internationally comparable data, essential for developing evidence-based policies and programs and for tracking progress towards national goals and global commitments. MICS-Palu, DRC, 2017-2018 provides quality data that is disaggregated and assess the situation of children, adolescents, women and households in the Democratic Republic of Congo. It provides data needed to monitor Progress towards achieving national goals, as a basis for future action. From this survey, adolescents and young people represent 32.8% of the total population of DRC. Adolescents and young people face SRH challenges that include early and unprotected sex, sexual violence, STIs and HIV and AIDS, early motherhood, early and unwanted pregnancies, risky and unsafe abortions and exposure to harmful cultural and traditional practices.

Teenage Fertility: the DRC DHS of 2013-14, found that 27% of women age 15-19 had begun child bearing, with already, 21% being mothers and 6 % are currently pregnant. According to the ***MICS-Palu, DRC, 2017-2018***, 22% of adolescents aged 10-14 have already had their first sexual intercourse. 48% of the teenager age 15-19 have already engaged in sexual intercourse. The 2013-13 DHS found that the Age of first sexual intercourse varies compared to men and women. Half of women age 25 – 49 initiate sexual intercourse by age 16.8. Among men aged 25-49, the median age at first sex is 17.6 Women without formal education initiate intercourse more than women with secondary education. 22% of women in DRC report being in a polygamous union.

The prevalence of HIV is 1% among boys and 0.4% among girls aged 15-24 (DRC DHS 2013-14). There is tendency to feminize HIV infection. The Prevalence of STIs among the age 15-24 id 6.4 for boys. **Knowledge of family planning** and use of contraceptives previously was fairly good. 88 % of women and 95% of men know at least one modern method of contraception, (DRC DHS 2013-14). There is low use of contraceptive methods by adolescents and young person's especially those married. Among those age 15-19, 9.5 % use modern contraceptive method, 6.3 % of the adolescents use traditional methods while 15.9 use contraception method. However, family planning commodities are not always available, making the levels of unmet needs of family planning to remain high at 33.2 among adolescents age 15-19 years and 32,3 among those ages 20-24. This exposes the adolescent and young women and girls to the risks of having unwanted pregnancies. (*MISC-PALU DRC 2017-2018)*

According to (*MISC-PALU DRC 2017-2018*), findings measuring HIV knowledge and screening, 33% of girls aged 20-24 and 23.8% of boys of the same age have already been screened. However, the lowest screening rate was recorded among boys of age 15-19. From the (DRC DHS 2013-14) assessing attitudes and Behaviors, 94% of women and 97% of men have knowledge on using condoms and limiting sex to one uninfected partner as a means of reducing the risk of contracting HIV. PMTCT services are provided for pregnant women and newborn babies. *In the 2013-14* study*, 3* % of women and 22 % of men aged 15-49 reported having two or more sexual partners. Among them only 12 % of women and 13 % of men reported using a condom at their last sexual intercourse. More than half of women (52 %) have ever experienced physical violence since the age of 15. More than 27 % have experience physical violence in the last 12 months. Overall 27 % of women have ever experienced sexual violence and 16 % experience sexual violence.

Maternal mortality ratio was very high estimated at 846 death per 100,000 live births. (DRC DHS 2013-14). This was attributed to numerous causes including delays arising from infrastructure and inexperience of practitioners and poor education of pregnant women and communities. Many deaths occur from young mothers. The recent survey indicates that the 2nd cause of maternal mortality, adolescent girls contribute up to 30 % of the death arising from clandestine abortions. *MISC-PALU DRC 2017-2018)*

The **under 5 child mortality** rate stands at 104 death per 1,000 live births being a decrease from 148 death in 2007.Infant mortality is at 43 per 1,000 live births and neonatal at 28 per 1,000 live births. *MISC-PALU DRC 2017-2018)*

Table 1: Summery of Selected Sexual and Reproductive Health–Related Statistics from DRC varied sources compiled in 2022

	Parameter	Detail	Value
1.	Under 5 mortality	# deaths Per 1,000 live births (*MISC-PALU DRC 2017-2018)*	104
	Infant mortality	# deaths per 1,000 live births (*MISC-PALU DRC 2017-2018*)	43
	Neonatal mortality	# deaths per 1,000 live births (*MISC-PALU DRC 2017-2018*)	28

2.	Maternal mortality ratio	# maternal deaths per 100,000 live births	846
3.	Teenage Fertility rate	(*MISC-PALU DRC 2017-2018*) % Among women aged 15-19 who have begun childbearing	10.9
4.	Adolescent seeking Contraceptives	(*MISC-PALU DRC 2017-2018)* % The total demand for family planning for ages 15-19 years Unmet need (15-19 years)	33.2
5.	Births by skilled health personnel	(*MISC-PALU DRC 2017-2018)* % of mothers with live births received some antenatal care from a skilled provider	82.4
6.	Health expenditure	Estimates not available	
7.	Contraceptive prevalence rate	Modern methods (*MISC-PALU DRC 2017-2018)* % Sexually active Married women Sexually active Unmarried women	17.6 28.2
8.	Unmet needs for family planning	(*MISC-PALU DRC 2017-2018)* % of currently married women 15 to 49 years old	28.7%
9.	Literacy level	*(DRC DHS 2013-14)* % among 15- to 49-year-olds Women Men	 60.4 80.8
10.	Proportion of women who have begun childbearing	*(DRC DHS 2013-14)* % among 15- to 49-year-olds Women Men	 64% 88%
11.	HIV & AIDS	(*MISC-PALU DRC 2017-2018)* % Prevalence among the adult population age 15-49 Prevalence among women Prevalence among men	1.2% 0.4 % 1%
12.	Gender-based violence	*(DRC DHS 2013-14)* Prevalence among women age 15-19	 16.4

13.	Total Fertility Rate	(*MISC-PALU DRC 2017-2018)* % Varies from 5.4 children per woman in urban areas to 7.3 in rural areas	6.2 6.2
14.	Early Marriage	*(DRC DHS 2013-14)* % of women aged 20-24 were married between before age 18	29

The Findings and Analysis

B. Legal and Policy content Analysis

1. Equality and non-discrimination Principles

The signing and ratification of Maputo Protocol[cxxxvii] was a welcome move and it has formed the major event that has shaped the Legal Framework of women's rights in DRC. To fully domesticate the Maputo Protocol, several laws and policy frameworks have been developed and adopted as below. It took 10 years after ratification of Maputo protocol in 2008 to get it

published in the official Journal to commence implementation. The efforts to have the publication was led by African Population Health and Research Centre (APHRC) partners under the platform WE ENGAGE. The domestication has paved way for implementation of Article 14 of the Maputo Protocol calling on States to provide medical and safe abortion among other services.

The 2006 Constitution reaffirmed the commitment of DRC to human rights and domestication of international and regional treaties.[cxxxviii] Article 215 of the Constitution makes International Treaties Agreements regularly concluded and published a greater authority. Therefore, all ratified treaties automatically become laws enforceable in the country. The Constitution further devolves a higher authority on Treaties and Agreements ratified. For the treaties to be enforced, they have to be published in the Official Journal. In 2018, the Constitutional Court ruled that noting was preventing the enforcement of the Maputo Protocol. The Protocol was finally published in the official Government Journal in 2018.

The Ministry of Gender has been appreciated for disseminating the Maputo Protocol, and reporting to the African Commission on human and People's Rights as a means of accountability. Article 42 of the Constitution of the DRC recognizes that Public authorities have an obligation to protect young people from any attack on their health, education and integral development. Ministerial Order No. 1250/CAB/MIN/S/CJ/001/2003 of 13/01/2003 establishing and organizing a National Adolescent Health Program (PNSA).[cxxxix] The National Adolescent Health Policy, provides guidelines and standards for the effective management of these various health problems of young people. Law No. 18/035 of 13th December 2018 lays down the fundamental principles relating to the organization of Public Health. The law on universal health coverage (UHC) in DRC provides for the establishment of several mechanisms or "schemes" for financing the health sector. The law on Implementation of the rights of women prohibits discrimination. (Law No. 15 /03. The policies follow by encouraged availability and accessibility of family planning services and commodities.

The National Strategic Plan for the Health and Well-being of Adolescents and Youth 2016-2020 seeks to contribute to the development of the country by improving the state of health and well-being of adolescents and young people for their harmonious development and their better social and economic productivity.

On the regulatory and normative level, the National Adolescent Health Program / PNSA has developed some normative framework. *The legal framework* is mainly supported by the **Maputo Protocol**. The PNSA has developed the following normative documents:

a. **National adolescent health policy:** Provides strategic guidance to actors working in the field of adolescent health. Its objective is to contribute to the improvement of the health and development of adolescents by organizing and delivering services adapted to their age group.
b. **Guide to good practices in adolescent and youth health:** This guide lists good practices in adolescent health for use by providers at all levels of the health pyramid in the DRC.

c. **The standards of services adapted to adolescents and young people:** Sets the quality criteria for the supply of health services adapted to adolescents and young people at all levels of the health system
d. **The operating guide for youth information and communication spaces:** Provides guidelines for the creation, organization and proper operation of youth information and communication spaces.

In an assessment of policies, laws and regulations affecting the contraceptive needs by adolescents in DRC in 2020,[cxl] it found that family Planning among the adolescent faces challenges that included inadequate regulations and standardization.

This study find the normative framework(legal and policy framework) good and favourable . However the implementation does not respond in equal measures, and require better implementation frameworks that are adolescent focused/friendly with meaningful participation of the adolescents to enhance the uptake of SRH services..

2. Age of consent to sexuality

The age of consent as per the Constitution and family code is set at 18 years in DRC for both girls and boys. The review of the Penal code in 2006 -law No. 6/019/2006, , increased the age of minority from 14 to 18 years, made the penalties for sexual offences stiffer and widened the definition of statutory rape.[cxli] Adolescents aged below 18 years have no capacity to consent to sexual acts. Consensual sex among minors under age of 18 is criminalized as statutory rape.

However, there are very few known cases that have been prosecuted. This is because cultural practices continue to compromise reporting and prosecuting the perpetrators. The judicial officers appear to give lenient sentences despite the amendments of the penal code. It calls for a lot of sensitization among community members and judicial officers.

3. Age of consent to marriage

DRC has for a long time experienced high cases of child marriages, including customary marriages. According to the Child Protection Act, and Article 407 of the Family code DRC has set the age of Marriage at 18 years for both boys and girls with no exceptions. No State Official can celebrate a marriage where both spouses or one of them is under 18 years. Despite the law, child marriages are rampant. Despite the provisions of the law, child marriages are prevalent and the consequence is high rates of school dropouts for adolescent girls. Traditional practices continue to allow girls below 18 years to get married by consent of parents and guardians, contrary to the law.

The Ministry of Gender, Women and Children with support from UNICEF has continued working to implement the adopted in June 2017 Action plan to End Child Marriages. Girls and no Brides, a CSO together with other partners are working to create awareness of the law against child marriages and also to address the harmful consequences of child marriages to families,

traditional leaders and with Parliament and legal governance. This has been effective through digital learning clubs in schools and life skills programmes for girls in and out of school.[cxlii]

4. Age of consent to health services-Contraceptive information and services

The Ministry of Public Health, Hygiene and Prevention (MSPHP) committed to FP 2020 to increase contraceptive rate from 5.4% in 2010 to 19% in 2020 and to increase the numbers of users to 2.1 million from 700,000.[cxliii]

The Family planning policy guarantees access to sexual and reproductive health services, and sets the terms of use of contraceptive methods by adolescents and young people. The Policy provides among others that any women of childbearing age can access contraceptives. Contraceptives are made available to women of ages above 10 years. Before the age of 15 years, parental and guardian, consent is required for all contraceptive methods. For legally married persons, consent of spouse is required for contractive methods. However, in cases of disagreement between the spouses on the contraceptive method to be used, the will of the spouse concerned shall prevail. However, for adolescent's ages 15-17 years, free consent can be obtained for non-surgical methods. However, parental or guardian consent is required to authorize injectable and surgical methods.

DRC's legal environment is very restrictive for access of contraception and Family Planning for adolescents. Placing children, age of 18 years and below under parental authority with regard to health, limits their access to SRHR and services and thus the low percentage of young girls seek family planning services. Adolescent's health has an impact on the health and development of future generation. They continue to suffer hugely and the countries health indicators remain alarming and worrisome.

5. Criminalization of consensual sexual acts among adolescents

DRC does not have a legal framework to protect LGBT people from violations of their rights, as there is no specific law that condemns violence based on sexual orientation or gender identity, gender or protects them from such violence or discrimination. The only law that specifically refers to homosexuals is the People Living with HIV/AIDS Protection Act of 2008, which identifies homosexuals and sex workers as high-risk and HIV-exposed groups.

DRC does not have a political nor legal framework to implement Resolution 275 on prohibiting violence against sexual minorities including adolescents. The country has not passed any laws promoting LGBTI rights LGBTI people are protected against any offense committed against them under common law provisions that apply to all other citizens, i.e. the non-discrimination and access to services.

The LGBTI people in Congo face huge stigma and discrimination and their rights are often violated, including freedom of association. The environment is not friendly for them they suffer greater violations and threats. There is no explicit criminalization of same sex sexual acts in DRC. It has never been illegal. Homosexuality is not an offence in Congo. However, under the Congolese Penal Code Article 176, it can be criminalized under the Public Decency Provisions.

There is no tolerance of LGBTI in large towns where majority reside for gainful employment i.e. Lubumbashi & Kinshasa, where police often crack them down and arrest them. LGBTI people are frowned upon and do not enjoy the rights to equality (Constitution Article 12) non-discrimination (Article 13 and the right to privacy (Article 31). The LGBTI people are afraid to come out. There is no legal recognition for same sex couples (Article 40). The Constitution defines marriage to be for straight couples. It provides thus:

Every person has to marry someone of the opposite sex. There are no support services for LGBTI. They suffer threats and LGBTI women faces discrimination and are at a risk of being forced by families to marry and also subjected to sexual violence. Mostly, organizations working to support them work underground for fear of being repressed. Since 2010, there has been a campaign in parliament against homosexuals through proposals for laws against homosexuality. These laws have not since been debated in plenary, but remain under study by one of the Congolese parliament's committees. Although the country does not have age-disaggregated data, a few cases of violation of women's rights have been reported:

- Between January and July 2016, civil society organizations recorded 93 cases of human rights violations against LGBT people in the province of North Kivu (city of Goma and the two municipalities of Goma and Karisimbi).
- Other reports indicate that in 2014, in a district of the city of Kinshasa, a couple of the men were handed over to the police because they kissed in the changing rooms of a public swimming pool. The manager of the place handed them over to the police. The police forced the couple to pay the sum of $100 to calm the situation. They were threatened with humiliation and exposure to the public eye
- In 2016, in Kinshasa, during the funeral of a gay boy, some members of the community were arrested for inciting and promoting homosexual practices in public.

In the DRC, defenders of the rights of sexual minorities also suffer human rights violations Between July 2016 and July 2017, a local organization documented 9 cases of death threats and blackmail by telephone and physical. In addition, human rights defenders and activists defending the rights of LGBT people face challenges in exercising their right to associate freely without interference from the state. Most organizations are not legally registered because legislators and notaries do not approve the organization's statutes that refer to working with LGBT people or sex workers. As such, organizations that have been successfully registered have indicated that they have focused on developing young people in order to gain access to registration.

6. Criminalization of HIV /AIDS

In 2008, the Democratic Republic of Congo (DRC) adopted the omnibus law on HIV that included criminalization of HIV transmission. Article 41 provides that a person who knows that he or she is HIV positive must inform his or her sexual partners within reasonable time and before having sex. However, if in light of that period, the person concerned fails to inform his/her sexual partners, the doctor may, exceptionally, derogate from professional secrecy.

In 2018 through lobbying and advocacy by CSOs, Parliament voted to amend Article 41 on non-disclosure of deliberate infection. However, the law still contains 2 sections that are still criminal. There is Article 174 and 177 on 'deliberate' transmission of a Sexually Transmitted Infection including HIV to a child, which is s punishable by life sentence. Notably, review of cases that have been prosecuted in DRC courts reveals that in most cases, accused persons end up being acquitted for lack of evidence.

7. Sexual and Reproductive Health services for young people-Pregnancy and child birth

Over the years, stakeholders have made several attempts to draft a reproductive health bill, but was overtaken by the adoption of the health sector law. Huge challenges are experienced by adolescent girls who suffer unwanted pregnancies and consecutive unsafe abortions for adolescent girls as well as adult women. The law only refers to women of childbearing age without specifying they are women aged 15-49. The law lacks implementation framework as well. There are doubts as to whether the law will increase update of family planning for adolescents aged 15-19.

DRC is guided by numerous policy documents including the National Health Development Plan (PNDS) 2016-2020 and reviewed in 2019-2022, the Sustainable Development Goals, the United Nations Global Strategy for women's children's and Adolescent Health (2016-2030). The Integrated Strategic Plan for Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition (2019-2022) was adopted to significantly contribute to improving the health status of the population within the framework of Universal Health Coverage.

The Government has put in place a programme responsible for adolescent's health aimed at warning adolescents against early and unwanted pregnancy and risks of contracting HIV/AIDS and Sexually Transmitted diseases as well as against unsafe abortion in schools in particular among youth in general.

Adolescent and Youth Centers exist throughout the Country to offer Specific Reproductive Health Services as well as ensure the promotion of the use of Contraceptives for the prevention of STIs and HIV/AIDS and establishment of the Network of Youth to control HIV/AIDS. Under the coordination of the PNSA, the government ensured the training of sex workers, particularly women in order to protect themselves and their sex partners from HIV/AIDS and STIs. There is a national adolescent program (PNSA) within the Ministry of Public Health, Hygiene and Sanitation DRC; The National Adolescents Health programme continue to train peer educators of young people educating other young people (boys and girls in schools and sports circles) on the various aspects of life, including youth, sexuality and the right against HIV/AIDS.

The National Adolescents Health Policy is supported by the Strategic Plan, which clearly outlines factors that threaten the survival and health of adolescents and include. Key among them are early pregnancies, early marriages and unsafe abortions.

8. Cultural Religious and Harmful Traditional Practices

DRC acknowledges continued existence of harmful cultural practices. These include early and child marriages, and girls being subjected to early sexuality. The laws on sexual violence of 2006 provides sanctions against perpetrators of harmful practices. Other offences notable in that act include sexual mutilation, exploitation of minors for purposes of debauchery, pimping, forced prostitution, harassment and sexual slavery, forced marriage, harassment and sexual slavery, forced marriage, zoophilia, deliberate transmission of sexually transmitted infections, child trafficking and exploitation for sexual purposes, pregnancy and forced sterilization, prostitution and pornography involving children. Polygamous marriages persist despite the recognition of monogamous unions. It remains quite widespread with 22% of women in polygamous union, where upon 8% are girls of age 15-19.

9. Learner Pregnancy Retention and Re-entry law and policy

DRC continues to register high levels of girls 111 per 1000 girls (15-19) who give birth annually (UNFPA data).[cxliv] At the primary level, the school enrollment between girls and boys have reduced. Education of many girls suffers because of early marriage and pregnancies.

DRC has no law nor policy to protect young mothers by offering re-entry in schools after delivery. DRC's 2016 Girls Education Strategy provides for protection of pregnant students against education exclusion. However, it fails to provide practical steps how this should be done. This has left the situation in the hands of school administrators who decide when they should re-admit or not. Without regulatory framework, the implementation of the re-entry policy becomes haphazard and discriminatory. The county requires to have a human rights-based policy that will deal the barriers adolescent mothers face as they strife to access their right to education after delivery.

10. Laws and policies on Comprehensive Sexuality Education (CSE)

According to UNFPA, CSE guidelines, effective sexuality education (CSE) enables young people to adopt positive sexual bahaviours, that include delaying sexual debut, reducing the frequency of sex and number of partners and increasing use of contraception, especially condoms.[cxlv] It is preferred that CSE be made age appropriate for both in and out of school adolescents. CSE is delivered through family life education courses (FLEC) in the country whose curriculum is prepared by the family life education. The program is not well designed nor evaluated. Finding from studies undertaken to assess the comprehensiveness of CSE found the same the scope was very limited with a lot of misconceptions and ignorance on basic information on contraceptives by both learners and teachers. There is little knowledge on SRH by the learners and how to prevent adolescent pregnancies among the adolescent girls.

Sex education services are mainly targeted at adolescents and the youth and sometimes adults. There is strong opposition in the country mainly from the Catholic Church, the Protestant Church and Other religious organizations. Aspects linked to sexuality education are either included in life long education lessons or presented in the form of sensitization sessions. An FGD from adolescents affiliated to the Catholic Church during the study found that the school CSE programme does not provide the learners with enough information on topics like safe abortion, knowledge on how to prevent pregnancies and FP methods. Further that some

teachers were uncomfortable teaching details of aspects on SRH in the course for example abortion.

11. Unsafe abortion

DRC has ratified the Maputo Protocol. APHRC as earlier indicated led CSOs to engage in a successful advocacy campaign that led to publication of the Maputo protocol in the official Journal that essentially kick started its implementation. SAFE ENGAGE project through a multi sectoral approach has been credited for have the treaty published. Article 14 of the protocol authorizes medical abortion.

However, there is no law authorizing abortion in DRC. Articles 166 and 167 of the Criminal code strictly penalizes the practice of abortion. The code further states that any person who through food, beverages, medicine, violence or any other means makes a woman undergo an abortion, shall be sentences to a term of 5 to 15 years. A woman who undergoes an abortion voluntarily shall be sentences to 5 to 10 years. DRC has continued to suffer high maternal mortality, illegal unsafe abortions among other barriers.

The Penal Code criminalizes all kinds of abortion except therapeutic abortion preserving the health of the mother. It states thus, termination is allowed by a medical profession when the pregnancy endangers the mental and physical health of the mother or the foetus. Such a procedure must be approved by a forensic scientist who will prepare a document to be attached to the file of the sick woman.

The Standards and Guidelines for Women – Centered Comprehensive Abortion Care in the DRC was validated by the Ministry of Public Health Ethics Committee in December 2020. It represents a milestone in expanding access to care. The guidelines codify a progressive and expansive interpretation of the Maputo Protocol; circumventing many of the Procedural Barriers to case that exist in other guidelines i.e. like Zambia, where abortion is widely legal. Women do not need to give proof of rape or incest or non-marital consent. Minors seeking abortion care are automatically eligible to receive care under the legal age of consent. While they must be accompanied by an adult, this can by any trusted adult of their choice. The guidelines follow the WHO definition of Health as a State of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.

There is need to review the Penal code to align it to the new framework of implementation based on the publication of the Maputo protocol and development of standards and guidelines.

12. Freedom from Gender Based violence

The penal code and the penal code procedures have been reviewed to punish sexual violence (which has been used as a weapon of war) for a long time. The National Gender Policy (NGP) has strategies on integrating matters Gender. Others are the National Gender Integration Strategy for Gender Sensitive Planning and Budgeting, the National Gender Strategy for combating Gender Based Violence (SNVBG) and National Strategy for combating maternal and

child mortality and National Strategy for political participation of women in Democratic Governance-ongoing.

Factors underlying gender-based violence include economic (monetary poverty) legal and political (weakness of authority impunity) social cultural outdated customs, prolonged celibacy, conception about sexuality, obscene music and dances, men's superiority, stereotyping women, violence films and pornography and other economic factors. Sexual Harassment continues to occur in an out of workplace and it is a great risk to sexual favors and one contracting HIV/AIDS and other STIs.

13. Budgeting /Financing ASRHR

Because of the ever-rising conflicts and humanitarian setting most resources in DRC are diverted from health and other socio-economic causes to other prioritized areas (managing the conflict).

The government funds the implementation of several programs, including the National Adolescent Health Program (PNSA), the National Reproductive Health Program (PNSR), and universal health coverage implementation structures. There is a budget line that is voted each year to support the activities of adolescents, but this budget has not been disbursed for almost 10 years. The PNSA works with funds from United Nations system organizations Over the past three years, the amount is around 1million US dollars.

The resources received from development partners have made it possible to implement SRHR activities, in particular campaigns to offer contraceptive methods to adolescents and young people, the development of spaces for young people and the training of peer educators, etc.
In view of the current challenges such as the increase in the supply of health services to adolescents and young people, it is important to increase the resources to be allocated to interventions in favor of adolescents and young people. Currently in the DRC, there is no financial commitment on the government side except that the United Nations population organization UNFPA, jointly with CSOs i.e. and IPAS continue to finance some health activities. DRC has not met the Abuja Declaration on putting aside 15% of its budget to health. However, no budget estimates were available.

C. The Accountability Framework-The National Human Rights Commission (CNDH).

The National Human Rights Commission is established by ordinance Law. No. 0011/2013 of 21st March 2013. The CNDH in as advisory body with legal status, independent from other institutions, tasked with promoting and protecting human rights and it is to assist the government through its advisory opinions, proposals and considerations on human rights, international humanitarian law, humanitarian action and respect of fundamental guarantee among others. It is also tasked with promoting and protecting the rights of women in the sub-committee on 'Special Rights of Women'. This gives it greater insides to understand the human rights of women and girls and to raise issues of discrimination in law or policy.

The commission has continued to receive complaints related to SRHR. However, it has low capacity to engage on the ASHR specifically. The National Human Rights Commission(CNDH) as a democracy oriental support institution has participated in Consultations for reporting together with CSOs, UN Women, UNFPA and UNDP.

International and Treaties & Maputo Protocol Reporting: DRC responds and is committed to the following: The Solemn Declaration on Gender Equality in Africa, the Maputo Protocol and the AU Gender Strategy and the Gender Policy, the Continental Policy Framework and SRHR and its Maputo Plan of Action (MPOA) provide the guidance to African States on the implementation of the UN 1994 ICPA Plan of Action and the AU Abuja Declaration of 2001. The Addis Ababa Declaration on Population Development in Africa,[cxlvi] the African Women Decade and the Continental Campaign on Ending Child Marriage, Maternal Mortality (CARMMA).

The Gender is my Agenda advocacy Platform[cxlvii] has been used by CSOs as an accountability mechanism to hold governments accountable. The African Population and Health Research Center through its project SAFE ENGAGE has worked to build capacity for policy dialogue to advance access to safe abortion in Africa. In DRC, they were instrumental in domesticating the Maputo protocol.[cxlviii] The Project works with multi-sectoral taskforce and used data to strengthen communication for effective advocacy. The commission has been engaged in most of the CSOs activities. The CNDH has the capacity to work with the Government to continue with timely reporting as per the Maputo Protocol reporting guidelines.

D. RECOMMENDATIONS

For NANHRI

1. To disseminate the findings from the study to the NHRIs involved and promote understanding of the legal and policy frameworks on ASRHR in each country, to ensure rights of all adolescents are promoted, protected and fulfilled.

2. To engage in continuous capacity building and understanding of each country's policy and legal framework on ASRHR and work toward achievement of Universal Adolescents Sexual and Reproductive Health and Rights in conformity with the Maputo protocol and SDGs 3 and 5, calling for full implementation of all regional commitments.

3. To establish a broader and strong political advocacy movement at the African Union level comprising of NHRIs, CSOs and Partners to advocate and lobby for implementation of Resolution 275 and to hold governments accountable towards full domestication and implementation.

FOR NHRI

T**he National Human Rights Commission (CNDH) to consider the following: -**

1. Arising from the findings herein to engage the Government through the Ministry of Justice to consider reviewing of the offending laws including proposal to Harmonize laws 165 and 166 of the penal code in the light of the resolutions of the Maputo protocol to promote access for all women to safe abortion services.

2. To work with identified stakeholders, partners and development partners to advocate for the review of the Reproductive Health Policies that limit access to information for adolescents and especially adolescent girls.

3. Advocate for removal of the restrictive and punitive penal laws that does not allow women and girls to access safe legal abortion in terms of the Maputo protocol. This is towards reducing the high level of maternal mortality in the country.

4. Lobby and advocate to the Government for increased funding/Budget allocations for activities related to sexual and reproductive health and rights: The low disbursement rate for SRHR resources is a factor that affects the quality of interventions and leads to low service coverage.

5. Lobby and advocate for increase in availability of adolescent and youth friendly services across the country, well equipped to provide services to all without discrimination brought about by policies on age restrictions for family planning commodities.

6. Conduct regular visits to the facilities and monitor to see whether they meet AAAQ. Ensure facilities are
    a. Adequate budgets.
    b. Have essential infrastructure.
    c. Provide adolescent friendly services.
    d. Treat adolescents especially girls with respect.
    e. Guarantee privacy and confidentiality of adolescents.
    f. Uphold dignity of health worker.
    g. Not charge fees.
    h. Address barriers related to harmful cultural practices.

CSOs and Other Non-State Actors

1. Increase accountability platforms to demand that duty bearers adopt policies/regulations and where they exist, implement ASRHR and services as per the WHO guidelines and recommendations, and advocate for review of restrictive laws/policies that act as a barrier for adolescents in accessing SRH services.

2. Engage in targeted advocacy at domestic level to lobby for increased Budget allocations to Health as well as mobilize external resources toward implementation of State's set priorities on ASRHR and advocate for States to adopt, develop and implement

commitments existing at the international, regional and sub regional levels that advance ASRHR, i.e. CEDAW, ICPD Cairo, Maputo Protocol, etc.

3. Advocate for inclusive joint programming approaches through partnerships and collaboration that will empower communities and integrate sustainability frameworks, and avoid duplication.

4. Form and/or join existing networks to engage with policy makers and advocate for inclusive policies to invest more in ASRHR to guarantee the availability, accessibility, affordability and quality SRH for all adolescents respecting intersectionality.

5. Form alliances to undertake targeted public education and awareness creation on Sexual and Reproductive Health Rights of adolescents and young people using a multi sectoral approach that brings on board different actors involved in ASRHR programming, thus religious, women organizations and youth, private and adolescent specific actors).

6. Engage in continuous dialogue with policy makers including National Parliaments and provide them with available sex disaggregated data to make a case for the need to adopt and or review existing policies and or legal framework that hinder adolescents seeking SRH services and advocate for local allocation of more resources to meet the demands by the adolescents for quality services.

7. Partner with CNDH and report complaints of ASRHR violations and participate in monitoring human rights violations, undertaken by CNDH.

8. Link with regional organizations working at African Union Level (ECOSOC accreditation) to use regional mechanisms, for example writing Shadow and alternative Reports and filing complaints after exhausting domestic remedies on ASRHR.

9. To strengthen partnership and collaboration to understand and build their own capacity address the legal, policy and administrative barriers on Adolescent SRHR.

10. Advocate and put in place programmes for adolescents in and out of school adolescents to bolster their participation and understanding of SRHR and the available accountability mechanisms when the rights are violated.

3.5 Engagement with East Africa Community

A. East African Community Engaged on ASRH

The East African Community acknowledges good governance, gender equality, human rights, mainstreaming of gender, participation and addressing discrimination. The EAC Gender Equality and Development Policy was adopted in 2018.[cxlix] The policy provides for the principles of non-discrimination, harmonization of gender equality commitments in the sub region and promotes women's rights including addressing gender-based violence, health, peace and security or marginalized groups.

The EAC has adopted an HIV and AIDS Prevention and Management Act,2012. [cl] There has been attempts to adopt a Sexual and Reproductive Health Bill.[cli] The last draft bill was presented in the house in 2021 but failed to go through. The aim of the policy is to protect and facilitate the attainment of the life-course Sexual and Reproductive Health and Rights for all persons in the Community. The Bill is anchored on Article 118 of the EAC Treaty. [clii]

The draft bill brought as a private member motion, having been rejected by the ministers responsible for health from the member states. Specifically, the bill provides for Sexual and Reproductive Health for all including adolescents and young people (Art. 7-13) and general (13-21), part 111 on Harmful Practices.

The EALA members have not been very keen on passing the bill into law. While the members admit that the bill is for the purposes intended, there has been disquiet among the honourable members. The study learnt that the members are opposed to what they term as an "***abortionist"*** bill that also seeks to allow Lesbians, Gays, Bisexual, Transgender and Queer (LGBTIQ) practices to be acceptable in the region despite total rejection of the same in member States' laws and policies.

The EAC SRH bill has faced challenges for the following reasons;

i) Authorizing Comprehensive Sexuality Education.
ii) Abortion / Termination of pregnancy.
iii) Key populations accessing SRHR.
iv) Surrogacy – legal issues not well defined.

There is an opportunity to put the bill before the next Parliament once it resumes. The bill will still be presented as a private member's bill.

B. RECOMMENDATIONS

NANHRI

To engage with EALA members in providing capacity on the pending bill from a human rights framework and support its enactment, in law as a good regional Framework towards realization of the Maputo Protocol and other SRH related commitments.

NHRIs within EAC -Kenya, Tanzania and DRC

To join hands with CSOs/networks working at State level and at the EAC level to advocate for passage of the draft SRH bill that has been pending.

- Promote a human rights-based approach engagement at country levels with Ministries responsible for health and gender to advocate for inclusion of the contentious issues allegedly that constrain the acceptance and passage of the draft SRH bill.
- Advocate and promote the greater understanding of the Maputo protocol, EAC gender policy and EAC HIV Prevention and Control Act as entry points for discussing the draft SRH bill.
- Advocate for increased funding to ministries of health to address the barriers/gaps and challenges of ASRHR, access to services including SRH commodities.

CSOs and Other Stakeholders

- Engage in Advocacy to ensure States at domestic level understand the Draft proposed EAC SRH Bill to hold their EALA members Accountable.
- Create awareness at both EAC level and State level on the important of ASRHR as a greater investment in the future generation and thus need to set aside specific Budget item lines for SRHR implementation at domestic level.
- Advocate through strategic annual campaigns to States to honour their regional and sub regional commitments and establish and or adopt and implement Adolescents and Youth friendly integrated services including SRHR.
- Engage with States through the Ministries of Health (MOH) to ensure support of the draft SRH bill.
- Advocate for increased Budget allocation at States levels to at least meet the Abuja Declaration of at least minimum 15% of domestic Budget to be allocated to Health including ASRH.
- Advocate for participatory approaches at State and Sub Regional levels calling for active and meaningful engagement of Adolescents and Young people in decision making processes on their SRHR.

Annexes: Map of ASRH Networks/Platforms/Partners at Country level

Annex 1

Kenya: Map of ASRH Networks/Platforms/Partners at Country level

Organization	Role
KELIN	• HIV/TB key affected population. • Health and Governance. • Sexual and Reproductive Health Rights. • Building the capacity of both duty bearers and rights holders on sexual and reproductive health rights. • Creating awareness and promoting dialogue with key stakeholders at both grassroot and policy level. • Litigating on emerging issues. • Strategic Litigation. • Women, Land and Property Rights. • They engage in long-term human based approach work, build resilience, respond to health violation situations, and seek to address the root cause of health violations through advocacy work.
IPAS Africa Alliance	• They focus on people who want contraception or abortion, and they programs around their needs. • Legalizing Abortion. • Monitor Gender and Human Rights. • Quality care. • Gender Based Violence and Gender Equality. • Abortion Self-care and Stigma. • Sexuality Education. • Work with global, national and local institutions to advocate for the inclusion of accurate, non-biased information on abortion in comprehensive sexuality education programs and seek to help governments uphold their obligation to provide comprehensive information on sexual and reproductive health to all young people.
Centre for Reproductive Rights (CRR)	• Ensure reproductive rights are protected in law as fundamental human rights for the dignity, equality, health, and well-being of every person. • Litigation. • Legal Policy and Advocacy. • Resource and Research. • Landmark cases on promotion and protection of SRHR • Annual update of Annual Abortion Law Maps. The map categorizes the legal status of abortion on a continuum from severe restrictiveness to relative liberality. • Reflecting changes in national laws

	• Human rights advocates monitor how countries are protecting, or denying reproductive rights around the world.
Reproductive Health Network (RHNK)	• Bring together public and private trained reproductive health providers committed to the provision of Comprehensive Sexual and Reproductive Health and Rights, advocacy and service provision, including comprehensive abortion care, (safe abortion and post-abortion care) through strategic partnerships and capacity building. • Adolescent and Youth Programme. • Advocacy. • Legal support. • Opposition monitoring and management. • Service delivery.
African Population& Health Research Centre(APHRC)	• Research institution and think tank, generating evidence to drive policy action to improve the health and wellbeing of African people. • Research and Capacity strengthening. • Policy engagement and communication.
International Centre for Research on Women ICRW	• *Promoting a culture of equity through recruitment processes, staff training, policies & procedures.* • Advisory practice. • Research and Analysis. • Monitoring and evaluation. • Capacity building. • Advocacy and policy engagement.
USAID – DREAMS Project: Partnership to reduce HIV/AIDS in Adolescent Girls and Young Women.	• DREAMS– (Determined, Resilient, Empowered, AIDS-Free, Mentored and Safe), Partnership is an ambitious public / private partnership aimed at reducing rates of HIV among adolescents' girls and young women (AGYN) in the highest HIV burden Countries. • It was announced during the World AIDS Day 2014. • Activities commenced in 2015 in the following Sub-Saharan African Countries (Eswatini, Kenya, Lesotho, Malawi, Mozambique, South Africa, Tanzania, Uganda, Zambia and Zimbabwe). • The above countries accounted for nearly half of the new HIV infections that occurred among GGYN globally. • The DREAMS objectives are: - • Empower adolescent girls and young women and reduce risk through youth friendly reproductive health care and social asset building. • Mobilize communities for change with school-and-community-based HIV and violence prevention. • Reduce risk of sex partners through PEPFAR Programming, including HIV

	testing, treatment, and voluntary medical male circumcision and • Strengthen families with social protection (education subsidies, combination, social economic approaches) and parent/care giver programs. • USAID is the lead implementer of DREAMS. • In 2021, USAID contributed to supporting 2,414,719 adolescent girls and young women through the Dreams Program.

Annex 2

United Republic of Tanzania: Map of ASRH Networks/Platforms/Partners

Centre for Reproductive Rights (CRR)	• Uses the human rights and reproductive justice frameworks to address the root causes and systemic violations of the sexual and reproductive rights of women and girls in the Africa region. • UNFPA Tanzania supports to ensure universal access to sexual and reproductive health and rights remains at the very centre of development. • Maternal and newborn health. • Voluntary family planning. • The prevention of sexually transmitted infections and HIV. • Equitable adolescent and youth-friendly sexual and reproductive health information and services. • Quality and consistent sexual and reproductive health services for local communities and displaced people in humanitarian settings.
Human Rights Watch	• Freedom of expression and media. • Legislative reforms. • Women and children rights. • Refugee rights.
Engender Health Tanzania	• Focus primarily on family planning (FP) and sexual and reproductive health (SRH), comprehensive abortion care (CAC), including post abortion care (PAC); • HIV and AIDS prevention and care; • Health systems strengthening—while also integrating social and behavior change communications and gender, youth, and social inclusion. • We employ a rights-based approach that emphasizes full, free, and informed choice regarding all aspects of sexuality and reproduction. • Expanding access to information and services related to contraception, safe abortion and post abortion care, HIV and other sexually transmitted infections, cervical cancer, and more • Strengthen service delivery by integrating contraceptive care with other health services that women and their families need, including immunizations, screening and treatment for HIV and other sexually transmitted infections, cancer screening, and maternal and obstetric care.
Tanzania Youth & Adolescent Reproductive Health Coalition (TAYARH)	• Committed to enhancing advocacy capacity through the AFP SMART training to 40 youth-led organizations working on sexual and reproductive health rights (SRHR) and other issues such as HIV, environment, and agriculture, etc.

FP 2030 Partnership	• It partners to promote and protect the rights of adolescents and youths to sexual and reproductive health (SRH) services, including contraception. • Facilitating access to high-quality SRH services responsive to their needs, and ensuring a supportive policy and social environment. • Stronger and more coordinated youth-led civil society in East and Southern Africa that can promote, address and advance SRHR and its intersections with HIV and gender inequalities at the regional level, with a key focus on a highly vulnerable and underserved population: girls and boys, adolescents, and young women and men.
Women Fund Tanzania Trust	• Every Tanzanian woman to be empowered and live free from sexual corruption/sextortion, violence and having representation of women during and post elections. • Coalition that will bring together organizations, individual activists, and others passionate about Sexual and Reproductive Health in Tanzania for collective action was needed. • Deepen knowledge on feminism, cross movement building, and current SRHR issues. • Strategize on how to build inclusive campaigns and strengthen collective voice and actions around ongoing campaigns. • Experience and knowledge sharing on ongoing advocacy initiatives.
Msichana Initiative	• Seeks to educate young girls on the areas of sexual health, sexual rights, reproductive health and reproductive rights.
Doris Mollel Foundation	• Lead the Tanzania Sexual Reproductive Health and Rights Coalition comprised of 73 organizations, and guide its long-term strategic goals, objectives, and activities of the coalition.
UNFPA Tanzania	• Informed and empowered citizens to protect themselves from sexually transmitted infections. • Women must have access to skilled health care providers and services that can help them have a fit pregnancy, safe birth and healthy baby. • Every individual has the right to make their own choices about their sexual and reproductive health. UNFPA, together with a wide range of partners, works toward the goal of universal access to sexual and reproductive health and rights, including family planning. • Ensure sexual and reproductive health and rights remain at the

	very centre of development.
Pathfinder International Tanzania	• Empower adolescents and youth to make their own decisions about their bodies and their futures by changing community norms related to gender, adolescent sexuality, early marriage, and childbearing. • Strengthen health services to offer young people the sexual and reproductive health care they need without judgment or bias, including access to long-acting contraceptive methods. • Support young women and first-time parents to delay their first pregnancy and space their births to ensure the health of the mother and her children. • Partner with young people to develop new and creative behavior change strategies—like digital health and games—that lead to healthier practices and lifelong good habits.
USAID – DREAMS Project: Partnership to reduce HIV/AIDS in Adolescent Girls and Young Women.	• DREAMS–(Determined, Resilient, Empowered, AIDS-Free, Mentored and Safe), Partnership is an ambitious public / private partnership aimed at reducing rates of HIV among adolescents girls and young women (AGYN) in the highest HIV burden Countries. • It was announced during the World AIDS Day 2014. • Activities commenced in 2015 in the following Sub-Saharan African Countries (Eswatini, Kenya, Lesotho, Malawi, Mozambique, South Africa, Tanzania, Uganda, Zambia and Zimbabwe). • The above countries accounted for nearly half of the new HIV infections that occurred among GGYN globally. • The DREAMS objectives are:- • Empower adolescent girls and young women and reduce risk through youth friendly reproductive health care and social asset building. • Mobilize communities for change with school-and-community-based HIV and violence prevention. • Reduce risk of sex partners through PEPFAR Programming, including HIV testing, treatment, and voluntary medical male circumcision and • Strengthen families with social protection (education subsidies, combination, social economic approaches) and parent/care giver programs. • USAID is the lead implementer of DREAMS. • In 2021, USAID contributed to supporting 2,414,719 adolescent girls and young women through the Dreams Program.

Annex 3

Zambia: Map of ASRH Networks/Platforms/Partners

Zambia CSOs / Networks / Development Partners

Name of Institution	Broad Area of Working
YWCA	• YWCA (provides counseling and shelter to women affected by GBV including sills training and empowerment)
UNDP in Zambia	• Provides programming on gender and narrowing inequalities between men and women including in leadership and decision-making positions.
UNFPA in Zambia	• Supports programmes for family planning, emergency obstetric and neonatal care, midwifery, HIV prevention, and adolescent sexual and reproductive health at national and subnational levels. • Work on improving sexual and reproductive health as a key effort towards achieving SDG 3, which calls for good health and well-being. • Advance Goal 5, which calls for gender equality, as well as many of the other goals included in the 2030 Agenda.
UNAIDS in Zambia	• Leading the global effort to end AIDS as a public health threat by 2030 as part of the Sustainable Development Goals. • A problem-solver. It places people living with HIV and people affected by the virus at the decision-making table and at the centre of designing, delivering and monitoring the AIDS response. • Charts paths for countries and communities to get on the Fast-Track to ending AIDS and is a bold advocate for addressing the legal and policy barriers to the AIDS response. • Provides the strategic direction, advocacy, coordination and technical support needed to catalyze and connect leadership from governments, the private sector and communities to deliver life-saving HIV services.
National HIV/AIDS/STI/TB Council (NAC)	• National HIV/AIDS/STI/TB Council (NAC) (anchors programming on minority rights including SRHR for key populations)
WILDAF)	• Women in Law and Development in Africa (WILDAF)(carries research and general programming relating SRHR and general women's rights)
WLSA	• Women in Law in Southern Africa (WLSA)(undertakes research and general programming particularly around law and gender issues). • Also respond to the social legal needs of women and promotes women's

	rights.
National Legal Aid Clinic for Women	National Legal Aid Clinic for Women (provides legal representation to vulnerable women on matters of family law and other public interest litigation for gender related cases)
African Rights Monitor.	• To promote and protect human rights for all people in Zambia. • To investigate, educative and advisory.
Centre for Reproductive Rights.	• Focuses on sexual and reproductive health including HIV/AIDS amongst all men, women and specifically youth in Zambia. • Focuses on evidence, proven effective practices, experiences, lessons that then transfer and exchange this knowledge to improve sexual and reproductive health.
Human Rights Watch.	• Investigates and reports on abuses happening in all corners of the world. • Works for lesbian, gay, bisexual, and transgender peoples' rights, and with activists representing a multiplicity of identities and issues. • Document and expose abuses based on sexual orientation and gender identity worldwide, including torture, killing and executions, arrests under unjust laws, unequal treatment, censorship, medical abuses, discrimination in health and jobs and housing, domestic violence, abuses against children, and denial of family rights and recognition. • Advocate for laws and policies that will protect everyone's dignity.
Swedish Embassy in Zambia	• Supporting Members of Parliament through the National Assembly of (2019 &- 2022) to enhance capacity of MPs in SRHR. Topics covered included the following; • Gender equality and Sexual Gender based violence. • Early-unwanted pregnancy and safe abortion. • Commodity security. • Comprehensive sexuality education. • Non-discrimination of key population.
VSO Zambia	• Work to support the most vulnerable people realize the SRHR. • Work to improve the SRHR general well-being of prisoners. • They use peer to peer education to improve prisoners SRH knowledge. Girls and adolescents are included.
Plan International	• Promoting children's rights alongside communities, partners and the government. • Tackle the root causes of issues facing girls, such as child marriage, teenage pregnancy, violence, exclusion and poverty. • Increase teenagers' knowledge of SRHR, promote access to and use of sexual health services among adolescent girls and young people and develop youth leadership skills.

	• Providing opportunities for adolescent girls and young people to learn financial literacy and entrepreneurial skills so they can live independently.
Health Action International (HAI) in conjunction with Medicines Research and Access Platform (MedRAP)	• Stronger health systems, including adequate numbers of qualified health workers. • Access to essential Sexual and Reproductive Health (SRH) commodities urgently needed. • Contribute to achieving Sexual and Reproductive Health and Rights (SRHR) by creating space for a strong civil society to engage effectively with governments. • To deliver equitable, accessible and high-quality SRHR services.
Pathfinder Zambia	• Empower adolescents to make their own decisions about their bodies. • Strengthen health services to offer young people SRH care they need without judgement and bias. • Support young women. • Correct young adolescents and policy makers to foster supportive policies that promote young people's health and rights.
Reproductive Health Advocacy Partnership (PAI)	• It supports CSOs in Malawi and Zambia to influence funding and policy decisions in SRHR.
Youth Vision Zambia	• Works to increase knowledge about SRHR among youth aged 10 – 24.
Population Council	• Conducts research to address critical health and development issues. • Allows couples to plan their families and chart their futures. • Help people avoid HIV infection and access life-saving HIV services. • Empower girls to protect themselves and have a say in their own lives. • Conduct research and programs. • Give voice and visibility to the world's most vulnerable people. • Increase awareness of the problems faced and offer evidence-based solutions. • We use state-of-the-art biomedical science to develop new contraceptives and products to prevent the transmission of HIV.
Youth Coalition & CRR	• Working on programe known as "SHE SOARS", the Sexual Reproductive Health and Economics Empowerment – Supporting out of School Adolescent Girls' Rights and Skills Project. • Interventions in Kenya, Uganda and Zambia. • The target is refugee and host communities in Uganda, Urban and informal settlement in Kenya, and rural settings in Zambia. This is the first time the centre is working in Zambia. • Focus Areas • Improving access to high quality/evidence-based Sexual and Reproductive

	Health information and services. • Addressing health information and services. • Addressing not caucuses of gender-based inequalities. • Increasing adolescents' ability to make decisions about their bodies.
USAID – DREAMS Project: Partnership to reduce HIV/AIDS in Adolescent Girls and Young Women.	• DREAMS–(Determined, Resilient, Empowered, AIDS-Free, Mentored and Safe), Partnership is an ambitious public / private partnership aimed at reducing rates of HIV among adolescents girls and young women (AGYN) in the highest HIV burden Countries. • It was announced during the World AIDS Day 2014. • Activities commenced in 2015 in the following Sub-Saharan African Countries (Eswatini, Kenya, Lesotho, Malawi, Mozambique, South Africa, Tanzania, Uganda, Zambia and Zimbabwe). • The above countries accounted for nearly half of the new HIV infections that occurred among GGYN globally. • The DREAMS objectives are:- • Empower adolescent girls and young women and reduce risk through youth friendly reproductive health care and social asset building. • Mobilize communities for change with school-and-community-based HIV and violence prevention. • Reduce risk of sex partners through PEPFAR Programming, including HIV testing, treatment, and voluntary medical male circumcision and • Strengthen families with social protection (education subsidies, combination, social economic approaches) and parent/care giver programs. • USAID is the lead implementer of DREAMS. • In 2021, USAID contributed to supporting 2,414,719 adolescent girls and young women through the Dreams Program.

Annex 4

Democratic Republic ff Congo: Map of ASRH Networks/Platforms/Partners

Institution	Area of Focus
CAFCO	• Has carried and continues to carry out the advocacy lead in the field of Family Planning (for the creation of budget lines emerging from the Government budget (central and provincial), for the disbursement of funds allocated to the purchase of contraceptive products) • Works to advocate for the revision of restrictive laws on sexual and reproductive health • It is the initiator of the law on reproductive health which is still in the pending at the national assembly). • It has championed the creation and existence of the Permanent Multi-sectoral Technical Committee / Family Planning created in 2015; a synergy that involves all stakeholders (Government, civil society and technical and financial partners) whose mission is to monitor the implementation of the recommendations of the National Conference on the Repositioning of Family Planning held in 2009 as well as the National Strategic Plan for Family Planning with a multi-sectoral vision in the Democratic Republic of Congo.
UNFPA	• Works with governments and partners to promote universal access to quality, integrated sexual and reproductive health services. • Promotes comprehensive sexuality education and youth leadership, which empower young people to exercise autonomy, choice and participation with regard to their sexual and reproductive health and rights. • Quality assured adolescent friendly sexual and reproductive health services provided in at least 25% of the public health services.
Ipas DRC	• Works to popularize the Maputo protocol and on the right to access abortion. • Comprehensive sexuality education (CSE) as a critical means of improving young people's access to sexual and reproductive health (SRH) services and their ability to make safe and informed decisions.
Youth Ministry	• Prayer meetings • Youth training • Evangelization • HIV / AIDS training • Distributing evangelical literature
Save the children	• Working across the country to respond to the various threats that children face e.g. conflict, epidemics, food insecurity and natural disasters. • With the support of donors supporting farming families who have been uprooted from their homes to gain access to farmlands.
UNICEF	• UNICEF has been present in the Democratic Republic of the Congo since 1963 to reach the most disadvantaged children, to save their lives, to defend their

	rights and to help them fulfil their potential. • Focus on adolescents. • Providing gender equality. • Preventing sexual violence.
UN AIDS DRC	• The global effort to end AIDS as a public health threat by 2030 as part of the Sustainable Development Goals. • Problem-solver It charts paths for countries and communities to get on the Fast-Track to ending AIDS. • Provides the strategic direction, advocacy, coordination and technical support needed to catalyze and connect leadership from governments, the private sector and communities to deliver life-saving HIV services. • Generates strategic information and analysis that increases the understanding of the state of the AIDS epidemic. • Helps to position, shape and scale up the response to HIV. • Has transformed policy. UNAIDS has shaped public policy on HIV at the global, regional and national levels.
Coalition de Lutte Contre les Grossesses Non Désirées (CGND) and Coalition Article 14 in Kinshasa DRC (Coalition for the Fight Against Unwanted Pregnancy (CGND) and Coalition Article 14 in Kinshasa DRC)	• Foundation brings together major civil society actors working on advancing access to safe abortion and related topics in Sexual & Reproductive Health and Rights. They have worked mainly in Kinshasa • The coalitions have work to identify a cohesive policy objective to respond to opposition to reach targeted policies. • Brought together international partners. • Enhancement and strengthening of messages to policy decision-making. • Understand the context of SRHR landscape. • Legal studies by pathfinders. • Humanization of laws – (Penal Code, The Reproductive Health Law, the Code of Medical Ethics. • DRC has a monist Constitution, in which international treaties take precedence over national laws. In DRC, 10 years after ratification of Maputo Protocol, Standards and Guidelines to comprehensive abortion care were adopted within 2 years of the publication of the Protocol in the official gazette. • The Coalition has worked more in Kinshasa to change laws including the publication of the Maputo protocol in the official journal; the issuing of circular n°04/SPCSM/CFLS/EER/2018 of April 06, 2018 having instructed the courts and civil and military prosecution offices on the conduct to be followed in the presence of abortion cases provided for by the Protocol of Maputo; on the domestication of the Maputo Protocol in collaboration with the Ministry of Health and Gender, Family and Children.
CHAI	• The Clinton Health Access Initiative, Inc. (CHAI) is a global health organization committed to saving lives and reducing the burden of disease in low-and middle-income countries.

	• Works with our partners to strengthen the capabilities of governments and the private sector to create and sustain high-quality health systems that can succeed without our assistance. • Developed a unique set of capabilities that enable us to identify and address market inefficiencies that impede access to affordable health products. • Lowers prices, enhances product design to fit the needs of resource-limited settings, decreases supply risks, and accelerates the availability of new products.
LCVT	Helping the most vulnerable and marginalized populations in the *DRC KINSHASA* and *CONGO –BRAZZAVILLE.*
Suzanne Thompson Buffet Foundation (STB),	• Strengthens sexual and reproductive health services in Africa.
ABEF-ND	• A National non-governmental organization of a non-profit social and humanitarian character working in the field of Sexual and Reproductive Health/ Family Planning (SSR/PF), of which it is a pioneer in the DRC. • Campaigns for the defense and access to Health and Sexual and Reproductive Rights (SRHR) of any individual without discrimination. • To provide leadership for civil society organizations in the advocacy for rights and health sexual and reproductive health services (SRHR) • Facilitates access to quality services for all and especially to the underserved. • Seeing a DRC where every individual enjoys his or her health rights Sexual and Reproductive without discrimination. • Uses its volunteer members and staff to expand the coverage of its interventions in the country.
EGPAF	• A proven leader in the global fight to end HIV and AIDS, and an advocate for every child to live a full and healthy life into adulthood. • Advance research and innovations that lead to new, improved and scalable solutions to ending HIV and AIDS. • Advocate on the global stage and at local levels for the resources, policies and leadership needed to address the epidemic. • Strengthen local health care systems to effectively respond to HIV and AIDS and related health concerns. • Grow the capabilities of governments and communities through providing technical expertise and proven solutions.
ENGENDER HEALTH	• Strive for gender equality in and through sexual and reproductive health and rights programming. • Delivering high-quality, gender-equitable programs and services that advance

	sexual and reproductive health and rights in the world's most disadvantaged and underserved communities. • Focus on SRHR, maternal and obstetric care and Gender Based Violence
KINSHASA PUBLIC HEALTH SCHOOL	• Aims to be a center of excellence in public health training, research and community services at the national and regional levels. • To contribute to the improvement of the health and well-being of Congolese people. • Excellence in research • A multi-disciplinary approach • High ethical standards, integrity and discipline • Responsiveness to change • Transparency and good governance • Gender equality • Promotion of partnerships • Responsibility and accountability in relation to the population
AFIA MAMA	• The organization works to empower and support girls through education, skills training and the elimination of poverty and harmful traditional practices. • Collaborate to prevent child marriage and support girls who are – or have ever been – married. • Amplify the voices of girls at risk of child marriage and defend girls' rights to health, education and the opportunity to fulfil their potential. • Enhance and strengthen efforts to end child marriage at every level. • Raise awareness of the harmful impact of child marriage by encouraging open, inclusive and informed discussion at the community, local, national and international level. • Facilitate learning and coordination between organizations working to end child marriage. • Mobilize all necessary policy, financial and other support to end child marriage.
SOFEPADI	• Contribute to the promotion of gender. • As part of the campaign against domestic violence and access to services and justice for survivors in the DRC. • GBV Case Reporting • Prevention of gender-based violence
Si Jeunesse Savait affiliated with International Lesbian, Gay, Bisexual, Transgender and	• LGBTI Rights. • Sexual and Reproductive Health and Rights, HIV/AIDS and Gender-based Violence. • The sexual and reproductive health and rights (SRHR)of LGBTI people

Inter sex Association.	
Rainbow Sunrise Mapambazuko	• Rainbow Sunrise Mapambazuko, operates in Bukavu. • Promote the defense of the rights of LGBTQI+ people in all the territories of the DR Congo and Africa in general. • Promote the well-being of LGBTQI+ people in Bukavu. • Inform and sensitize sexual minorities on topics related in particular to HIV / AIDS, sexually transmitted infections (STIs), human rights and sexual violence.
Networks	
Association of Women Lawyers of Congo (AFEJUCO).	• Collaborative grant making. • Powerful advocacy. • Strengthening models. • Asili business model - Asili is a revolutionary model for people in the world's most challenging places to build lasting, world-class essential services — for life. It's powered by Eastern Congo Initiative. • Reinvents humanitarian aid as startup capital for self-sustaining businesses, operated by and for the people who need them.
Africa Reproductive Rights Initiative	• It was launched in 2017 and is dedicated to accelerating progress towards the full realization of African Women and Adolescents Sexual and Reproductive Rights by coordinating, linking and strengthening legal and policy advocacy at the National, Regional and Global levels. • AFRI's vision is to see an Africa where all women and adolescents in their diversity are able to make autonomous decisions on their sexual reproductive rights movement by creating a forum where members can share experiences, exchange valuable knowledge and skills, and utilize their collective strength to advance accountability and increase access to SRH information and services (CRC).
Students and school pupils (LRADEEL).	• The education system in the Democratic Republic of the Congo (DRC) is characterized by low coverage and low quality. • Designate reading as a specific subject in the curriculum. • Add more instructional time during the school day for reading • Create a National Reading Commission.
Inter-Agency Working Group on	Committed to advancing sexual and reproductive health and rights in humanitarian settings.

Reproductive Health in Crisis	

Annex 5

East Africa Community: Map of CSOs / Networks / Development Partners working on ASRHR

Name of Institution	Broad Area of Working
The East Africa Sub Regional Support Initiative for Advancement of Women (EASSI)	• Ending violence against women and girls. • Advancing women's economic rights. • Strengthening women participation and leadership. • Fulfilment of Women's Rights by influencing decision-makers to live up to their promises and the international conventions they have ratified. • Promoting affirmative action mechanisms for women in politics. • Supporting the development and implementation of public economic policies and programmes that empower women. • Peace and Security for Women by promoting women's equal participation and full involvement in peace building initiatives and peace processes. • A Society Free of Gender-Based Violence (GBV) by promoting awareness among rights holders and duty bearers of the root causes and consequences of GBV. • Sexual and Reproductive Health and Rights (SRHR) by creating awareness among rights holders and duty bearers of existing rights and obligations according to international human rights law. • Gender Equality for Men and Boys by promoting the involvement of men in activities that enhance women's empowerment. • Comprehensive Sexuality Education (CSE) and rights education so as to contribute to the elimination of gender-based violence and harmful practices, including Child/Early and Forced Marriages and Unions (CEFMU), Female Genital Mutilation (FGM) and child sexual abuse.
East African Civil Society Organization's Forum (EACSOF)	• EACSOF joins Reproductive Health Advocacy Network for Africa (RHANA) convention to advocate for domestication and implementation of sexual reproductive health rights. • Provides opportunity for members to play part in advocating for domestication and implementation of Sexual Reproductive Health Rights.
East African Health Platform (EAHP)	• Promotes gender equality and women's rights. • A unique coalition of youth-serving organizations, faith organizations, feminist groups and sexual and reproductive health and rights activists coming together to develop a joint campaign to promote women's rights in Africa. • Have baseline data pointing to a lack of sufficient intergenerational discussions about Adolescent Sexual and Reproductive Health and Rights (ASRHR) between adults and adolescents. • Brings communities and faith leaders together to debate ASRHR concepts.
Eastern Africa	• It's a regional umbrella body bringing together CSOs and community

National Networks of AIDS and Health Service Organizations (EANNASO)	group voices to inform policies and improve programming on HIV, TB, Malaria and other health issues within communities. • Has led the dialogues for Stakeholders on the EAC Sexual Reproductive Health Bill. The Bill is to protect and facilitate the attainment of the life-course sexual and reproductive health and rights of all persons in the Community;
EAC Consultative Dialogue Framework on participation of Civil Society	• Allow CSOs, PSOs, other interest groups and EAC to consultatively work towards realizing the Community Objectives and promote ensure a people-centred integration process. • Enhances and strengthens partnerships between CSOs and PSOs and with the EAC.
EACC Court of Justice	• Contributes to regional Integration by ensuring adherence to justice, rule of law and fundamental rights and freedoms through the interpretation and application of and compliance with the East African Community Law.
50 Million African Women Speak Campaign	• This platform aims to facilitate a dynamic and engaging exchange of ideas among women entrepreneurs, using in-built social media functionality to connect them with one another in ways that will foster peer-to-peer learning, mentoring and the sharing of information and knowledge within communities. • Access to financial services and market opportunities between urban and rural areas, and across borders and between countries. • Designed to help women to learn from each other, inspire each other and draw from the most comprehensive resource bank for information on various aspects of doing business. • Facilitate access to training, business management tools and financing options specifically targeted to women. The expected outcome is to directly impact 50 million African women and create fair waged jobs for young people from the increased business activities and capital flow.
EAC Gender Equality and Development Barometer	• The East African Community (EAC Partner) States have signed and ratified various regional and international instruments relating to gender equality and women's rights. They also have national legislations on gender equality. • Campaigning for one consolidated and legally binding document to advance gender equality and equity in the EAC. • The overall purpose of the proposed EAC Gender and Development Bill is to advance Gender Equality across the 5 EAC Partner states in the economic, political, social and cultural spheres. • The bill will benefit women and men by consolidating into one legally binding document, the various instruments to which the EAC partner

	states are party or signatory at the continental and International levels. • To harmonize the national laws of the EAC Member States with regional and international standards of protection and promotion of gender equality and women's human rights. • To enhance the level of implementation of women's rights instruments through the incorporation of emerging development issues and gender concerns. • To promote non-discrimination and gender equality in the processes of governance for strengthened regional integration and sustainable development of the Community • To provide a participatory framework for strengthening, monitoring and evaluating the level of adherence to regional and international standards on gender equality and equity in the EAC partner states . • To promote the equal participation of women and men in regional trade by entrenching enabling policies and macro-economic frameworks that are gender sensitive and responsive.

Endnotes

[i] See the Amma Declaration & Programme of Action adopted at the 11th ICC of NHRIs in 2012
[ii] www.who.int/health-topics/adolescent-health
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[x] See Aspiration 6 of Agenda 2063.
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