



# **THE EASTERN AND SOUTHERN AFRICA MINISTERIAL COMMITMENT (2021-2030): A LEGAL ANALYSIS**

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## List of Acronyms

<b>ACHPR</b>	African Charter on Human and People's Right
<b>ACRWC</b>	African Charter on the Rights and Welfare of the Child
<b>AYC</b>	African Youth Charter
<b>CEDAW</b>	Convention on the Elimination of All Forms of Discrimination Against Women
<b>CESCR</b>	Committee on Economic, Social and Cultural Rights
<b>CRC</b>	Convention on the Rights of the Child
<b>CRPD</b>	Convention on Rights of Persons with Disabilities
<b>CRR</b>	Center for Reproductive Rights
<b>CSE</b>	Comprehensive Sexuality Education
<b>DRC</b>	Democratic Republic of Congo
<b>EAC</b>	East African Community
<b>ESA</b>	Eastern and Southern Africa
<b>ESA</b>	Eastern and Southern Africa
<b>FGM</b>	Female Genital Mutilation
<b>HIV / AIDS</b>	Human Immunodeficiency Virus Infection and Acquired Immune Deficiency Syndrome
<b>ICESCR</b>	International Covenant on Economic, Social and Cultural Rights
<b>ICESCR</b>	International Covenant on Economic, Social and Cultural Rights
<b>ICPD</b>	International Conference on Population and Development
<b>MDGs</b>	Millennium Development Goals
<b>PoA</b>	Programme of Action
<b>RDHS</b>	Rwanda Demographic and Health Survey
<b>SADC</b>	Southern African Development Community
<b>SDGs</b>	Sustainable Development Goals
<b>SRH</b>	Sexual Reproductive Health
<b>SRHR</b>	Sexual and Reproductive Health and Rights
<b>TDHS</b>	Tanzania Demographic and Health Survey
<b>UNAIDS</b>	United Nations Programme on HIV/AIDS
<b>UNICEF</b>	United Nations Children's Fund
<b>UNWOMEN</b>	The United Nations Entity for Gender Equality and the Empowerment of Women.
<b>WHO</b>	World Health Organisation

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# 1. INTRODUCTION

In 2013, the Ministers of Health and Education of the East African Community (EAC) and Southern African Development Community (SADC) endorsed the Eastern and Southern Africa (ESA) Inter-Ministerial Commitment, which ended in 2020. The Commitment largely aimed at preventing new HIV infections, curbing early and unintended pregnancies, eliminating gender-based violence and child marriages. The Ministers committed their respective countries to support scientifically accurate, age-appropriate, gender sensitive and culturally relevant comprehensive sexuality education (CSE) and promote access to youth-friendly sexual and reproductive health (SRH) services for adolescents and young people. In 2016, the Ministers reaffirmed their countries' commitment and agreed on a roadmap to achieve the 2020 targets. They recognized the urgent need for a more systematic scale up of sexuality education and youth friendly services in the ESA region. Although countries registered some progress against the 2020 targets, adolescents and young people still experienced challenges in relation to their sexual and reproductive health and rights (SRHR). The situation was even exacerbated by the Covid-19 pandemic and the related lock-down interventions that disrupted the lives

of adolescents and young people and increased their vulnerability.

On 6 December 2021, the Ministers of Education, Health, Gender, and Youth from the ESA met in South Africa and reaffirmed the vision of the 2013-2020 ESA Commitment 'of supporting African adolescents and young people to be continental and global citizens who are educated, healthy, resilient, socially responsible, informed decision-makers with the capacity to contribute to their communities, countries, and region'.

<sup>1</sup> The Ministers noted some progress in achieving the agreed upon targets, including increased political will and engagement on adolescent and young people's SRHR; increased provision of training programmes in the delivery of quality adolescent and youth-friendly health services; a decline in new HIV infections and improved access to HIV related care and support among adolescents and young people; and positive masculinities and improved perceptions on gender equality. However, the Ministers observed a number of challenges, including inequalities in education; high rates of gender-based violence with serious ramifications for the health and well-being of adolescents and young people; significant numbers of young

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1. Preamble.

girls and adolescents being infected with HIV; adolescent pregnancy; child marriages; uneven participation of young people in matters concerning their health; menstrual health; and exposure to sexually explicit harmful and inappropriate content.

In their renewed ESA Commitment (2021-2030), the Ministers undertook to: continue investing in high-quality, evidence-based, gender-transformative, and age-appropriate sexuality education; address the structural factors that increase the vulnerability of adolescents and young people and their risk of acquiring HIV and STIs; ensure the inclusion of adolescents' SRHR within the national Universal Health Coverage packages; connect health, education, and social service systems and other support mechanisms; and promote meaningful and effective participation of adolescents and young people in decision making, planning, implementation, monitoring and evaluation of programmes, legislative and policy frameworks. The Ministers also committed to: strengthening the role of community organizations and actors to improve engagement and dialogue; promoting and supporting increased investments in SRHR in accordance with the size of the youth population and their needs; coordinating and supporting

the development of national multi-sectoral and multi-stakeholder plans. Consequently, the Ministers committed their individual countries to achieve the following ten targets by end of 2025:

**Target 1:** 95% of adolescents and young people are reached with good quality, age-appropriate, culturally relevant and evidence-based sexuality education through in-and out-of-school programmes.

**Target 2:** Adolescent and youth-friendly SRHR services are integrated into Universal Health Coverage packages.

**Target 3:** A functional multi-sectoral framework is in place to facilitate linkages between sexuality education programmes for in and out of school youth and youth-friendly integrated SRH and psychosocial services.

**Target 4:** Laws and regulations that guarantee full and equal access to both young women and men aged 15 years and older to SRH care, information and education.

**Target 5:** Increased number of youth-led organizations, groups, or networks who are regularly engaged and participate in policy and decision-making processes relating to SRHR. The Ministers also committed that

they would work towards achieving the following targets by 2030:

**Target 6:** Fast-track regional and country level actions to reduce EUPs among adolescents and young people aged 10-24 years by 40%.

**Target 7:** Reduce new HIV infections among adolescents and young people aged 15-24 years by 60%.

**Target 8:** Eliminate all forms of violence including sexual and gender-based violence, against adolescent girls and young women.

**Target 9:** Eliminate harmful practices such as child marriage and female genital mutilation (FGM) among adolescents and young people.

**Target 10:** Establish sustainable financing modalities including direct allocation of domestic resources, innovative and blended financing modalities to mobilize resources to be allocated to all the relevant sectors contributing to the realization of the SRHR of adolescents and young people.

In spite of the above progressive commitments and targets, a number of countries in the EAC region such as Uganda, Kenya, Burundi and the Democratic Republic of Congo have not yet endorsed the 2021-

2030 ESA Ministerial Commitment. Failure to endorse the Commitment will undoubtedly affect further efforts to promote the realization of SRHR of adolescents and young people in the region. Against the above backdrop, CEHURD in collaboration with Planned Parenthood Global and UNESCO engaged a consultant to undertake a legal analysis of the 2021-2030 ESA Ministerial Commitment in the context of the Sexual and Reproductive Health Bill, 2020 (SRH Bill) and other national, regional, global legal and policy frameworks on health and SRHR. The aim and objective of the consultancy is to demonstrate that the ESA Commitment will play a role in the realization of state obligations in the national, regional and global laws and policies on SRHR. The results of the legal analysis will be used to advocate for and convince the Ministers of Health in the EAC in general and Uganda in particular to endorse the renewed commitments.

## 2. METHODOLOGY

We employed library and desk research to analyse the ESA Commitment 2021-2030 (hereinafter, ‘the Eastern and Southern African Ministerial commitment’). This type of research is based on the study and analysis of existing or secondary data, that is, material published in reports and similar documents available in libraries and websites. We analysed the EAC Commitments of 2013-2020 and 2021-2030 and the SRH Bill; relevant international, regional, and national legal and policy instruments on the right to health generally and SRHR in particular. We also examined scholarly publications and governmental, intergovernmental and non-governmental organizations’ reports on issues raised in the ESA Commitment. The usefulness, reliability and authority of data from the relevant documents were subjected to serious scrutiny given that they are already collected by someone else.

## 3. WHY EAC COUNTRIES SHOULD ENDORSE THE ESA COMMITMENT: THE SRH STATUS OF ADOLESCENTS AND YOUNG PEOPLE IS ALARMING

Adolescents and young people in the EAC region, like most of Sub-Saharan Africa, face various SRH challenges. These include initiation of sexual activity at an early age, early pregnancy and parenthood, unplanned and unwanted pregnancies, early marriage and child bearing, forced marriages, difficulty accessing contraception and safe abortion (where it is legal), unsafe abortion, limited post-abortion care services, sexual and gender based violence, the abuse of alcohol and other substances, high rates of HIV and sexually transmitted infections (STIs), and lack of or limited access to sexual and reproductive health information. Thus, one of the compelling reasons why all the EAC countries should endorse the ESA Commitment is that the SRH situation of adolescents and young people is alarming as the data below illustrates.



## 3.1 Democratic Republic of Congo

In the Democratic Republic of Congo (DRC), the rates of early sexual initiation and child bearing within and outside marriage are high. A 2018 study found that the onset of sexual intercourse was initiated during adolescence and only two in ten adolescent women were using modern contraception (Mbadu Muanda et al, 2018). In war torn Eastern DRC, the contraceptive prevalence rate is at a paltry 7.5% and 18-20.7% of adolescents have children (Binezero Mambo et al, 2022; Casey et al, 2020). The majority of girls have had sexual intercourse by the age of 19 years while over 37% have been married by the age of 18 years (Olela Odimba et al, 2021). Almost 34% of women aged 18-22 years married when they were children (World Bank, 2016). Yet, the law explicitly provides that marriage must be between two consenting adults (18 years and above).<sup>2</sup>

The adolescent birth rate among girls aged 15-19 years is 138/1000, which contributes to high rates of maternal mortality and morbidity and unsafe abortion (UNICEF, 2019; (Olela Odimba et al, 2021). In 2017, the maternal mortality rate was at an estimated 473

2. Articles 334, 351, 352 and 402-404 of Law No. 16/008 of 15 July 2016, amending and supplementing Law No. 87-010 of 1 August 1987 on the Family Code.

per 200,000 live births (Inter-Agency Group, 2019). Adolescent women in Kinshasha had an estimated 70,700 pregnancies in 2016, about 13% of the city's total pregnancies. About 80% of the pregnancies among adolescents were unintended while an estimated 49% of the pregnancies in adolescents ended up in abortion. About 27,600 abortions occurred among adolescents in 2016 (Guttmacher Institute, 2021). An estimated 51% of women have experienced physical and sexual intimate partner violence in their lifetime while about 16% of young women have been subjected to sexual violence by the age of 19 years (UN Women, 2016; Mac Quarrie, et al 2017). In 2020, there was an estimated 5,100 new infections among young people aged 15-24 years each year, the majority of these occurring in young women (UNAIDS, 2020).

## 3.2 Rwanda

In Rwanda, seven percent of girls and one percent of boys are married before the age of 18 years.<sup>3</sup> More than 25% of girls aged 15-19 years have their first sexual experience by the age of 15 and 15% of births occur to teenage mothers. An estimated 15% of births occur to mothers below 20 years of age mostly due to unwanted and unplanned

3. Girls Not Brides, 'Rwanda', <https://www.girlsnotbrides.org/learning-resources/child-marriage-atlas/regionas-and-cuntries> (accessed 30 November 2022).

pregnancies (Asimwe, 2019). In Rwanda, although family planning has been prioritized by the government, which has led to a significant drop in maternal mortality from 750 per 100,000 live births in 2005 to under 400 (Mugenzi, 2022), there is a high unmet need for contraception among young unmarried sexually active women aged between 15 and 29 years (RDHS, 2020; Kawuki, 2022).

An estimated 15% of adolescents have begun childbearing at the age of 19 years (RDHS, 2020). Although sexual and reproductive health services are fairly accessible, the quantity is insufficient (Ndayishimye, 2020) and adolescents face significant barriers to access SRH information and services (HDI, 2022). The Health Development Institute (HDI) attributes this state of affairs to 'the belief that adolescents should not engage in sexual activities and thus should not need access to SRHR information and services without parental consent' (HDI, 2022). There is also still a challenge of unsafe abortion although the law criminalizing abortion was liberalized in 2012<sup>4</sup> and expanded the exceptions for permissible abortion to include rape, incest, forced marriage, or risk to the health of the woman or the fetus (Umuhuza et al, 2013; IPAS, 2015). Implementing the liberalized criminal

4. The Law (Republic of Rwanda), Organic Law No. 01/2012/OL of 02/05/2012.

law has its own challenges, including the tension between personal values of healthcare providers against the abortion procedure, legal ambiguities and the laborious approval procedure (Jessica, 2020; Jessica, 2016) and stigma at the community, organizational and structural levels (Nuriye, 2017).

In 2016, Rwanda Parliament passed a reproductive health law,<sup>5</sup> which among others, provides for equal rights to reproductive health (article 5), human reproductive health education in schools (article 19), parents' obligation to discuss with their children issues concerning reproductive health (article 14), raising public awareness about family planning (article 20), HIV/AIDS related services (articles 10 and 11), and the right to decide but only for persons who have attained the age of 18 years (article 7). In 2016, pursuant to the ESA Ministerial Commitment, Rwanda integrated age-appropriate comprehensive sexuality education (CSE) into the Rwandan national curriculum in order to promote early adolescents' SRHR (Mbarushimana et al, 2022). However, certain aspects of SRH such as sexual pleasure, sexual orientation, sexual desire and modern contraceptive methods were not included.

### **3.3 Kenya**

5. The Law No. 21/05/2016 of 20/05/2016 Relating to Human Reproductive Health

In Kenya, 23% of girls are married before they attain the age of 18 years and 4% are married before the age of 15 years while 3% of boys are married before the age of 18.<sup>6</sup> Like in many other African countries, the percentages of underage marriages are not uniform across the country. Citing a 2017 UNICEF study, Girls Not Brides reports that 64% of girls of Pokot origin got married before reaching the age of 18 years, followed by 54% of Somali girls and 28% of Maasai girls. 38% of Pokot boys got married before attaining the age of 18 years.<sup>7</sup> Most of these underage marriages are driven by poverty, low levels of education, harmful traditional practices such as Female Genital Mutilation (FGM) and adolescent pregnancy. A 2016 study found that out of 310 respondents, 49.1% were married when they were below 18 years (Gitau et al, 2016). Of the married respondents, 19.4% were married when they were below 14 years; 43.8% were married between 15 to 18 years and 36.7% between 19-24 years. The child marriage rate among female respondents aged 18-24 years was 22%, while the overall teenage pregnancy rate among young women aged 20-24 was 42%. 12% of all female respondents aged 15-24 had dropped out of school because of a pregnancy. 9.8% of the female respondents aged

6. Girls Not Brides, 'Kenya', <https://www.girlsnotbrides.org> (accessed 2 December 2022).

7. Ibid.

15-19 dropped out of school because of becoming pregnant (Gitau et al, 2016). Between 2015-2019, there were a total of 2,380,000 pregnancies in Kenya annually and of these, 1,450,000 were unintended and 551,000 ended in abortion (Gutmacher Institute, 2022).

Complications during pregnancy and child birth among girls aged 15-19 is a leading cause of maternal mortality in Kenya (Kasiira Ziraba et al, 2015). Adolescent pregnancy increases the risk of disability and death due to unsafe abortion, prolonged labour and delivery, and complications after birth (Mutea et al, 2022). Unsafe abortion is responsible for the deaths of nearly 2,600 women and girls in Kenya every year, translating to about seven deaths per day (CRR, 2020). About 50% of all post abortion care clients reporting to health facilities were less than 25 years of age, with 17% between 10 and 19 years of age (Opondo, 2020). The 2010 Kenya Constitution guarantees the right to life, which begins at conception and prohibits abortion except where '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' (Article 26). Despite these exceptions, and the constitutional guarantee of the right to health services, including reproductive health care (article 43(1)(a)), accessing safe abortion services

in Kenya is a daunting task. Because of abortion stigma, access is limited and many healthcare providers still believe it is illegal (Deeqa Mohamed et al, 2018).

There is also a challenge of sexually transmitted infections (STI), including HIV (Shewarega, 2022) with limited knowledge of STI among young people, including college students (Mungai Mbugua, 2018). Regarding HIV, approximately 29% of all new HIV infections in Kenya are among adolescents and young people with 30% of the infections occurring among those aged below 24 years of age. Of these, young women aged 15-24 years post the highest number of HIV infections and contribute 21% of all new infections (Ministry of Health, 2015).

### 3.4 Tanzania

Child marriages are reported to be on the rise in Tanzania with around two out of five girls having married before the age of 18 years (Life Africa, 2022). According to Girls Not Brides,<sup>8</sup> about 776,000 women are married or in a union before the age of 18 years with 59% in Shinyanga; 58% in Tabora; 55% in Mara; and 51% in Dodoma. Three out of ten 18-22-year-old

8. Girls Not Brides 'Tanzania' <https://www.girlsnotbrides.org/learning-resources/child-marriage-atlas/regions-and-countries/tanzania/> (accessed 3 December 2022).

women (32%) in Tanzania are married before the age of 18 years; one out of three women is married by age of 18 years while one out of 20 is married by the age of 15 years and among married girls aged 15-19, almost none are in school (Twaweza, 2021). However, the law on marriage, which allows under age marriage has been successfully challenged in court. In *Rebeca Z. Gyumi v. Attorney General*,<sup>9</sup> the plaintiff brought an action in the High Court of Tanzania challenging the constitutionality of sections 13 and 17 of the Law of Marriage Act, which allows girls to marry when they are 15 years old with parental consent and 14 years old with permission of the court on grounds that they violated the girls' rights to equality and access to education. The High Court held that a child is any person below the age of 18 years and declared sections 13 and 17 as unconstitutional and directed the government to amend the law within one year. The Attorney General appealed. In *Attorney General v Rebecca Z. Gyumi*,<sup>10</sup> the Court of Appeal upheld the decision of the High Court and dismissed the appeal.

By 2016, one in four adolescents aged 15-19 had begun child bearing in Tanzania with percentages ranging from as low as five to over 40. For example, in Mini Magharibi region

9. Tanzania Civil Cause No.5 of 2016.

10. Civil Appel No. 204 of 2017.

in Zanzibar, the teenage pregnancy rate was five percent, in Kilimanjaro region, the rate was six percent, while in Tabora and Katakwi, the rates were at 45% and 43% respectively (TDHS, 2015/16). Teenagers in rural areas are more likely to have begun childbearing earlier than their urban counterparts. According to the TDHS, 2015/16, 32% of rural teenagers had a live birth or are pregnant, compared with 19% of urban teenagers. The main drivers of teenage pregnancy include low level education attainment, poverty, gender inequality and social norms and child marriage.<sup>11</sup> The late President John Magufuli endorsed the expulsion of pregnant girls from public schools and barred them from returning to class after giving birth. However, the policy has now been reversed and pregnant girls have a chance to return to school after delivery (Kizito Makoye, 2022). Gender-based violence is also a matter of concern in Tanzania. About 44% of women aged 15-49 years have experienced physical or sexual violence (World Bank, 2022).

HIV among adolescents and young people remains a serious challenge in Tanzania. By 2019, 99,000 aged 10-19 years were living with HIV, out of which 57,000 were females. 93,000 children aged 0-14 years were living with HIV.

11. UNFPA, 'Tanzania, fact Sheet: Teenage pregnancy' [https://tanzania.unfpa.org/sites/default/files/pub-pdf/factsheet\\_teenage%20pregnancy\\_UNFPA\\_14oct.pdf](https://tanzania.unfpa.org/sites/default/files/pub-pdf/factsheet_teenage%20pregnancy_UNFPA_14oct.pdf) (accessed 3 December 2022).

Young women are twice likely to get HIV compared to young men in the same category.<sup>12</sup> According to UNFPA, the drivers of HIV among adolescents and young people include risky sexual behaviours such as not using condoms; early sexual debut (where 12% of 15 to 24 years had their sexual debut before the age of 18); and young people's limited knowledge about HIV prevention and transmission.<sup>13</sup>

### 3.5 Burundi

In Burundi, 20% of girls are married before the age of 18 years while three percent are married before attaining the age of 15 years.<sup>14</sup> In 2016, it is estimated that over 400 girls in Burundi were forced into marriage (IWACU, 2022). Yet, the 1993 Burundi Code of Person and Family provides that legal age of marriage is 18 and 21 for women and men respectively and marriage must happen with the consent of the future spouses.<sup>15</sup>

#### Eight percent of women aged 15-19

12. UNICEF 'HIV and AIDS' <https://www.unicef.org/tanzania/media/2436/file/HIV> (accessed 2 December 2022).

13. UNFPA 'Factsheet: Young people and HIV and AIDS: Taking action to realize the 90-90-90 targets' [https://tanzania.unfpa.org/sites/default/files/pub-pdf/Factsheet\\_hiv\\_aids\\_23nov.pdf](https://tanzania.unfpa.org/sites/default/files/pub-pdf/Factsheet_hiv_aids_23nov.pdf) (accessed 30 November 2022).

14. Girls Not Brides 'Burundi' <https://www.girlsnotbrides.org/learning-resources/child-marriage-atlas/regions-and-countries/burundi/> (accessed 2 December 2022).

15. Article 29 of the Constitution of the Republic of Burundi, 2005.

are mothers, including at 6% who had at least one live birth and 2% who were pregnant with their first child (World Bank, 2017; Ndibaruta, 2022; Manishate, 2022). The average age at which adolescent girls have their first baby is 17.7 years while the average age at which adolescent boys become first fathers is 18 years (Republic of Burundi, 2016). Among all unmarried, sexually active girls aged 15-19, the majority (90.7%) were not using a method of contraception (Republic of Burundi, 2016). In 2018, the Minister of Education is reported to have banned pregnant girls and teenage mothers and the boys that impregnated them from attending either public or private schools.<sup>16</sup> Though it may be difficult to get accurate data on gender-based violence in Burundi, it is estimated that women and girls are nearly four times more likely than men to experience sexual violence (UNICEF, 2018).

Regarding HIV, it is reported that in 2017, an estimated 25% of new infections were among young people aged 15-24 years (Nshimirimana, 2022). In 2019, there were 168 and 963 new infections among boys aged 15-19 years and among women aged 20-24 years respectively. There were more HIV infections among women

16. Global Citizen, 'Burundi just banned pregnant girls and teen fathers from school' <https://www.globalcitizen.org/en/content/burundi-pregnant-adolescent-girls-school-ban/> (accessed 3 December 2022).

and girls with 563 and 2089 in the 15-19 and 20-24 age groups respectively (Nshimirimana, 2022).

### 3.6 South Sudan

South Sudan has been ravaged by civil war ever since it obtained independence from Sudan in 2011. Thus, obtaining relatively accurate data on the SRH status of adolescents and young people in this country and the extent of the realization of their SRHR is a daunting task. In 2014, the uptake of SRH services was low at 24.2% among young people (Marle, 2014). Child marriage is prevalent with 52% of girls estimated to be married before the age of 18 years (UNICEF, 2013). By the age of 19 years, one out of three girls is already married or in a union and the same proportion has already started child bearing (Gawar, 2021).

### 3.7 Uganda

"Being married, pregnant and having a child are major life events. For adolescent girls (aged 10-19 years), experiencing these events often means facing harsh social sanctions and difficult choices that have life-long consequences. It could mean dropping out of school, being shamed and stigmatized by family, community members and peers; increasing

vulnerability to violence and abuse, increased risk to STIs and HIV/AIDS, greater poverty and economic hardship and at worst death” – Hon. Betty Among Ongom, Minister of Gender, Labour and Social Development, 2022 - National Strategy (Republic of Uganda, 2022).

In Uganda, like in other EAC countries, there is a relationship between child marriage and teen pregnancy. Child marriage is a major contributing factor to teenage pregnancy with one in four girls either pregnant or having already had her first child by the age 19. An estimated 43% of women aged 25-49 were married before the age of 18 (UDHS, 2016). One in four Ugandan women aged 15-19 have given birth or are pregnant with their first child by the age of 18 years with teenage pregnancy more prevalent in rural than urban areas (Republic of Uganda, 2022). Teenage pregnancy accounts for 22.3% of school dropouts among girls aged 14-18 years and 15-20% of dropout for girls is caused by child marriage and teenage pregnancy (Republic of Uganda, 2022). Only 21% of girls aged 15-19 are currently using any modern contraceptive method (Republic of Uganda, 2022). The National Strategy (Republic of Uganda, 2022) paints an alarming picture of what will happen if no action is taken to tackle the challenge of childhood sexual abuse. First, child marriage

and teenage pregnancy will continue with 50% of teenage girls at risk per year. Second, about 64% of teenage mothers will not complete their primary education level while about 60% of teenage mothers will end up in peasant agriculture work. Third, there is a heavy socio-economic cost. Each year, more than 645 billion shillings will be spent by the government on the health care of teenage mothers and the education of their children.

In 2016, the prevalence of modern contraceptive utilization among female adolescents was only 9.4% (UDHS, 2016). Thus, the majority of female adolescents in need of contraceptive methods in Uganda are not using any (Sserwanja et al, 2021; Namusoke et al, 2022), yet the use of contraceptives among adolescents and young people is one of the most cost-effective strategies to address many SRH challenges, including unintended pregnancies, early marriages and STIs (Mulubwa, 2021). Some of the unintended pregnancies end in abortion, which is an emotive, sensitive and complex subject in Uganda. In 2013, an estimated 314,300 abortions took place, which roughly translates to 14 of all pregnancies or a rate of 39 per 1000 women aged 15-49 (Guttmacher Institute, 2017). Out of these, approximately 57,000 abortions took place among adolescents aged 15-19 (Guttmacher Institute, 2018). In

2013, 93,300 women were treated for complications from unsafe abortion (Gutmacher Institute, 2017). Abortion is restricted in Uganda, except where it may be authorized by law. The 1995 Constitution of the Republic of Uganda protects the right to life and explicitly prohibits abortion and provides that '[n]o person has the right to terminate the life of an unborn child except as may be authorised by law'.<sup>17</sup> The Penal Code Act criminalizes abortion and all related acts<sup>18</sup> except for a surgical operation upon a mother in order to save her life.<sup>19</sup>

There is also the challenge of HIV among adolescents and young people. In 2013, it was estimated that children below the age of 15 years accounted for 11% of the 1.6 million Ugandans living with HIV.<sup>20</sup> There has been a reduction in the number of new HIV infections among young people aged 15-24 from 29,000 in 2010 to 14,000 in 2020, roughly translating into a 53% decline of infections in this category. 37% of all new HIV infections were among young people aged 15-24 years with 79% of these infections among young women (UAC, 2021). These numbers are still high. In any case, as UNICEF has observed, adolescent girls 'are more

17. Article 22(2).

18. Sections 141-143.

19. Section 224.

20. UNICEF, 'HIV and AIDS: Improving HIV prevention and care for children and women' [www.unicef.org](http://www.unicef.org) (accessed 4 December 2022).

vulnerable to HIV infection because their reproductive systems are not fully developed. Gender inequality and patriarchal norms also make it difficult for girls and young women to negotiate safe sex'.<sup>21</sup> Many children born with HIV need to be supported to live positively so that they may not pass it on to others.

Adolescents and young people in Uganda also face risks of gender-based violence. In 2016, 23% and 16.8% of girls aged 15-19 years were subjected to physical and sexual violence respectively. 9.4% suffered both physical and sexual violence (UDHS, 2016). There is also a challenge of female genital mutilation (FGM), which is an internationally recognized violation of human rights of women and girls. Although FGM was declared illegal in Uganda by the 2010 Prohibition of Female Genital Mutilation Act, it is still practiced in some districts in Eastern Uganda, especially Sebei and Karamoja where its prevalence is more than 50% among women aged 15-49 years (UBOS/UNICEF, 2020).

Over the years, Uganda has promoted an 'abstinence-only' policy in schools. On 17 August 2016, the Parliament of Uganda passed a resolution banning all comprehensive sexuality education in schools. This order was challenged in

21. Id.



the High Court in *CEHURD v Attorney General & Family Life Network*<sup>22</sup> where the court directed the Ministry of Education and Sports to develop a comprehensive sexuality education policy within two years and report to the Registrar of the court every six months on the progress. Following the court order, the Ministry, in 2018, developed an age-appropriate National Sexuality Education Framework, which, unfortunately has not been implemented.

## **4. WHY EAC COUNTRIES SHOULD ENDORSE THE ESA COMMITMENT: THEY ARE OBLIGED TO DO SO BY LEGAL AND POLICY FRAMEWORKS THAT PROVIDE FOR SRHR**

### **4.1 State obligations at the international level**

SRHR, and attendant state obligations, including providing sexuality education, are recognized in international instruments such as the International Covenant on Economic and Cultural Rights (ICESCR); Convention on the Rights of the Child (CRC); International

22. Miscellaneous Cause No. 309 of 2016.

Covenant on Civil and Political Rights; Convention on the Elimination of all forms of Discrimination against Women (Women's Convention); Convention on the Rights of Persons with Disabilities (CRPD); ICPD, 1994; Beijing Platform of Action; and the Sustainable Development Goals (SDGs).

The ICESCR provides for the right of everyone to the highest standard of physical and mental health.<sup>23</sup> The Committee on Economic, Social and Cultural Rights (CESCR), which is charged with providing guidance to states parties on implementations of their obligations under the ICESCR, stated in General Comment No. 14,<sup>24</sup> that one of the underlying determinants of the right to health is 'access to health related education and information, including on sexual and reproductive health'.<sup>25</sup> States parties have an obligation to ensure availability, accessibility, acceptability and quality of sexual and reproductive health goods and services, including access to family planning, pre- and post- natal care, emergency obstetric services, and access to information as well as to resources to act on that information.<sup>26</sup> States parties are also obliged to devise 'policies to provide access to a

23. Article 12(1).

24. General Comment No 14, 'The right to the highest attainable standard of physical and mental health, article 12 of the International Covenant on Economic, Social and Cultural Rights', E/C.12/2000/14.

25. Para. 11.

26. Para. 14.

full range of high quality and affordable health care, including sexual and reproductive services'.<sup>27</sup> The CESCR has also stated in General Comment No. 22<sup>28</sup> that the right to sexual and reproductive health is integral to the right to health and states parties to the ICESCR have a number of core obligations, which include, 'to repeal or eliminate laws, policies and practices that criminalize, obstruct or undermine access by individuals or a particular group to sexual and reproductive health facilities, services, goods and information'.<sup>29</sup> Other relevant core obligations are, to: 'guarantee universal and equitable access to affordable, acceptable and quality sexual and reproductive health services, goods and facilities, in particular for women and disadvantaged and marginalized groups, enact and enforce legal prohibition of harmful practices and gender based violence, including female genital mutilation, child and forced marriage and domestic and sexual violence, and take measures to prevent unsafe abortions and to provide post-abortion care and counselling for those in need'.<sup>30</sup>

The CRC guarantees a child (below 18 years), the right 'to the enjoyment of the highest attainable standard of

health and to facilities for the treatment of illness and rehabilitation of health'<sup>31</sup> and obliges states parties to strive to ensure that no child is deprived of his right to access such health care services'.<sup>32</sup> States parties are obliged to take appropriate measures 'to diminish infant and child mortality'<sup>33</sup> 'to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care',<sup>34</sup> and 'to ensure appropriate pre- natal and post- natal health care for mothers'.<sup>35</sup> States parties should also 'take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children'.<sup>36</sup> The Committee on the Rights of the Child, which is charged with providing guidance to states parties on implementation of their obligations under the CRC, in General Comment No. 4,<sup>37</sup> recognized the peculiar nature of adolescence, which 'is a period characterized by rapid physical, cognitive and social changes, including sexual and reproductive maturation; the gradual building up of the capacity to assume adult behaviours and roles involving

27. Para. 21.

28. General Comment No. 22, 'The right to sexual and reproductive health' E/C.12/GC/22.

29. Para. 49(a).

30. Para. 49(c)-(e).

31. Article 24(1).

32. Article 24(1).

33. Article 24(2)(a).

34. Article 24(2)(b).

35. Article 24(2)(d).

36. Article 24(3).

37. General Comment No. 4 (2003) 'Adolescent health and development in the context of the Convention on the Rights of the Child' CRC/GC/2003/4.

new responsibilities requiring new knowledge and skills'.<sup>38</sup> To this end, the Committee stated that adolescents 'have the right to access adequate information essential for their health and development and for their ability to participate meaningfully in society.'<sup>39</sup> States parties have an obligation 'to ensure that all adolescent girls and boys, both in and out of school, are provided with, not denied, accurate and appropriate information on how to protect their health and development and practice healthy behaviours. This should include information on the use and abuse, of tobacco, alcohol and other substances, safe and respectful social and sexual behaviours, diet and physical activity'.<sup>40</sup> Justice Lydia Mugambe held in *CEHURD v AG & Family Life Network*<sup>41</sup> above that these provisions confirm the right to sexuality education.

The Committee further obliges states parties to provide adolescents with access to sexual and reproductive information, including on family planning and contraceptives, the dangers of early pregnancy, the prevention and management of HIV/AIDS and sexually transmitted diseases. The Committee also provides that states parties should ensure that adolescents 'have access to appropriate information, regardless

of their marital status and whether their parents or guardians consent'<sup>42</sup> and that it is critical 'to find proper means and methods of providing information that is adequate and sensitive to the particularities and specific rights of adolescent girls and boys'.<sup>43</sup> States parties should also ensure that 'appropriate goods, services and information for prevention and treatment of sexually transmitted diseases, including HIV/AIDS, are available and accessible'.<sup>44</sup> The Committee urges states parties to develop effective measures aimed at changing cultural views and attitudes about adolescents' needs for contraception and address taboos surrounding sexuality and take measures to remove barriers hindering access of adolescents to information for example the use of condoms.<sup>45</sup> States parties are urged to 'develop and implement programmes that provide for access to sexual and reproductive health services, including family planning, contraception and safe abortion services where abortion is not against the law, adequate and comprehensive obstetric care and counselling'.<sup>46</sup> States parties should ensure that primary health care includes services essential to the needs of adolescents, paying particular attention to their sexual and

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38. Para. 2.

39. Para. 22.

40. Para. 22.

41. Misc. Cause no. 309 of 2016.

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42. Para. 22.

43. Para. 22.

44. Para. 30.

45. Para. 30.

46. Para. 31.

reproductive health.<sup>47</sup>

In General Comment No. 20,<sup>48</sup> the Committee enjoined states parties to 'adopt comprehensive gender and sexuality-sensitive sexual and reproductive health policies for adolescents, emphasizing that unequal access by adolescents to such information, commodities and services amounts to discrimination'.<sup>49</sup> The Committee observed that 'lack of access to such services contributes to adolescent girls being the group most at risk of dying or suffering serious or lifelong injuries in pregnancy and childbirth'.<sup>50</sup> To this end, the Committee recommended that 'age appropriate, comprehensive and inclusive sexual and reproductive health education, based on scientific evidence and human rights standards and developed with adolescents, should be part of the mandatory school curriculum and reach out-of-school adolescents'.<sup>51</sup>

The CRC recognizes the fact that minors (persons below 18 years) have evolving capacities to make decisions affecting their lives.<sup>52</sup> Some minors may be more mature than others depending

on individual circumstances. Albeit the CRC recognizes the role of parents and guardians in providing guidance in the exercise of children's rights, this must be guided by the best interests of the child. Indeed, the CRC provides that states parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child'.<sup>53</sup> The Committee, in General Comment No. 4 above, encourages states parties and health workers to respect the right to privacy and confidentiality of adolescents with respect to advice and counselling on health matters. An adolescent deemed mature enough may receive confidential counselling and services, without the presence or consent of a parent or any other person.<sup>54</sup>

The Women's Convention obliges states parties to 'take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health services, including those related to family planning'.<sup>55</sup> States parties 'shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services

47. Para. 41(a).

48. Committee on the Rights of the Child General Comment No. 20 (2016) on the implementation of the rights of the child during adolescence, CRC/C/G/20 OF 2016.

49. Para. 59.

50. Para. 59.

51. Para. 61

52. Article 5.

53. Article 12(1).

54. Para. 11.

55. Article 12(1).

where necessary'.<sup>56</sup> The Committee on the Elimination of all Forms of Discrimination (CEDAW), which is charged with providing guidance to states parties on the implementation of their obligations under the Women's Convention, in General Comment No. 28, enjoins states parties to 'pay attention to the specific needs of (adolescent) girls by providing education on sexual and reproductive health and carrying out programmes that are aimed at the prevention of HIV/AIDS, sexual exploitation and teenage pregnancy'.<sup>57</sup> CEDAW has also noted that states parties are obliged to take measures to eliminate discrimination against women and girls as per article 1 of the Women's Convention, which includes gender-based violence, that is, violence which is directed against a woman because she is a woman or that affects women disproportionately and is a violation of their human rights.

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In respect to the SRHR of adolescents and young people, it is necessary to recall what was agreed at the 1994 International Conference on Population and Development (ICPD), which placed

56. Article 12(2).

57. CEDAW, General Comment No. 28 on the Core Obligations of states parties under article 2 of the convention on the elimination of all forms of discrimination against women' CEDAW/C/GC/28 (2010).

58. CEDAW, General Recommendation No. 35 on gender-based violence against women, updating General Recommendation No. 19 of 1992. CEDAW/C/GC/35 of 2017.

women and girls at the centre of an integrated approach to reproduction. The ICPD was a land mark event because it marked a paradigm shift from a narrow focus on population control through family planning to a recognition that human rights have a critical role to play in relation to sexual and reproductive health. The ICPD Programme of Action (PoA) provided some ground-breaking principles and definitions in the context of sexual and reproductive health. The PoA emphasized not only fertility control, but also safe sex and pregnancy free from coercion, discrimination, and violence. The POA stressed that human rights, as well as women's empowerment and gender equality, are cornerstones of population and development programmes. In this vein, the PoA stated:

*Advancing gender equality and equity and the empowerment of women, and the elimination of all kinds of violence against women, and ensuring women's ability to control their fertility, are cornerstones of population and development-related programmes. The human rights of women and the girl child are an inalienable, integral part of human rights. The full and equal participation of women in civil, cultural, economic, political, and social life at the national, regional and international levels, and the eradication of all*

*forms of discrimination on grounds of sex, are priority objectives of the international community.<sup>59</sup>*

The PoA also called upon states to take appropriate steps to ensure realization of the right to health, including access to SRH services. In this regard, the PoA stated:

*Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care, which includes family planning and sexual health. Reproductive health-care programmes should provide the widest range of services without any form of coercion.<sup>60</sup>*

The PoA explicitly calls on governments to provide education on sexuality in order to promote the well-being of adolescents.<sup>61</sup> That education should take place both in schools and at the community level, be age-appropriate, begin as early as possible, foster mature decision-making, and aim at alleviating gender inequality. The topics to be addressed in such education include,

59. Principle 4.

60. Principle 8.

61. Paras. 4.29, 7.37, 7.41, and 7.47.

gender relations and equality, violence against adolescents, responsible sexual behaviour, contraception, family life and sexually transmitted infections (STIs), HIV and AIDS prevention. In 1999, at ICPD+5, the United Nations General Assembly (UNGA) stressed the obligation of governments to provide formal and informal sexual and reproductive health information as part of 'promoting the well-being of adolescents, enhancing gender equality and equity as well as responsible sexual behaviour, and protecting them from early and unwanted pregnancy, sexually transmitted diseases including HIV/AIDS, and sexual abuse, incest and violence'.<sup>62</sup>

At the Fourth World Conference on Women held in Beijing in 1995, government agreed to, among others, provide more accessible, available and affordable primary health services of high quality, including sex and reproductive health care, which includes family planning in formal planning information and services, and giving particular attention to maternal and emergency obstetric care'.<sup>63</sup> Governments also recognized and agreed to 'deal with the health impact of unsafe abortion as a major public health concern'.<sup>64</sup> To this end,

62. UNGA 'Key activities for the further implementation of the Programme of Action of the International Conference on Population and Development' A/RES/S-21/2, 8 November 1999.

63. Para. 106(e).

64. Para. 106(j).

governments undertook to ‘reduce the recourse to abortion through expanded and improved family planning services.’<sup>65</sup> On the burden of unwanted pregnancies, it was stated:

*“Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling. In all cases, women should have access to quality services for the management of complications arising from abortion. Post-abortion counselling, education and family planning services should be offered promptly, which will also help to avoid repeat abortions.”*<sup>66</sup>

The CRPD guarantees persons with disabilities the right to health<sup>67</sup> and enjoins states parties to ‘provide persons with disabilities with the same range, quality and standard of free or affordable healthcare and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes’.<sup>68</sup> These health services should be provided ‘as close as possible to people’s own communities,

65. Para. 106 (k).

66. Para. 106(k).

67. Article 25(1).

68. Article 25(1)(b).

including in rural areas’.<sup>69</sup> In enjoining governments to take SRHR seriously, the ICPD PoA stated:

*Governments at all levels should consider the needs of persons with disabilities in terms of ethical and human rights dimensions. Governments should recognize needs concerning inter alia, reproductive health, including family planning and sexual health, HIV/AIDS, information, education and communication. Government should eliminate specific forms of discrimination that persons with disabilities may face with regard to reproductive health rights, household and family formation.”*<sup>70</sup>

In spite of these guarantees, persons with disabilities, including adolescents and young people suffer a lot of stigma and discrimination and other challenges in the community and healthcare settings. Persons with disabilities are faced with stereotypes regarding their sexuality; they are viewed as asexual or in some instances hypersexual, incapable of reproduction and even unfit for marriage. They continue to face multiple barriers in the quest to access and utilize RHR, which include lack of physical access, for example, transportation, lack of ramps, adapted examination tables; lack of information and communication,

69. Article 25(1)(c).

70. Para. 6.3.

for example, braille, large print, sign language interpreters; healthcare providers' negative attitudes and lack of knowledge and skills about persons with disabilities; and exclusion of persons with disabilities from decision-making (WHO/UNFPA, 2009; Twinomugisha, 2018; Kuumuori Ganle et al, 2020; Mureil et al, 2022).

At the 2012 United Nations Conference on Sustainable Development held in Rio de Janeiro, governments came up with 17 Sustainable Development Goals (SDGs), which replaced the 2000 Millennium Development Goals (MDGs). SDG 3 enjoins governments to ensure healthy lives and promote wellbeing for all at all ages. Governments committed to meet following targets by 2030:

**Target 3.1:** Reduce global mortality ratio to less than 70 per 100,000 live births.

**Target 3.3:** End the epidemic of AIDS.

**Target 3.7:** Ensure universal access to sexual and reproductive healthcare services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes.

**Target 3.8:** Achieve universal health coverage, including access to quality essential healthcare services and

access to safe, effective, quality, and affordable essential medicines.

SGD 5 calls upon governments to attain gender equality and empower women and girls everywhere by achieving the following targets by 2030:

**Target 5.1:** End all forms of discrimination against all women and girls everywhere.

**Target 5.2:** End all violence against and exploitation of women and girls.

**Target 5.3:** Eliminate forced marriages and all harmful practices such as female genital mutilation.

**Target 5.6:** Universal access to reproductive health and rights.

## 4.2 State obligations at the regional level

In addition to their obligations at the international level, EAC countries are obliged by various regional instruments to realize the right to health generally and SRHR in particular. These instruments include, the African Charter on Human and Peoples' Right (ACHPR); the Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa (the Protocol); and the African Charter on the Rights and Welfare of the Child (ACRWC).



The ACHPR guarantees every person the right to enjoy the best attainable state of physical and mental health<sup>71</sup> and obliges states parties to ‘take necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick’.<sup>72</sup> The Protocol enjoins states parties to eliminate discrimination at all levels and all fields [including SRH].<sup>73</sup> To this end, states parties are obliged to ‘enact and effectively implement appropriate legislative or regulatory measures, including those prohibiting and curbing all forms of discrimination particularly those harmful practices which endanger the health and general well-being of women’.<sup>74</sup> States parties should tackle harmful cultural and traditional practices through public education, information and communication strategies.<sup>75</sup> Under the Protocol, women are guaranteed the respect of dignity and protection from all forms of violence, especially sexual and verbal violence.<sup>76</sup> The Protocol guarantees women the right to life, integrity and security of the person and obliges states parties to enact and enforce laws to prohibit all forms of violence against women, including unwanted or forced sex and eradicate all forms of violence against women and punish the

71. Article 16(1).

72. Article 16(2).

73. Article 2(1).

74. Article 2(1)(b).

75. Article 2(2).

76. Article 3(4).

perpetrators of such violence.<sup>77</sup> States parties should eliminate and condemn all forms of harmful practices that violate women’s human rights.<sup>78</sup> The Protocol obliges the states parties to prohibit, ‘through legislative measures backed by sanctions, all forms of female genital mutilation, scarification, medicalisation and para-medicalisation of female genital mutilation and all other practices in order to eradicate them’.<sup>79</sup>

The Protocol provides that states parties ‘shall ensure that the right to health of women, including sexual and reproductive health, is respected and promoted’.<sup>80</sup> According to the Protocol, this right includes:

1. The right to control their fertility;
2. The right to decide whether to have children, the number of children and the spacing of children;
3. The right to choose any method of contraception;
4. The right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS;
5. The right to be informed of one’s health status and on the health status of one’s partner, particularly if affected with STIs, including HIV/AIDS, in accordance

77. Article 4(2).

78. Article 5.

79. Article 5(b).

80. Article 14(1).

with internationally recognised standards and best practices; The right to have family planning education.<sup>81</sup>

**States parties are obliged to take all appropriate measures to:**

- Provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas;
- Establish and strengthen existing pre-natal delivery and post-natal delivery and post-natal health nutritious services for women during pregnancy and while they are breastfeeding;

Protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or foetus.<sup>82</sup>

Although article 14 above is fairly progressive in respect of SRHR of adolescents and young people in the EAC, Kenya ratified the Protocol with a reservation to article 14(2)(c). The state argued that this provision

81. Article 14(a)-(f).

82. Article 14(2)(a)-(c).

on medical abortion is inconsistent with the provisions of the laws of Kenya on health and reproductive rights. However, the 2010 Kenyan Constitution, which was promulgated after ratification of the Protocol, permits abortion where '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 is permitted by any other written law'.<sup>83</sup> The Kenyan Constitution also explicitly provides for the right to health and health services, including reproductive health care.<sup>84</sup> Uganda entered a reservation in respect of article 14(1)(a) and article 14(1)(c). Uganda argued that article 14(1)(a) in respect of women's right to control their fertility covered all women regardless of their marital status. In respect of article 14(2)(c), the state argued that it is not bound by the provision unless medical abortion is expressly provided for in domestic legislation. Abortion is prohibited in Uganda unless it is authorized by law.<sup>85</sup> The Penal Code Act only allows a defence by a medical doctor who has, in good faith, performed a surgical procedure on a woman to save her life.<sup>86</sup>

The ACRWC guarantees every child 'the right to enjoy the best attainable state of physical, mental and spiritual

83. Article 26(4).

84. Article 43(1)(a).

85. Article 22(2); sections 141-143 of the Penal Code Act.

86. Section 224 of the Penal Code Act.

health'.<sup>87</sup> States parties are enjoined to take appropriate measures 'to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child'.<sup>88</sup> These include customs and practices prejudicial to the health or life of the child and those discriminatory on grounds of sex or other status.<sup>89</sup> The ACRWC explicitly prohibits child marriage and betrothal of girls and boys.<sup>90</sup>

The African Youth Charter, which is guided by the international and regional human rights regime, provides that young men and women shall enter marriage based on their free consent.<sup>91</sup> States parties are obliged to take steps to encourage regular school attendance and reduce drop-out rates.<sup>92</sup> Young men and women are guaranteed 'the right to enjoy the best attainable state of physical, mental and spiritual health'.<sup>93</sup> States parties are obliged to take measures to 'secure the full involvement of youth in identifying their reproductive and health needs and designing programmes that respond to these needs with special attention to vulnerable and disadvantaged youth'.<sup>94</sup> States parties

are enjoined to provide access to youth friendly reproductive health services, including contraception, antenatal and post-natal services'.<sup>95</sup> States parties should institute programmes to prevent the transmission of STIs, including HIV/AIDS 'by providing education, information, communication and awareness creation as well as making protective measures and reproductive health services available'.<sup>96</sup> States parties should also 'expand availability and encourage uptake of voluntary counselling and confidential testing of HIV/AIDS'<sup>97</sup> and take steps 'to provide equal access to healthcare services and nutrition to girls and young women'.<sup>98</sup> The Charter enjoins states parties to only 'recognize and value beliefs and traditional practices that contribute to development'<sup>99</sup> and obliges them to 'eliminate all traditional practices that undermine the physical integrity and dignity of women'.<sup>100</sup> In fact, states parties are obliged to 'enact and enforce legislation that protects girls and young women from all forms of violence, genital mutilation, incest, rape, sexual abuse, sexual exploitation, trafficking, prostitution and pornography'.<sup>101</sup>

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87. Article 14(1).

88. Article 21.

89. Article 21(a) and (b).

90. Article 21(2).

91. Article 8(2).

92. Article 13(4)(c).

93. Article 18(1).

94. Article 18(2)(b).

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95. Article 18(2)(b).

96. Article 18(2)(e).

97. Article 18(2)(f).

98. Article 20(b).

99. Article 20(b).

100. Article 20(a).

101. Article 23(l).

## 5. THE EAC SEXUAL AND REPRODUCTIVE HEALTH BILL, 2020

### 5.1 What the Bill contains: A bird's eye view

The EAC Sexual and Reproductive Health Bill, 2020 (the SRH Bill) covers most of the SRHR norms and standards in the international and regional human rights instruments considered above. According to the long title, the purpose of the SRH Bill is 'to protect and facilitate the fulfilment of the life-course sexual and reproductive health and rights of all persons in the Community; to provide for the progressive realization of integrated sexual and reproductive health information and services as part of the universal health coverage of each Partner State; and to prohibit harmful practices from the Community and provide for related matters'.<sup>102</sup> In addition, the SRH Bill seeks to: 'promote and provide for age-appropriate sexual and reproductive health information and services of all persons, including adolescents and young people; 'facilitate and promote the prevention of new-born, child mortality, maternal mortality and morbidity from preventable causes'; 'facilitate and promote reduction and elimination of unsafe abortions, HIV and other sexually transmitted

102. Long title.

infections, early and unintended pregnancies'; and 'prohibit and facilitate the elimination of harmful practices from the Community'.<sup>103</sup>

The SRH Bill obliges each partner state to integrate sexual and reproductive health service in its universal health coverage<sup>104</sup> and to 'provide adequate, accessible and where they are not free, affordable, sexual and reproductive health services to facilitate the realization of the highest attainable standard of health by every person'.<sup>105</sup> The relevant sexual and reproductive health services are listed under clause 4(3) and they include, family planning and contraceptives information, education and services; accessibility, availability and education on contraceptives; counselling relating to sexual and reproductive health; pre-natal, delivery and post-natal health care; and sexual and reproductive health services for people living with disabilities.<sup>106</sup>

The SRH Bill provides for age and culturally-appropriate comprehensive sexuality education<sup>107</sup> and obliges every partner state to 'provide and include in the curriculum scientifically

103. Clause 2(b)-(e).

104. Clause 4(1).

105. Clause 4(2).

106. For a full list of the SRH services, see, article 4(3) (a)-(l). On details of family planning and contraceptives education and services, see, section 13.

107. Clause 5.

based, age, gender and culturally appropriate education for the health and wellbeing of adolescents and young people'.<sup>108</sup> Comprehensive sexuality education shall include 'in-school and out-of-school programmes designed to cover the life-cycle of an individual'.<sup>109</sup> The nature of sexuality education to be offered shall take into account a number of factors including, the age, evolving capacity, needs and understanding of the adolescent or young person at each stage of the life cycle.<sup>110</sup>

According to the Bill, adolescents and young people are entitled to 'access to safe, effective, non-judgmental and acceptable age-appropriate sexual and reproductive health information, education and services'.<sup>111</sup> The information shall be 'confidential, adolescent and youth-friendly and non-discriminatory'.<sup>112</sup> The SRH Bill provides for the right of every adolescent or young person to exercise sexuality independently, free of violence and coercion; access to methods for prevention, diagnosis and treatment of STIs and HIV; information relating to contraceptives; and menstrual products.<sup>113</sup> On access

to sexual and reproductive health services, the SRH Bill provides that an adolescent or young person 'has a right to access sexual and reproductive health services regardless of their age and a health provider shall not require an adolescent or young person to provide evidence of age or the consent of a parent or guardian in order to access the sexual or reproductive health services'.<sup>114</sup>

The SRH Bill provides that a woman may terminate a pregnancy 'if in the opinion of a health professional, there is need for emergency treatment, the pregnancy endangers the mental or physical health or life of the woman, in the case of sexual assault, rape, incest or as may be permitted by the law of a Partner State'.<sup>115</sup> According to the Bill, the Council shall 'by directives published in the gazette, specify the emergency circumstances or procedures and the health professionals required for termination of pregnancy'.<sup>116</sup> The Bill guarantees the right to post-abortion care and treatment.<sup>117</sup>

The SRH Bill also provides for protection from HIV and AIDS and sexually transmitted infections;<sup>118</sup> pre-natal, delivery and post-natal

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108. Clause 5(1).

109. Clause 5(2).

110. Clause 5(3)(a). See Clause 5(3) for the full list of the items sexuality education should take into account.

111. Clause 7(1).

112. Clause 7(3).

113. Clause 7(5).

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114. Clause 8(1).

115. Clause 11(1).

116. Clause 11(2).

117. Clause 12.

118. Clause 14.

services;<sup>119</sup> and continuation of education after pregnancy.<sup>120</sup> The SRH Bill expressly prohibits harmful practices, including child marriage and betrothal; female genital mutilation; and forced sterilization.

## 5.2. Why some EAC countries may not endorse the SRH Bill

Most of the provisions of the SRH Bill promote the SRH of adolescents and young people. However, there are certain aspects of the SRH Bill that are contested. For example, sexual health is defined as ‘a state of physical, emotional, mental and social well-being in relation to sexuality. According to the Bill, the information, education and services to be given to adolescents and young people, shall include their right ‘to exercise sexuality independently’ [emphasis added].<sup>121</sup> World Health Organization (WHO) defines sexuality as ‘a central aspect of being human throughout life [that] encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction’. Target 1 of the ESA Commitment talks of ‘age-appropriate, culturally-relevant and evidence-based sexuality education’.<sup>122</sup> The EAC Bill

falls short of defining “sexuality” within the context of the EAC region. It will be essential to define sexuality and the content of sexuality that will be passed on to an adolescent. It will be essential to elaborate circumstances where a parent or guardian can be involved in sexual health matters of their adolescent. An adolescent or young person may access SRH services that are appropriate to their age and the Bill needs to be clear on this section.<sup>123</sup> There is thus need to ensure that all the contents of the SRH Bill on sexuality education ensure that it conforms with target 1 of the ESA Commitment standard: ‘good quality, age-appropriate, culturally-relevant and evidence-based sexuality education’. The SRH Bill proposes that every adolescent or young person shall have access to ‘non-judgmental’ SRH information, education and services. The Bill could consider putting “non-judgemental” into context.

The SRH Bill provides for termination of pregnancy. Although this can be interpreted in general terms and be a basis for contestation, the Bill recognises the diversity of laws in partner states.<sup>124</sup> In Uganda for example, termination of pregnancy is restricted. Its legislation allows a surgical operation to be carried out upon any person for his or her

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119. Clause 15.

120. Clause 16.

121. Clause 7(5).

122. See also Clause 5 of the SRH Bill.

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123. Clause 8(1).

124. Clause 11 of the EAC SRH Bill

benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time, and to all the circumstances of the case.<sup>125</sup> Further, Uganda entered a reservation on article 14(2)(c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol). Thus, such a country may not be bound by the exceptions contained therein. The only exceptions in clause 11, which are covered by the Kenyan Constitution are emergency treatment or life or health of the mother. Sexual violence, that is, sexual assault, rape and incest are not covered by the Constitution. If the drafters of the Constitution intended that they be covered, they would have stated so. So, Kenya may not endorse clause 11 of the SRH Bill. Perhaps only Rwanda, which has domesticated article 14, including the controversial sub-clause 2(c) may have no issues with section 11 of the SRH Bill.

## 6. CONCLUSION

The ESA Commitment is in concordance with international and regional human rights instruments that EAC countries subscribe to. Thus, the EAC countries should endorse it for two major reasons. First, the evidence

125. Clause 224 of the Penal Code Act.

on SRH status of adolescents and young people in EAC is alarming. Second, they are obliged by the human rights instruments to achieve the norms in the targets outlined in the ESA Commitment. However, sexuality education should be age-appropriate, culturally-relevant and evidence-based as Target 1 provides. Culture in this context, includes traditional religions such as Christianity and Islam. The countries should, as much as possible, take into account the views of the adolescents and young people, parents, religious and cultural leaders, legislators and policymakers, before endorsing the SRH Bill. Building on the ESA Commitment, each country should devise its own sexuality education framework based on its own laws and peculiarities. Lessons may be drawn from Rwanda's experience with sexuality education and Uganda's age-appropriate, abstinence-based/sexual risk avoidance, 2018 National Sexuality Education Framework, which incorporates the interests of various stakeholders and is anchored in Uganda's legal and policy frameworks.

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