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2gether 4SRHR

Assessment of the Domestication of Global, Continental and Regional Frameworks into National Policies, Strategies and Frameworks in East and Southern Africa

BASELINE REPORT

UNAIDS

UNFPA

unicef
for every child

World Health Organization

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Acknowledgements

This assessment provides a baseline of, and progress related to, the extent to which international sexual and reproductive health and rights (SRHR) frameworks have been domesticated into national policies, strategies and frameworks in 23 countries in East and Southern Africa (ESA).

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ASRH	Adolescent Sexual and Reproductive Health
COVID-19	Coronavirus Disease of 2019
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organization
DRC	Democratic Republic of The Congo
EAC	East African Community
ESARO	East and Southern Africa Regional Office
ESA	East and Southern Africa
FGM	Female Genital Mutilation
GBV	Gender-Based Violence
GOB	Government of Botswana
GOT	Government of Tazania
GOU	Government of Uganda
HIV	Human Immunodeficiency Virus
HTPs	Harmful Traditional Practices
ICPD	International Conference on Population and Development
KIIs	Key Informant Interviews
KP	Key Population
LGBTIQ	Lesbian Gay Bisexual Trans Intersex or Queer
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goal
MNCH	Maternal, Newborn Child Health
MP	Members of Parliament

MPoA	Maputo Plan of Action
NAPHS	National Action Plan for Health Security
OCHA	Office for the Coordination of Humanitarian Affairs
PHC	Primary Health Care
RECs	Regional Economic Communities
RIME	Research, Innovation, Monitoring and Evaluation
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
RTHD	Research and Training for Health and Development
SADC	Southern African Development Community
SDG	Sustainable Development Goal
SGBV	Sexual and Gender-based Violence
Sida	Swedish International Development Cooperation Agency
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VMCC	Voluntary Medical Male Circumcision
WHO	World Health Organization

Executive Summary

Background

The 1994 International Conference on Population and Development (ICPD) brought in substantial change in defining sexual and reproductive health (SRH) at the policy level. The ICPD broke new ground by linking reproductive rights to human rights already protected under international laws. It also brought diverse views on human rights, population, SRH, gender equality and sustainable development. It forged a global consensus that placed individual dignity and human rights, including the right to plan one's family, at the very heart of development (United Nations, 1995). Linked to the ICPD are the Sustainable Development Goals (SDGs), agreed to by the international community with specific targets on sexual and reproductive health and rights (SRHR). Most notably is SDG 3 (Good health and well-being) and SDG 5 (Gender equality).

At the continental level, the Maputo Plan of Action (MPoA) operationalizes the Continental Policy Framework on Sexual and Reproductive Health and Rights. The MPoA has been significant in guiding African countries on addressing SRHR issues. The MPoA addresses key elements of SRHR, such as universal access to comprehensive SRHR, maternal health and newborn care, prevention and management of sexually transmitted infections (STIs) and HIV and AIDS, and reduction of gender-based violence (GBV). Similarly, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) went into effect in 2005 and is a ground-breaking protocol that focuses on women's and girls' rights in Africa.

At the regional level, ministers of health and education from 20 countries in East and Southern Africa (ESA), endorsed the Ministerial Commitment on comprehensive sexuality education (CSE) and SRH services for adolescents and young people in ESA (ESA Commitment 2023). This framework commits governments to increasing access to CSE and SRH services for young people.

Regional Economic Communities (RECs), such as the Southern African Development Community (SADC) and the East African Community (EAC) have also developed policy frameworks aimed at harmonizing the regional response to improve SRHR outcomes. Key among these frameworks are the SADC SRHR Strategy and the EAC Integrated Reproductive Maternal Newborn Child and Adolescent Health (RMNCAH) Policy Guideline.

It is against this background that 2gether 4 SRHR, with funding from the Regional SRHR Team of Sweden, commissioned Research and Training for Health and Development (RTHD) to undertake an assessment of progress and provide a baseline of the extent to which international SRHR frameworks have been domesticated into national policies, strategies and frameworks in 23 countries in ESA. 2gether 4 SRHR is a Joint United Nations Regional Programme that harnesses the combined efforts of the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO) in ESA.

The specific objectives of the assessment were to:

1. Map the extent to which key global, continental and regional frameworks on SRHR, HIV and GBV have been domesticated in 23 countries in the ESA region and identify factors that facilitate or hinder their domestication.

2. Make recommendations on how United Nations agencies at a regional level can better support the African Union, RECs and countries to domestic regional frameworks.

Methodology

The assessment used a guided desk review approach, complemented by key informant interviews (KIIs) and additional inputs provided during the EAC RMNCAH/HIV Focal Points Meeting and the SADC SRHR Managers Meeting, both convened during 2023. The findings of the KIIs are reported in a separate document that highlights the key facilitators and barriers to domestication in ESA. The desk review was conducted in three stages, namely:

1. Reviewing relevant programme and background documents to better understand the context of the assessment.

2. Collection of data and review of the extent to which international SRHR frameworks are incorporated in relevant national policy frameworks. This involved collection and review of global, continental, regional and national policies, frameworks and strategies related to SRHR, policy evaluation reports and similar documents from all 23 countries in ESA.

3. An additional review and the incorporation of inputs provided during the EAC RMNCAH/HIV Focal Points Meeting (September, 2023) and the SADC SRHR Managers Meeting (June, 2023).

The policy documents were garnered through an online/internet search and retrieved from UNFPA and partners, as well as from national policy stakeholders.

Assessment of domestication of SRHR frameworks in 23 countries

The following documents were purposively selected to assess domestication of global, continental and regional policies into national policies in the 23 ESA countries:

Global

- Sustainable Development Goals (SDGs)
- International Conference on Population and Development (ICPD) Programme of Action

Continental

- Maputo Plan of Action (2016–2030) for the Operationalisation of the Continental Policy Framework for SRHR
- (Maputo) Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2005)

Regional

- SADC SRHR Strategy and Scorecard (2019–2030)
- Minimum Standards for the Integration of HIV and Sexual and Reproductive Health in the SADC Region (2015)
- SADC Regional Strategy for HIV Prevention, Treatment and Care and Sexual and Reproductive Health and Rights among Key Populations
- EAC Integrated Reproductive Maternal Newborn Child and Adolescent Health (RMNCAH) Policy Guideline (2016–2030) and EAC RMNCAH Scorecard

National Frameworks

- Key policy documents in the 23 countries on SRHR, HIV and GBV were reviewed to assess the extent of domestication of select global, continental and regional frameworks. A minimum of six policy frameworks were reviewed in each of the 23 countries

Findings

Domestication of global frameworks: SDGs and ICPD

During this assessment, SRHR-related provisions were purposively selected from the SDG and ICPD frameworks, namely: SDG 3 (Good health and well-being), SDG 5 (Gender equality), ICPD IV (Gender Equality, Equity and Empowerment of Women), ICPD V (The Family, Its Roles, Rights, Composition and Structure), ICPD VII (Reproductive rights and reproductive health) and ICPD VIII (Health morbidity and mortality).

This assessment reveals that all countries in ESA explicitly mention SDGs in their SRHR-related policy frameworks and align the frameworks to the SDGs. Sixteen out of 23 countries explicitly mention and align their SRHR-related policy frameworks to SDG 3. Thirteen out of 23 countries explicitly mention and align their SRHR-related policies to SDG 5.

The majority of countries (17 out of 23) explicitly mention ICPD in their SRHR-related policies and align the policies to the ICPD. While policies rarely mention specific ICPD provisions or SDG specific targets, several policies articulate and seek to realize thematic focus areas that significantly overlap with specific ICPD provisions and SDG targets. Notably, the roles, rights, composition and structure of families (ICPD V) and their impact on SRHR-related issues are rarely articulated in the national policies.

Domestication of continental policies: Maputo Plan of Action and Maputo Protocol

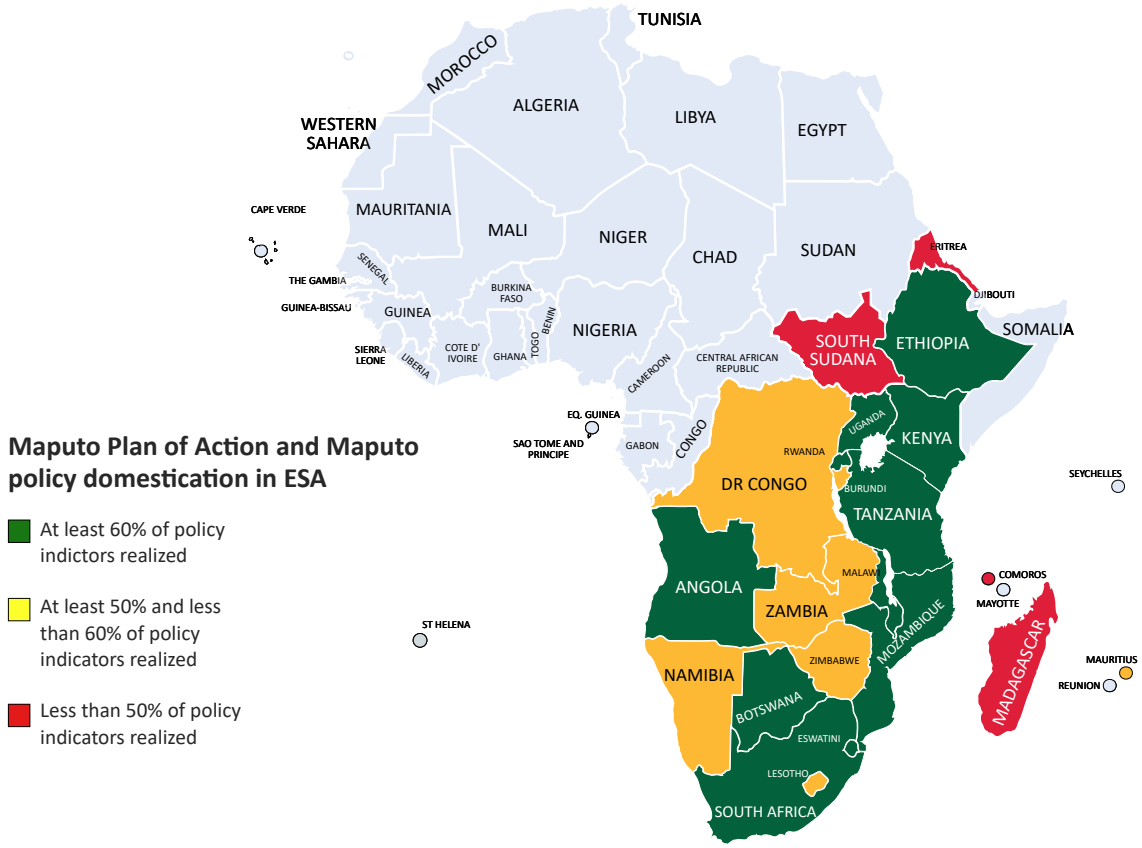
Policy indicators were isolated from the MPoA to assess the extent to which the framework was domesticated in the 23 ESA countries. Based on a composite of the MPoA policy indicators, the desk review suggests good progress in the domestication of the MPoA policy framework. See map below.

Close to half of countries in ESA (11 out of 23) have realized at least 60 per cent of the MPoA policy indicators. Comoros, Eritrea, Madagascar, Seychelles and South Sudan have realized less than 50 per cent of the MPoA policy indicators. Limited data was accessed from Comoros, Eritrea and Seychelles.

Costed roadmaps for the reduction of maternal, newborn and child morbidity and mortality were found in 21 out of 23 ESA countries. The availability of the costed roadmaps in Seychelles and South Sudan could not be ascertained. There is also remarkable progress in ESA (20 out of 23 countries) regarding countries putting in place national health policy frameworks and developing plans that integrate RMNCAH, HIV and AIDS, STI and malaria services.

There is significant progress (21 out of 23 countries) regarding development of country policies guaranteeing women access to SRH care, information and education irrespective of age. Countries in ESA (21 out of 23) have also made progress in establishing policy frameworks to support RMNCAH services for young people. This includes putting in place adolescent SRH policies. Data was unclear or missing on the proportion of national health budgets allocated for RMNCAH.

In 17 out of 23 countries, at least one of the reviewed national policy frameworks makes direct reference to the Maputo Protocol as a continental framework that informed the formulation of the specific national framework. These national frameworks are largely those addressing SRHR and/or GBV thematic areas. However, only six countries (Eswatini, Kenya, Lesotho, Malawi, Namibia and Zimbabwe) have submitted all their reports to the African Union on the Maputo Protocol domestication progress. This is in line with the requirements of Article 62 of the African Charter on Human and Peoples' Rights. Botswana, the Democratic Republic of the Congo (DRC), Eritrea and Rwanda are late by one or two reports, while the remaining countries are late by three or more reports. In the most recent reports submitted by the six countries that fully complied with Article 62, the African Union observed that the countries have put in place the necessary policy and legislative framework to promote the rights of women.



Domestication of regional frameworks: SADC SRHR Strategy and Scorecard (2019–2030)

Policy indicators from the SADC SRHR Scorecard were used to assess the extent to which these policy indicators have been realized in Southern Africa.

The table below shows that apart from Zambia and Zimbabwe, all countries in SADC have policies that allow adolescents to access SRH services without third party authorization. Almost all countries in SADC set minimum legal age of consent to marriage at 18 years. This, however, is hampered by the challenge of reconciling local customs and religious practices with international standards and formal law. Even in countries like Malawi where formal laws to end child marriage exist, the practice is still common, particularly in rural areas. In Botswana, while the Marriage Act (2001) sets the minimum marriage age at 21 years, the law explicitly indicates that this does not apply to customary or religious unions (Section 2 of the Act). Apart from South Africa where abortion is allowed on demand, abortion in SADC countries is only allowed under specific conditions, such as when the life of the mother is in danger.

SADC Scorecard Policy Indicators	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Policies that allow adolescents to access SRH services without third party authorization	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
Minimum legal age of consent to marriage, 18 years for all irrespective of age	Yes	Partial	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Partial	Yes	Yes
Legal status of abortion	Partial	Partial	No	Partial	Partial	No	No	Partial	Partial	Yes	Partial	Partial	Yes	Partial	Yes	Partial

Yes Partial No

Domestication of regional frameworks: Minimum Standards for the Integration of HIV and Sexual and Reproductive Health in the SADC Region (2015)

Policy indicators extracted from the Minimum Standards were used to assess the extent to which they have been realized in 16 SADC countries. There is a remarkable progress in review of policies and integration of SRH and HIV policies (15 out of 16 countries), integration of SRH and non-communicable diseases (13 out of 16 countries), and review and enactment of laws to address GBV (14 out of 16 countries).

Domestication of regional frameworks: EAC Integrated Reproductive Maternal Newborn Child and Adolescent Health (RMNCAH) Policy Guideline (2016–2030) and Scorecard

No policy framework reviewed in the seven EAC countries in the areas of SRHR, HIV and GBV makes direct reference to the EAC Integrated RMNCAH Policy Guideline. There is, however, reference to the EAC Treaty in Uganda's Ministry of Health Strategic Plan 2021–2025 and Tanzania's Health Sector Strategic Plan V, 2021–2026. Despite the Integrated RMNCAH Policy Guideline not being explicitly reflected in key policy frameworks in SRHR, HIV and GBV, there have been efforts at implementation level to realize the EAC RMNCAH Policy.

Recommendations

Recommendations based on the desk review are provided below. A separate report highlighting facilitators and barriers of domestication provides further recommendations on addressing these issues.

Resource allocation and budgeting

- Advocate for an increase in budget allocation to health to meet the African Union Abuja Declaration target of 15 per cent.
- Advocate for an increase in budget allocation to RMNCAH.
- Advocate for reporting and tracking of RMNCAH budget.

Social and behavioural change communication

- Develop a clear communication strategy for MPoA at country level.
- Design and implement social and behaviour change communication strategies aimed at addressing norms and cultural practices that violate women's and girls' rights at country level.
- Countries to develop integrated communication strategies for RMNCAH

Advocacy for legal reform

- Advocate for the alignment between formal law, customary law and cultural practices (especially in rural areas) to end child marriage.
- Advocate for the formulation, passing and implementation of laws to give effect to policies and strategies that articulate women's and girls' reproductive freedoms.
- Advocate for the recognition and inclusion of key populations (including the LGBTIQ community) in policies, laws and interventions.

Monitoring and Evaluation

- Countries to undertake and develop status reports on unsafe abortion.
- Countries to develop integrated monitoring and evaluation (M&E) strategies and mechanisms for reporting on SRHR and RMNCAH.

Acceleration of domestication

- Comoros, Eritrea, Madagascar, Seychelles and South Sudan need special attention to accelerate domestication of MPoA.
- Advocate for countries to report to the African Union on the Maputo Protocol domestication progress as required by Article 62 of the African Charter on Human and People's Rights. This will promote accountability and motivate for domestication of the Protocol.
- Advocate for countries to act on the African Union on the observations and recommendations on the domestication progress of the Maputo Protocol.
- Encourage countries to work on, and address reservations to, reservations, full adoption and domestication of the Protocol.
- Advocate for the recognition and alignment of national SRHR strategies to the EAC Integrated RMNCAH Policy Guideline.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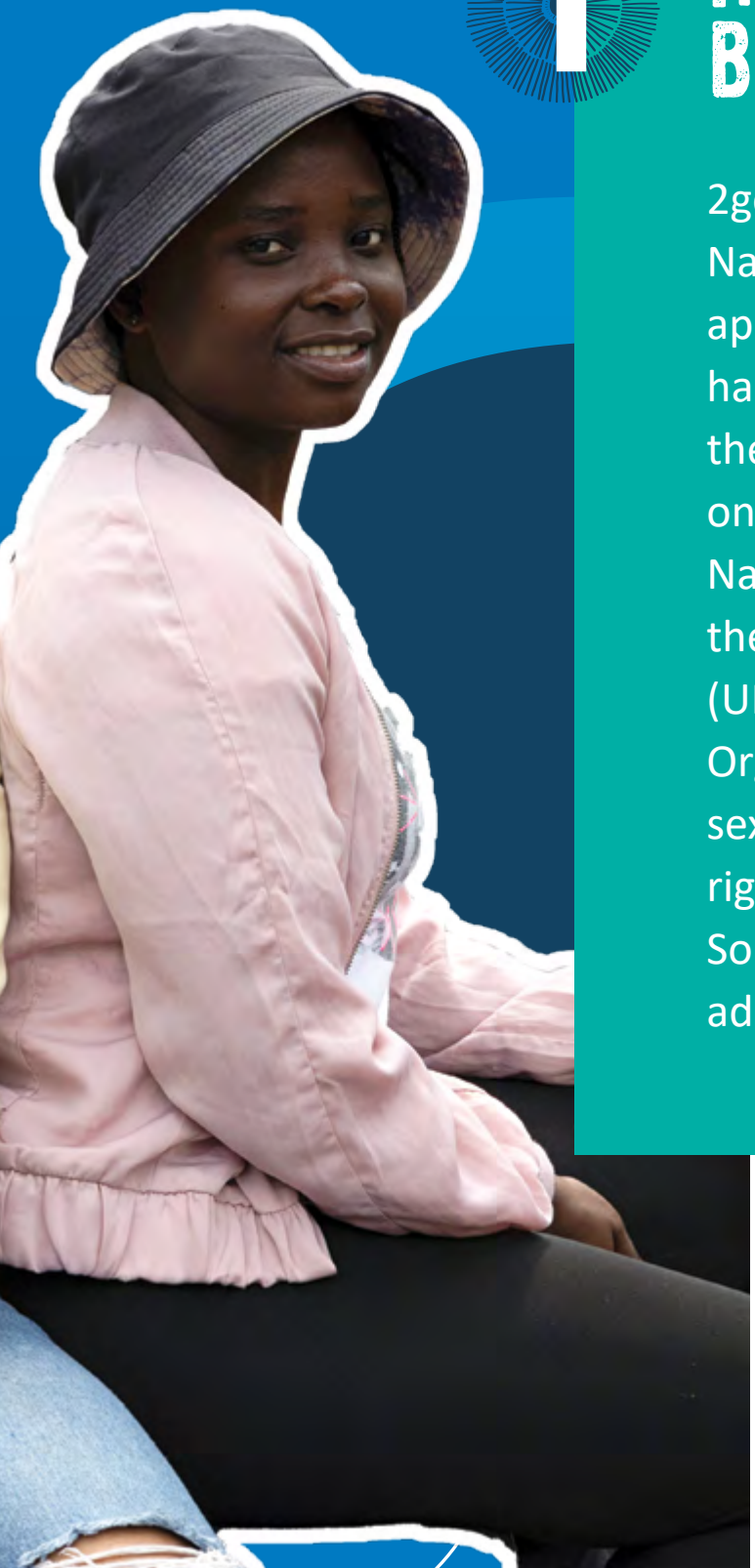


1 Introduction and Background

2gether 4 SRHR is a Joint United Nations Regional Programme with applied learning in 10 countries. It harnesses the combined efforts of the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO) to improve the sexual and reproductive health and rights (SRHR) of all people in East and Southern Africa (ESA), particularly adolescent girls, young people and

One objective of 2gether 4 SRHR is to create an enabling legal and policy environment for SRHR. To achieve this objective, the programme has supported the development or strengthening of regional SRHR frameworks, as well as a number of laws and policies (UNAIDS, UNFPA, UNICEF and WHO, 2021).

Several continental and regional SRHR frameworks aim at providing guidance for countries against which they can benchmark their SRHR policies and interventions in Africa. While some of these global, continental and regional frameworks have been adopted, the extent to which they have been incorporated into national level policies, strategies and programmes, and the factors that facilitate or hinder their domestication, need to be ascertained.

It is against this background that 2gether 4 SRHR, with funding from the Regional SRHR Team of Sweden, commissioned Research and Training for Health and Development (RTHD) to undertake this desk review. The scope of the review included assessing progress and providing a baseline of the extent to which global, continental and regional SRHR frameworks have been incorporated into national policies, strategies and frameworks in 23 countries in ESA. This report satisfies this scope, while two other reports were submitted separately. The first highlights facilitators and barriers of policy domestication, while the second outlines the extent to which SRHR frameworks include humanitarian situations and the extent to which humanitarian frameworks provide for SRHR.

1.1. Sexual and reproductive health and rights policy context

At a **global level**, the 1994 International Conference on Population and Development (ICPD) in Egypt broke new ground by defining SRHR and linking reproductive rights to human rights that were already protected under international laws. It is a platform that brought diverse views on human rights, population, sexual and reproductive health (SRH), gender equality and sustainable development into a remarkable global consensus that placed individual dignity and human rights, including the right to plan one's family, at the very heart of development (United Nations, 1995). In 2019, the world renewed commitments towards the ICPD on SRHR by acknowledging the importance of completing the unfinished business of the ICPD Programme of Action. In a bid to reach the Sustainable Development Goals (SDGs) by 2030, there was also agreement on the need to realize the strong and evidence-based investment case for ensuring SRHR for all, girls' and women's empowerment and gender equality (United Nations, 2019).

SRHR is linked to the three pillars of sustainable development – social, economic and environmental (Starrs et al., 2018). In 2015, the international community adopted the 2030 Agenda for Sustainable Development and its specific targets, some of which, as seen below, explicitly mention SRHR:

SDG 3 (Good health and well-being)

Target 3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

SDG 5 (Gender equality)

Target 5.6: Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.

At the **continental level**, the Maputo Plan of Action (MPoA) 2016–2030 provides guidance to African countries regarding SRHR. The MPoA focuses on achieving universal access to comprehensive SRH services. It is premised on SRHR as defined at ICPD 1994 taking into account the life cycle approach. These elements of SRHR include adolescent sexual and reproductive health (ASRH); maternal health and newborn care; safe abortion care; family planning; prevention and management of sexually transmitted infections (STIs), including HIV and AIDS; prevention and management of infertility; prevention and management of cancers of the reproductive system; addressing mid-life concerns of men and women; health and development; the reduction of gender-based violence (GBV); interpersonal communication and counselling; and health education.

In 2013, ministers of health and education from 20 countries in ESA endorsed the ESA Commitment, which commits governments to increasing access to comprehensive sexuality education (CSE) and SRH services for young people. Specifically, the ESA Commitment sets a target of reducing early and unintended pregnancies by 75 per cent by 2020.

In 2019, the SADC SRHR Strategy (2019–2030) was launched as a ground-breaking strategy with a corresponding Scorecard to measure progress. The Strategy provides a framework for Member States to fast-track a healthy sexual and reproductive life for people in the region where rights are protected and realized (UNFPA, 2018).

The East Africa Legislative Assembly, with support from the East African Community (EAC) Secretariat, is currently in the process of developing an EAC SRHR Bill. The Bill is anchored on Article 118 of the Treaty of the East African Community. In accordance with this, Partner States committed to cooperate generally in health and specifically in the development of reproductive health, and to harmonize national health policies and regulations in order to achieve quality health within the EAC. The Bill aims to further support the harmonization of the EAC Integrated Reproductive Maternal, Newborn Child and Adolescent Health Policy Guidelines 2016–2030, and the EAC Sexual and Reproductive Health Rights Strategic Plan. If assented to by the Partner States of the EAC, the Bill will protect and facilitate the attainment of the life-course SRHR of all persons, provide for the progressive realization of integrated SRH information and services as part of the Universal Health Coverage (UHC) of each Partner State, and prohibit harmful practices.

2 Assessment Objectives

The overall assessment objective was to measure and develop a baseline of the extent to which global, continental and regional frameworks on SRHR are incorporated into national laws, policies and strategies.

The specific objectives were to:

1. Map the extent to which key global, continental and regional frameworks on SRHR, HIV and GBV have been domesticated in 23 countries in the ESA region and identify factors that facilitate or hinder their domestication.

2. Make recommendations on how the United Nations agencies at a regional level can better support the African Union, regional economic communities (RECs) and countries to domestic regional frameworks.

Companion reports (based on key informant interviews) focus on the extent to which SRHR is incorporated into humanitarian polices and the key barriers and enablers of domestication.

3 Methodological Approach

The desk review was conducted in three stages, namely:

1. Review of relevant programme and background documents to better understand the context of the assessment as provided by UNFPA.

2. Review of global, continental, regional and national policies, frameworks, policy evaluation reports and similar documents from all 23 countries targeted by UNFPA in ESA.

3. An additional review and incorporation of inputs during the SADC SRHR Managers Meeting (June, 2023) and the EAC RMNCAH/ HIV Managers Meeting (September, 2023).

The policy documents were identified through online searches, UNFPA and partners and national policy stakeholders. All documents were reviewed in their original language by researchers fluent in those languages. A list of policy documents reviewed at each level is included in the Appendices.

3.1. Assessment of domestication in 23 countries

The following frameworks were purposively selected to assess domestication at national level.

1 Global level

i. Sustainable Development Goals (SDGs)

ii. International Conference on Population and Development (ICPD) Programme of Action

2 Continental level

i. Maputo Plan of Action (2016–2030) for the Operationalisation of the Continental Policy Framework for SRHR

ii. (Maputo) Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2005)

3 Regional level

i. SADC SRHR Strategy and Scorecard (2019–2030)

ii. Minimum Standards for the Integration of HIV and Sexual and Reproductive Health in the SADC Region (2015)

iii. SADC Regional Strategy for HIV Prevention, Treatment and Care and Sexual and Reproductive Health and Rights among Key Populations

iv. EAC Integrated Reproductive Maternal Newborn Child And Adolescent Health (RMNCAH) Policy Guideline (2016–2030) and EAC RMNCAH Scorecard

At national level, key policy documents in the 23 countries on SRHR, HIV and GBV thematic areas were reviewed to assess the extent of domestication of the above global, continental and regional frameworks. A minimum of six policy frameworks were reviewed in each of the 23 countries.[1]

[1] See list of policy documents in Appendices

4 Country Domestication and Operational Definition of Domestication for the Assessment

4.1. Legal context

In the context of a legalistic definition of domestication, it is important to note that most countries in Southern Africa have dualist legal systems. This means that international and regional legal obligations can only be part of domestic law after going through domestic legislative processes. Thus, in dualist systems "…international law stands apart from national law, and to have any effect on rights and obligations at the national level, international law must be domesticated through legislative process."[2] Few countries in ESA, notably Burundi, Mozambique, Namibia and Rwanda have displayed characteristics of a monist legal system subject to the countries' constitutions and court interpretation (Southern Africa Litigation Centre, 2013). In a monist system, international and regional legal obligations are part of the domestic law.

In this context, most countries in ESA require that international protocols be ratified by the countries' legislative process before they can be domestically enforceable. Ratification of the protocols is therefore essential to integration of subsequent strategies and standards.

4.2. Operational definition of domestication in this report

This assessment analyses international and regional frameworks related to SRHR which, in many cases, operationalize relevant international and regional protocols, the majority of which have already been adopted and ratified by member countries. In this context, this report adopts an understanding of domestication that goes beyond the legalistic perspective. Domestication in this assessment entails the process of transforming, incorporating and/or integrating provisions and standards from international, continental and regional policy frameworks related to SRHR, into relevant national frameworks and strategies.

Given the legal context outlined above in Section 4.1, the global, continental and regional frameworks do not provide much procedural domestication guidance because this is dependent on the specific legal domestication contexts of the adopting countries. However, these global, continental and regional frameworks do provide a measure against which countries can benchmark their own policies and strategies, taking into consideration their national contexts, laws and policies. They also recognize the interconnectedness of states and the importance of harmonization of responses across borders.

[2] http://www.judicialmonitor.org/archive_winter2014/generalprinciples.html.

5 Limitations of the Assessment

This assessment had two main limitations:

- Country data was not readily available in a few countries. In such cases, the assessment relied much on overarching policy frameworks (where available) that often covered limited policy parameters under assessment.

- There were some overlaps between policy and programme provisions. This study was, however, limited to policy frameworks and thus did not assess domestication of parameters located in programme frameworks.

The findings were refined after seeking further input from health officials from SADC and EAC countries; this exercise mitigated the above limitations.

6 Domestication of Global Frameworks

6.1. Sustainable Development Goals

SDGs are specific commitments made by United Nations Member States to guide development and transform the world between 2015 and 2030.[3] The following two of the 17 SDGs provide guidance in the area of SRHR:

a. SDG 3 (Good health and well-being) and its targets relating to the following thematic areas:

3.1 Maternal death reduction

3.3 HIV and other communicable disease reduction

3.7 SRHR and services

3.8 Universal health coverage

b. SDG 5 (Gender equality) and its targets relating to the following thematic areas:

5.1 End all forms of discrimination against women

5.2 End violence against women

5.3 Eliminate harmful practices

5.6 Universal access to SRHR

[3] https://sustainabledevelopment.un.org/content/documents/21252030%20Agenda%20for%20Sustainable%20Development%20web.pdf.

Table 1 presents the extent to which these goals and targets are incorporated into national policy frameworks (formulated after 2015) in the 23 ESA countries.

Table 1: Extent to which the Sustainable Development Goals 3 and 5 are incorporated in national sexual and reproductive health and rights related policies[4]

Mention and alignment of SDGs in policy frameworks	Angola	Botswana	Burundi	Comoros	DRC	Eritrea	Eswatini	Ethiopia	Kenya	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Rwanda	Seychelles	South Africa	South Sudan	Tanzania	Uganda	Zambia	Zimbabwe
Mention and alignment of SDGs in general in any policy frameworks reviewed	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mention and alignment of SDG 3 (Ensure healthy lives and promote wellbeing for all at all ages)	Yes	Yes	Partial	Partial	Partial	Yes	Yes	Yes	Yes	No	Partial	Yes	Yes	No	Yes	Yes	Yes	Yes	Partial	Yes	Yes	Yes	Yes
SDG target 3.1 (Maternal death reduction)	Yes	Partial	Partial	Partial	Yes	No	Partial	No	Partial	No	Yes	Yes	Partial	No	Partial	Partial	Yes	Yes	Not clear/no data	Yes	Partial	Yes	Yes
SDG target 3.3 (HIV and other communicable disease reduction)	Yes	Partial	Yes	Partial	Partial	Yes	Yes	No	Partial	Partial	Partial	Yes	Yes	Yes	Partial	Partial	Yes	Yes	Not clear/no data	Partial	Partial	Yes	Partial
SDG target 3.7 (SRHR services)	No	Yes	Yes	Partial	Yes	No	Yes	No	Partial	Partial	Yes	Yes	Not clear/no data	No	Partial	Partial	Yes	Yes	Not clear/no data	Partial	Partial	Yes	Partial
SDG target 3.8 (Universal Health Coverage)	Partial	Partial	Partial	Partial	Partial	Yes	Yes	No	Yes	Partial	Partial	Yes	Partial	Yes	Partial	Partial	Partial	Partial	Not clear/no data	Partial	Partial	Yes	Partial
Mention and alignment of SDG 5 (Achieve gender equality and empower all women and girls)	No	Yes	Partial	Partial	Not clear/no data	No	Yes	Yes	Yes	Yes	Partial	Partial	Yes	Yes	Partial	Yes	Yes	Yes	Not clear/no data	Partial	Yes	Yes	Yes
SDG target 5.1 (End all forms of discrimination against women)	No	Partial	Partial	Partial	Partial	No	Partial	No	Partial	Partial	Partial	Partial	Partial	Yes	No	Partial	No	Yes	Not clear/no data	Partial	Partial	Partial	Partial
SDG target 5.2 (End violence against women)	No	Partial	Partial	Partial	Yes	No	Partial	No	Partial	Partial	Partial	Partial	Partial	Yes	Partial	Partial	Yes	Yes	Not clear/no data	Partial	Partial	Partial	Partial
SDG target 5.3 (Eliminate harmful practices)	No	Partial	Partial	Not clear/no data	Partial	No	Partial	Yes	Partial	Partial	Partial	Partial	Partial	Yes	Partial	Partial	No	Yes	Not clear/no data	Partial	Partial	Partial	Partial
SDG target 5.6 (Universal access to SRHR)	Yes	Partial	Partial	Yes	Partial	No	Partial	No	Partial	Partial	Partial	Partial	Not clear/no data	No	Not clear/no data	Partial	No	Yes	Not clear/no data	No	Partial	Partial	Partial

Yes Partial No Not clear/no data

All countries in ESA explicitly mention SDGs in their SRHR-related policy frameworks and align the frameworks to the SDGs. A total of 16 out of 23 countries specifically mention SDG 3 (Good health and well-being) in any of the SRHR-related policy frameworks reviewed and align the policies to this SDG. Only two countries (Lesotho and Mozambique) make no mention of SDG 3 in particular, while five countries are aligned to the SDG 3 thematic area despite not specifically mentioning SDG 3.

Overall 13 out of 23 countries explicitly mention SDG 5 (Gender equality) in any one of their SRHR-related policies and align the policies to SDG 5. It should, however, be noted that most country policies on gender – which by all intents and purposes can be said to be aligned to SDG 5 – were formulated prior to the adoption of the SDGs in 2015 and thus were not reviewed under the SDG assessment.

The policy frameworks reviewed rarely mention specific SDG targets. This is understandable because most SDG targets are operational or outcome targets which would be highlighted in programme documents, the assessment of which was outside the scope of this study.

The policy frameworks reviewed articulated the relevant thematic areas that needed interventions, especially those under SDG 3 (Good health and well-being), even if specific SDG targets were not cited. For example, most policies articulated reduction of maternal death (SDG target 3.1); reduction of HIV and other communicable diseases (SDG 3.3); promotion and provision of SRHR and services (SDG 3.7); and ensuring universal health coverage (SDG 3.8). It is noteworthy that Tanzanian[5] policy documents articulate actions in the area of RMNCAH and there is rare mention of SRHR, possibly suggesting that SRHR is integrated into RMNCAH. Data from South Sudan were missing.

[4] The table uses the 'traffic light' system where green denotes that a specific parameter is incorporated into the national framework; yellow denotes that the specific parameter is partially incorporated; and red denotes that the specific parameter is not incorporated.
[5] Data from Tanzania in this document do not include Zanzibar.

6.2. International Conference on Population and Development

The 1994 ICPD was one of the largest inter-governmental conferences on population and development where a programme of action was adopted that notably provided for women's reproductive health and rights to be central to development efforts.[6]

In this assessment, four provisions from the ICPD related to SRHR were selected as follows:

- ICPD IV – Gender Equality, Equity and Empowerment of Women
- ICPD V – The Family, Its Roles, Rights, Composition and Structure
- ICPD VII – Reproductive Rights and Reproductive Health
- ICPD VIII – Health Morbidity and Mortality
  - C – Women's health and safe motherhood
  - D – HIV and AIDS

Table 2 below shows the results of the extent to which the above provisions were incorporated in SRHR-related national policy frameworks.

Table 2: Extent to which selected International Conference on Population and Development provisions are incorporated in sexual and reproductive health and rights related national policies[7]

Mention and alignment of ICPD in policy frameworks	Angola	Botswana	Burundi	Comoros	DRC	Eritrea	Eswatini	Ethiopia	Kenya	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Rwanda	Seychelles	South Africa	South Sudan	Tanzania	Uganda	Zambia	Zimbabwe
Mention and alignment of ICPD in general in any of policy frameworks reviewed																							
ICPD IV – Gender Equality, Equality and Empowerment of Women																							
ICPD V – The Family, its Roles, Rights, Composition and Structure																							
ICPD VII – Reproductive Rights and Reproductive Health																							
ICPD VIII- Health Morbidity and Mortality (Women and HIV and AIDS)																							

Yes Partial No Not clear/no data

The majority of countries (17 out of 23) where data were available, explicitly mention ICPD in their SRHR-related policies and align the policies to the ICPD provisions. While policies rarely mention specific ICPD provisions, several policies articulate and seek to realize thematic focus areas that significantly overlap with specific ICPD provisions and SDG targets. These areas include gender equality, equity and empowerment of women (ICPD IV); reproductive rights and reproductive health (ICPD VII); and health morbidity and mortality (ICPD VIII). Notably, the roles, rights, composition and structure of families (ICPD V) and their impact on SRHR-related issues are rarely articulated in the national policies. Eritrea policy frameworks can be strengthened to increase their alignment to ICPD.

[6] https://www.unfpa.org/sites/default/files/pub-pdf/programme_of_action_Web%20ENGLISH.pdf.
[7] The table uses the 'traffic light' system where green denotes that a specific parameter is incorporated into the national framework; yellow denotes that the specific parameter is partially incorporated; and red denotes that the specific parameter is not incorporated.

7 Domestication of Continental Frameworks

7.1. Maputo Plan of Action (2016–2030) for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights

7.1.1. Background and context

The first MPoA was adopted in 2006 by the Special Session of African Union Health Ministers to implement the Continental Policy Framework on SRHR. This was at the time when the African Union developed the plan for Africa's structural transformation for 50 years – ***Agenda 2063: The Africa We Want.*** It was accompanied by a 10-year implementation plan to influence and further accelerate Africa's transformation and development beyond 2015. The first MPoA expired in 2015 and a comprehensive review of it (2007–2015) was conducted to inform the continental SRHR policy direction post 2015. This led to the revised MPoA 2016–2030 for the Operationalisation of the SRHR Continental Policy Framework which is consistent with Africa's Agenda 2063 (African Union Commission MPoA 2016).

7.1.2. Key provisions of the Maputo Plan of Action

The MPoA contains several elements of SRHR as represented in the box below:

Adolescent sexual and reproductive health

Prevention and management of cancers of the reproductive system

Maternal health and newborn care

Addressing mid-life concerns of men and women

Safe abortion care

Health and development

Family planning

Reduction of gender-based violence

Prevention and management of sexually transmitted infections, including HIV and AIDS

Interpersonal communication and counselling

Prevention and management of infertility

Health education

7.1.3. Countries that have adopted the Maputo Plan of Action

In the first MPoA (2007–2015), the following 48 African countries, 19 of which are in the ESA region, adopted[8] the MPoA: Algeria, **Angola**, Benin, **Botswana**, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, **Comoros**, Congo, Cote d'Ivoire, **Democratic Republic of Congo (DRC),** Djibouti, Egypt, **Ethiopia**, Gambia, Ghana, Guinea, Guinea Bissau, **Kenya**, **Lesotho**, Liberia, Libya, **Madagascar, Malawi**, Mali, Mauritania, **Mauritius, Mozambique, Namibia,** Niger, Nigeria, **Rwanda,** Sahrawi Arab Democratic Republic (SADR), Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, Somalia, **South Africa, Swaziland, Tanzania,** Togo, **Uganda, Zambia and Zimbabwe.**

7.1.4. Domestication progress at country level

This desk review isolated policy indicators from the MPoA[9] and used them to assess the extent to which the MPoA has been incorporated into SRHR-related policy frameworks in the 23 countries in ESA. This involved review of SRHR-related policies (a minimum of six policy frameworks per country) in each of the 23 ESA countries.[10]

For each indicator that was incorporated or operationalized in any of the country policy frameworks, a score of 1 was allocated; for an indicator that was partially incorporated or operationalized, a score of 0.5 was allocated. A score of 0 was allocated to indicators not incorporated, unclear or in cases of missing data. The scores

[8] Adoption here means the formal expression of consent by Member States affirming the form and content of the plan (see https://treaties.un.org/pages/overview.aspx?path=overview/glossary/page1_en.xml).
[9] See Maputo Plan of Action (2016–2030), page 11.
[10] See Appendices for list of country policy documents reviewed.

were added both for country and for indicator, and converted by a percentage based on the numbers of indicators and countries respectively. Table 3 indicates the extent to which the MPoA policy indicators were realized in the 23 countries in ESA.

Evidence from the 23 countries suggests good overall progress in the domestication of the MPoA policy framework. As can be observed from the Table 3 below, except for Seychelles and South Sudan, almost all countries in ESA have a costed roadmap for the reduction of maternal, newborn and child morbidity and mortality. The data were not sufficiently clear to verify this in Botswana and Comoros.

Similarly, there is substantial progress in ESA relating to countries putting in place national health policy frameworks and plans that integrate RMNCAH, HIV and AIDS, STI and malaria services. Most national health policies provide for this integration (e.g. Namibia's National Health Policy Framework 2010–2020; Rwanda's Fourth Health Sector Strategic Plan 2018–2024; and Botswana's National Guidelines for Health Services Integration 2021).

Analysis of country policies also shows that most countries are aligning to the continental or global RMNCAH commitments. Most policies reviewed, specifically indicate being informed by, and aligned to, SDGs (more prominently SDG 3 – Good health and well-being), the MPoA, and the Ouagadougou Declaration on Primary Health Care (PHC) and Health Systems. The policy review shows that, while some policies do not explicitly align themselves to regional and continental commitments and frameworks, most policies at least expressly align themselves to global commitments, notably the SDGs as presented in Section 7.1 above.

As Table 3 shows, a notable 89 per cent of ESA countries have put in place, policy frameworks guaranteeing women's access to SRH care, information and education. However, it must be noted that most of these country policies do not specify the MPoA age bracket (15–49 years) but provide for and guarantee universal access irrespective of age. Overall, 89 per cent of ESA countries have also made progress in putting in place policy frameworks to support RMNCAH services for young people.

While there is progress in countries formulating strategies and action plans to end child marriage (85 per cent of ESA countries), such strategies are hampered by local customs and religious ethos. This is a challenge even in countries with formal laws setting marriage age at 18 years and above, as illustrated by the following examples:

- In **Lesotho**, it is a challenge to reconcile local customs and culture with international standards and civil law.
- The efforts to end child marriage in **Tanzania** are contradicted by laws that set the age of consent for sexual activity at 14 years for girls (within Marriage Act), and allow girls aged 14 years to get married (with parental consent unless orphaned). While in 2019 the Court of Appeal declared these laws unconstitutional,[11] they are yet to be repealed.
- In **Botswana**, the Marriage Act 2001 that sets the minimum marriage age at 21 years, does not apply to customary or religious unions (Section 2 of the Act).
- Even in countries with formal laws to end child marriage like **Malawi**, the practice continues in rural areas.

No evidence of national strategies to end child marriage was found in Eritrea and Seychelles.

As Table 3 shows, there is no evidence of countries developing communication strategies and implementation plans for the MPoA. An exception is Eswatini, where health officials, during further consultations, indicated the strategy was being drafted. Communication strategies in the countries were mostly theme-specific, for example a communication strategy on voluntary medical male circumcision (VMMC) in Burundi.

Data was mostly not clear or available on country health budgets allocated for RMNCAH. There was readily available data on health sector allocation, with many countries expressly aiming to achieve the African Union Abuja Declaration target of 15 per cent of national budget allocated to health. Many countries,

[11] https://www.hrw.org/news/2019/10/25/victory-against-child-marriage-tanzania

however, are only achieving around 10 per cent and below. For example, South Sudan has been allocating 2 per cent of the national budget to its health sector for the past five years, and only improved to 7.9 per cent in 2021–2022. There is also a lack of available data on tracking financial resources for RMNCAH.

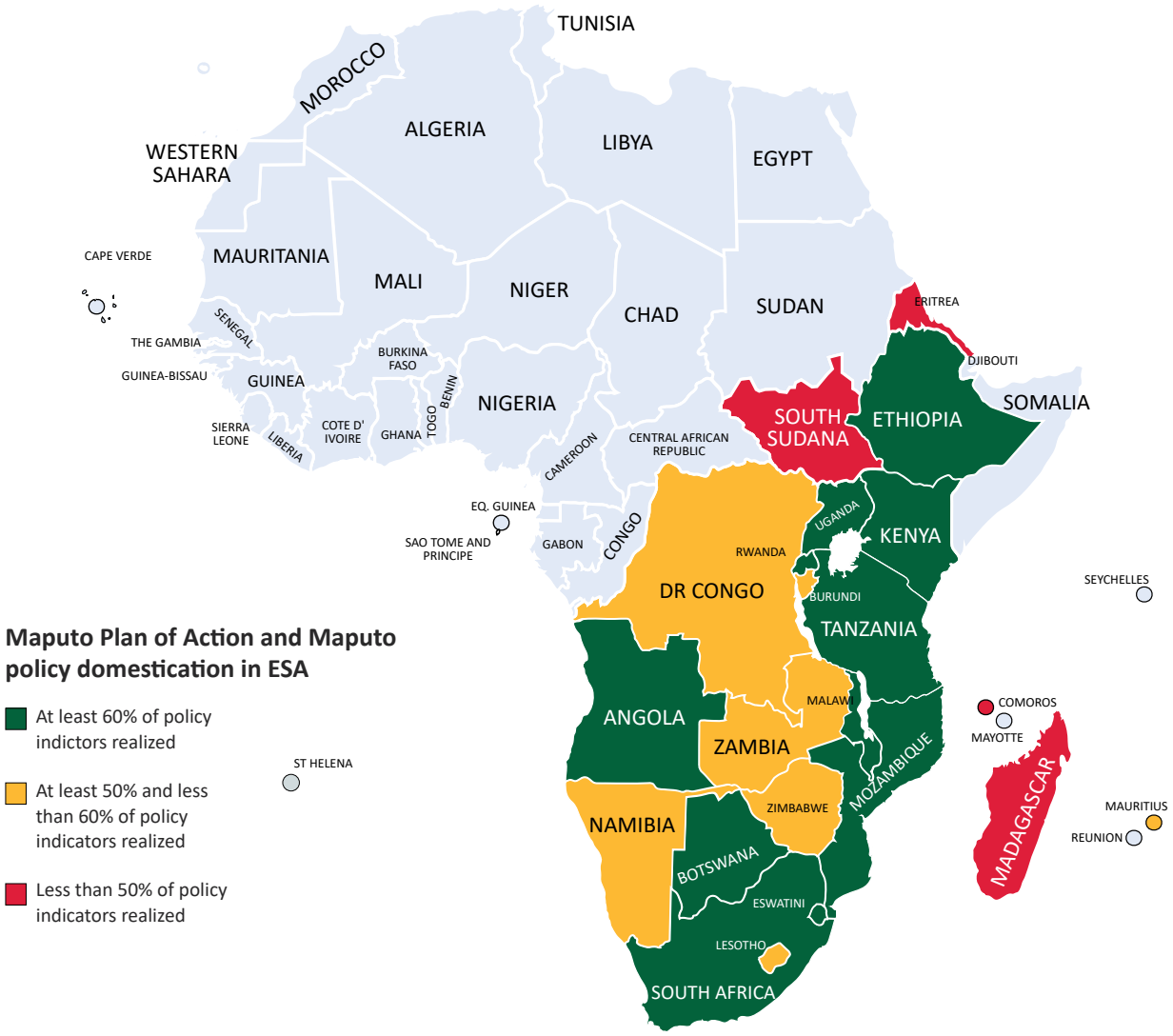
Table 3: Extent to which the Maputo Plan of Action policy indicators are realized in East and Southern Africa

MPoA Policy Indicators	Angola	Botswana	Burundi	Comoros	DRC	Eritrea	Eswatini	Ethiopia	Kenya	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Rwanda	Seychelles	South Africa	South Sudan	Tanzania	Uganda	Zambia	Zimbabwe	ESA (%)
Costed roadmap for the reduction of MNC morbidity and mortality																								83
National health policy frameworks and plans that integrate RMNCAH, HIV and AIDS, STI and malaria																								87
Communication Strategy and Implementation Plan for MPOA in place																								2
Achieving the continental/global RMNCAH commitments																								96
Country health budget allocated for RMNCAH																								9
National health accounts track RMNCAH allocations and expenditures																								24
Policy frameworks that guarantee women aged 15–49 yrs access to SRH care information and education																								89
Existence of policy, regulatory or legal frameworks to support RMNCAH services for young people																								89
Have national strategies and action plans on ending child marriage																								85
Preparing status report on unsafe abortion																								24
Implementing communications on strategy for RMNCAH that integrates gender, harmful traditional practices (HTPs) and GBV																								15
Existence of national health frameworks that links RMNCAH, HIV and AIDS, STI, malaria and TB services																								96
Existence of national reproductive cancer policy																								67
Fully complied with international Health Regulations 2005																								52
Implementing polices on public private partnership on SRHR																								63
Has integrated national Research, Innovation, Monitoring and Evaluation Systems (RIME)																								70
Has integrated national M&E Systems that captures equity trends																								41
Integrated national RIME systems that incorporated tracking financial resources for RMNCAH																								28
Legal and policy frameworks for local production of health equipment medicines and consumables																								74

Yes Partial No Not clear/no data

A composite for the MPoA policy indicators was created and depicts levels of MPoA integration by country (see Figure 1).

Figure 1: Levels of the Maputo Plan of Action policy integration in East and Southern Africa



Close to half of countries in ESA (11 out of 23 countries) have realized at least 60 per cent of the MPoA policy indicators. Comoros, Eritrea, Madagascar, Seychelles and South Sudan have realized less than 50 per cent of the MPoA policy indicators. South Sudan, as a relatively new country having gained independence from Sudan in 2011, is still in the process of establishing and consolidating systems. No data was available for Comoros, Eritrea and Seychelles.

7.2. Maputo Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2005)

7.2.1. Background and context

The Maputo Protocol was adopted in 2003 and came into force in 2005. It is a ground-breaking protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. The Maputo Protocol includes 32 Articles on women's and girls' rights and provides an explicit definition of discrimination against women, something which was notably absent in the African Charter (International Planned Parenthood Federation, 2018).

Women's rights have been recognized and guaranteed in all international human rights instruments, notably the Universal Declaration of Human Rights; the International Covenant on Civil and Political Rights; the International Covenant on Economic, Social and Cultural Rights; the Convention on the Elimination of All Forms of Discrimination Against Women and its Optional Protocol; the African Charter on the Rights and Welfare of the Child; and all other international and regional conventions and covenants relating to the rights of women as being inalienable, interdependent and indivisible human rights.

7.2.2. Country endorsements and reservations

In 2019, the African Union reported that 49 countries signed the Maputo Protocol and 42 ratified and deposited the protocol. In ESA, Botswana has neither signed nor ratified the Protocol. As reflected in Table 4, the countries that have signed, but not ratified are Burundi, Eritrea, Madagascar and South Sudan.

Table 4: Countries that have ratified Maputo Protocol in East and Southern Africa[12]

No	Country	Date of Signature	Date of Ratification	Date Deposited
1	Angola	22/01/2007	30/08/2007	09/11/2007
2	Botswana			
3	Burundi	03/12/2003		
4	Comoros	26/02/2004	18/03/2004	16/04/2004
5	Democratic Republic of Congo	27/02/2004	14/12/2011	06/08/2012
6	Eritrea	25/04/2012		
7	Eswatini	07/12/2004	05/10/2012	06/11/2012
8	Ethiopia	01/06/2004	18/07/2018	17/09/2019
9	Kenya	17/12/2003	06/10/2010	13/10/2010
10	Lesotho	27/02/2004	26/10/2004	05/11/2004
11	Madagascar	28/02/2004		
12	Malawi		20/05/2005	29/06/2005
13	Mauritius	29/01/2005	16/06/2017	23/06/2017
14	Mozambique	15/12/2003	09/12/2005	30/12/2005
15	Namibia	09/12/2003	11/08/2004	26/08/2004
16	Rwanda	19/12/2003	25/06/2004	01/07/2004
17	Seychelles	24/01/2006	09/03/2006	25/04/2006
18	South Africa	16/03/2004	17/12/2004	14/01/2005
19	South Sudan	24/01/2013		
20	Tanzania	05/11/2003	03/03/2007	07/05/2007
21	Uganda	18/12/2003	22/07/2010	22/07/2010
22	Zambia	03/08/2005	02/05/2006	07/06/2006
23	Zimbabwe	18/11/2003	15/04/2008	05/09/2008

[12] https://au.int/sites/default/files/treaties/37077-sl-PROTOCOL%20TO%20THE%20AFRICAN%20CHARTER%20ON%20HUMAN%20AND%20PEOPLE%27S%20RIGHTS%20ON%20THE%20RIGHTS%20OF%20WOMEN%20IN%20AFRICA.pdf

Despite these endorsements, some countries have raised reservations. This may impact the pace towards full and effective domestication. Table 5 presents examples of country reservations on the Maputo Protocol specific provisions (Equality Now, 2021).

Table 5: Country reservations to the Maputo Protocol

Country	Reservations
Kenya	❍ Article 10(3) which requires Member States to reduce military expenditure in favour of social development and the promotion of women. ❍ Article 14(2)(c) which provides access to health and reproductive rights including medical abortion in cases of sexual assault, rape, incest, and where pregnancy endangers the mental and physical health of the mother or the life of the mother or foetus.
Namibia	❍ Article 6(d) of the Protocol; until legislation regarding recording and registration of customary marriages is enacted. The Article requires that every marriage be recorded in writing and registered in accordance with national laws in order to be legally recognized.
South Africa	❍ Article 6(d) which requires that marriage should be recorded in writing and registered in accordance with national laws in order to be legally recognized. ❍ Article 6(h) which guarantees equal rights between men and women with respect to the nationality of their children except where it is contrary to national legislation or national security. It may remove inherent rights of citizenships and nationality from children.
Uganda	❍ Article 14(1)(a) and 14(2)(c) which mandates Member States to ensure that women's right to sexual and reproductive health is respected and promoted. These Articles have been interpreted to mean that women entirely have the right to control their fertility regardless of marital status and with regards to access to abortion, the State is not bound unless permitted by domestic legislation which expressly provides for abortion.
Mauritius	❍ Article 6(b) where these measures would be incompatible with provisions of the laws in force in Mauritius. ❍ Article 6(c) which states that monogamy is the preferred form of marriage and provides that the rights of women in marriage and family including in polygamous marital relationships are protected. ❍ Article 14(2)(c) which speaks to access to medical abortion in cases of sexual assault, rape and incest. This right is not provided when the matter has not been reported to the police or where the pregnancy has exceeded its fourteenth week.

7.2.3. Provisions for follow up /review processes

Article 62 of the African Charter on Human and Peoples' Rights provides for Member States to report to the African Union on legislative or other measures taken, with a view to giving effect to the rights and freedoms recognized and guaranteed by the Charter. This provision is also used in respect of the Maputo Protocol. Article 26(1) of the Maputo Protocol obligates Member States to report to the African Union every two years on the progress made in domesticating the Maputo Protocol. However, not all countries are doing this as can be seen from Figure 2. This process and its implications are expounded further.

7.2.4. Domestication progress

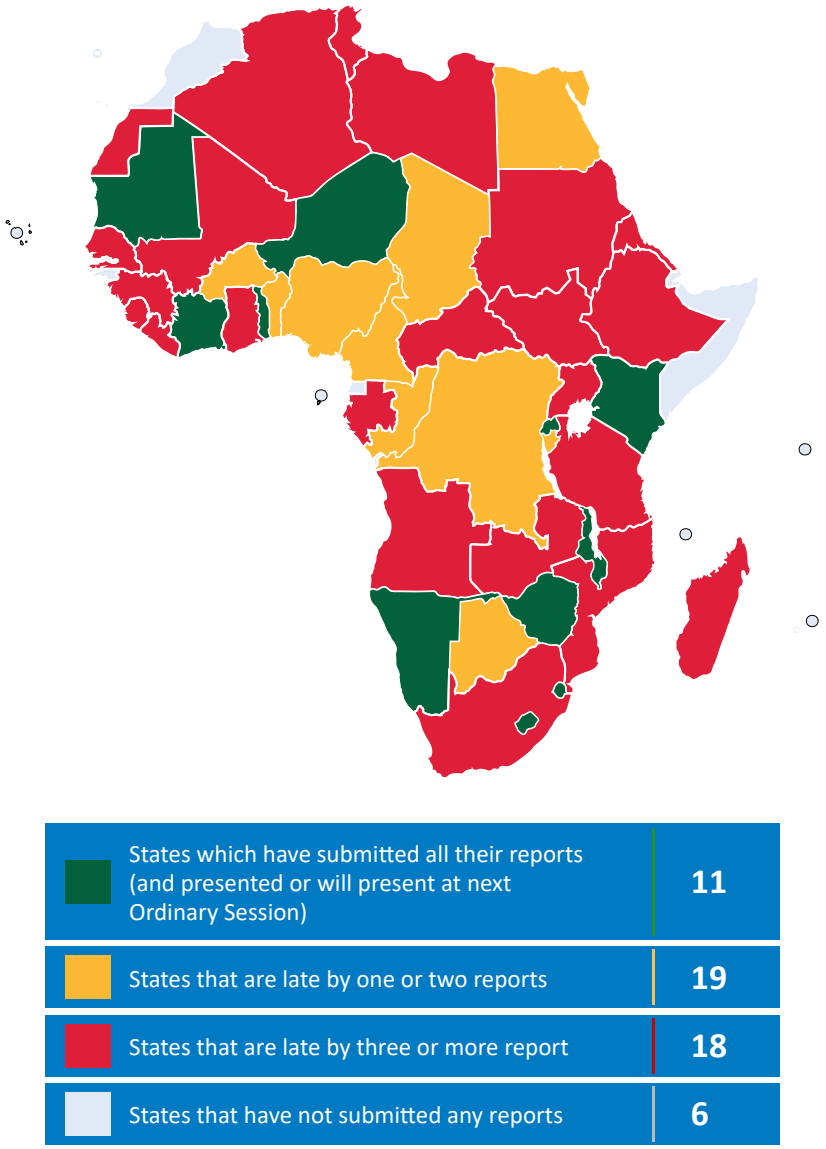
The review shows that in 17 out of 23 countries (74 per cent), at least one of the reviewed national policy frameworks makes direct reference to the Maputo Protocol as a continental framework that informed the formulation of the specific national framework. These national frameworks are largely those addressing SRHR and/or GBV thematic areas. Policies reviewed in Eritrea, Ethiopia, Namibia, Seychelles, South Africa and South Sudan do not make explicit reference to the Maputo Protocol though the policy provisions overlap significantly with Maputo Protocol provisions.

7.2.5 Country reports to the African Union on Maputo Protocol domestication

Figure 2 shows the status of countries' reports to the African Union on Maputo Protocol domestication progress. As mentioned, this is in line with the requirements of Article 62 of the African Charter on Human and People's Rights, which provides for Member States to report to the African Union on legislative or other measures taken to domesticate human rights protocols.

In ESA, only six countries (Eswatini, Kenya, Lesotho, Malawi, Namibia and Zimbabwe) have submitted all their reports. Botswana, DRC, Eritrea and Rwanda are late by one or two reports, while the rest are late by three or more reports.

Figure 2: Status of country reports to the African Union[13]



[13] https://achpr.au.int/en/state-reports/concluding-observations-and-recommendations-lesotho-combined-2nd-8th-period
https://achpr.au.int/index.php/en/state-reports/concluding-observations-and-recommendations-kenya-combined-8th-11th-period
https://www.maputoprotocol.up.ac.za/images/files/countries/concluding_observations/Zimbabwe_2021.pdf
https://achpr.au.int/index.php/en/state-reports/concluding-observations-and-recommendations-2nd-and-3rd-combined-periodic
https://achpr.au.int/index.php/en/state-reports/concluding-observations-and-recommendations-namibia-7th-periodic-report-2015
https://achpr.au.int/en/state-reports/kingdom-eswatini-combined-1st-9th-periodic-report-2001–2020

In the most recent reports submitted by the six countries that fully complied with Article 62, the African Union observed that the countries have put in place the necessary policy and legislative framework to promote the rights of women. These frameworks include policies and laws on marriage, GBV and land. Table 6 shows examples of the national frameworks from the six countries that give effect to the Maputo Protocol.

Table 6: Examples of national frameworks giving effect to the Maputo Protocol

Countries with updated reporting to African Union	Examples of frameworks giving effect to the Maputo Protocol
Eswatini	• National Strategy and Action Plan to End Violence against Women • The Sexual Offences and Domestic Violence Act of 2018
Kenya	• Female Genital Mutilation Act No. 32 of 2011 • Kenya National Policy on Gender and Development 2019
Lesotho	• Lesotho Gender and Development Policy 2018–2030 • National Action Plan on Gender-based Violence 2007
Malawi	• The Prevention of Domestic Violence Act • The Marriage Divorce and Family Relations Act • The Gender Equality Act • The HIV and AIDS (Prevention and Management) Act • The Customary Land Act
Namibia	• Namibia National Policy on Sexual, Reproductive and Child Health 2012–2022 • Namibia National Gender Policy 2010–2020
Zimbabwe	• Zimbabwe Gender Commission Act • Domestic Violence Act

The common areas of concern across the reporting countries include low participation of women in decision-making processes; strong patriarchal, cultural and religious values that hinder the promotion of women's rights; and weak implementation of the policies aimed at promoting women's rights. A notable example of weak implementation of the frameworks is, despite countries having in place frameworks to protect women, there are persistent harmful cultural practices, and early and forced marriages in communities.[14] The African Union concluding observations for Eswatini in 2022 also notes, "The Commission is concerned with the lack of effectiveness and implementation of the National Strategy and Action Plan to End Violence against women and the Sexual Offences and Domestic Violence Act of 2018".[15]

[14] African Union Concluding Observations and Recommendations - Zimbabwe: 11th, 12th, 13th, 14th and 15th Combined Periodic Report, 2007–2019; African Union Concluding Observations and Recommendations on Sixth Periodic Reports of the Republic of Namibia on the Implementation of the African Charter on Human and Peoples' Rights (2011–2013); https://www.maputoprotocol.up.ac.za/images/files/countries/concluding_observations/Zimbabwe_2021.pdf

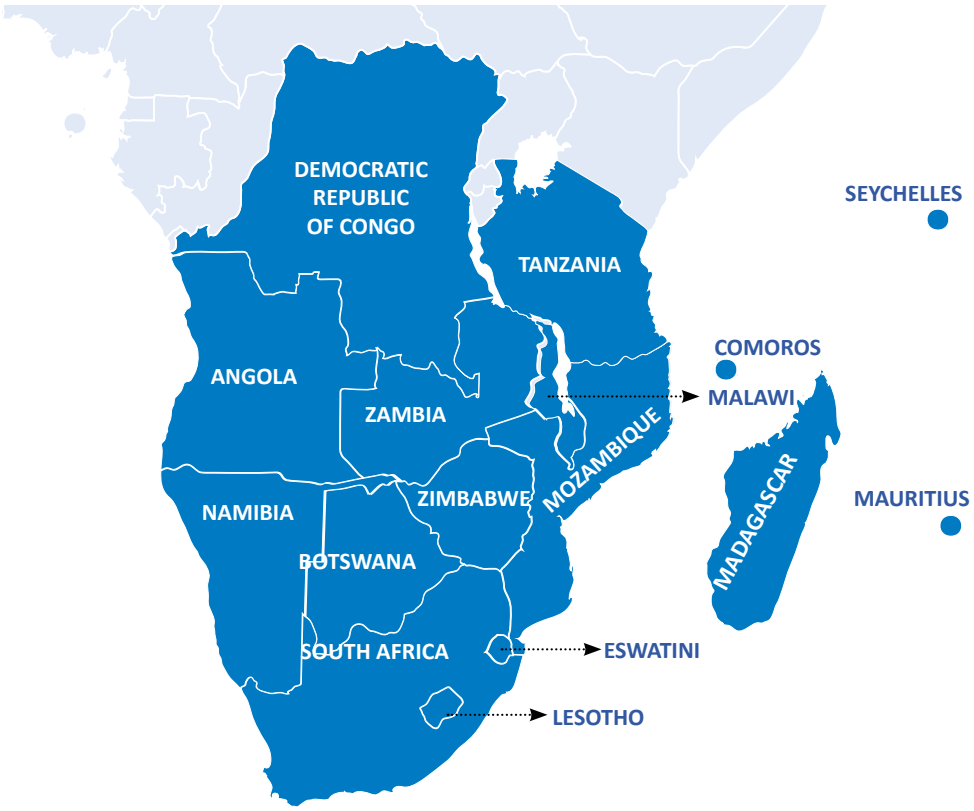
[15] African Union Concluding Observations and Recommendations on the Kingdom of Eswatini's Combined 1st to 9th Periodic Report on the implementation of the African Charter on Human and Peoples' Rights, and Initial Report on the Protocol to the African Charter on the Rights of Women in Africa (2022). https://achpr.au.int/en/state-reports/kingdom-eswatini-combined-1st-9th-periodic-report-2001-2020

8 Domestication of Regional Frameworks

8.1. Southern African Development Community sexual and reproductive health and rights policy

The SADC Protocol on Health forms the basis of health-related SADC frameworks, including those reviewed in this section. The protocol was formulated in 1999 and came into force in 2004 after ratification by two-thirds of the Member States. Key documents are the Strategy for SRHR in the SADC Region (2019–2030); Minimum Standards for the Integration of HIV and SRH in SADC; and the SADC Regional Strategy for HIV Prevention, Treatment and Care and Sexual and Reproductive Health and Rights among Key Populations. These SRHR frameworks are designed to operationalize the SADC Protocol on Health, notably Articles 16 and 17 that call for harmonization of reproductive health standards and provision of standard health services (SADC Protocol on Health, 1999).

Figure 3: Southern African Development Community Member States[16]



[16] https://www.sadc.int/member-states

8.1.1. Strategy for SRHR in the SADC Region (2019–2030) and Scorecard (2019–2030)

8.1.1.1 Background and context

The Strategy for SRHR in the SADC Region (2019–2030) (hereafter SADC SRHR Strategy), builds on the progress made in the region and on the SADC Sexual and Reproductive Health Strategy (2006–2015). The SADC SRHR Strategy aims to ensure that all people in the SADC region enjoy a healthy sexual and reproductive life; have sustainable access, coverage and quality SRHR services, information and education; and are fully able to realize and exercise their SRH rights as an integral component of sustainable human development in the SADC region. The SADC SRHR Scorecard is a strategic tool to track progress at a political level across the SADC region in the implementation of the SADC SRHR Strategy against core indicators. The indicators included in the Scorecard are multisectoral and seek to track progress on prevention of maternal mortality and newborn mortality; HIV and AIDS; sexual and gender-based violence (SGBV) and other harmful practices; unplanned pregnancies and unsafe abortion; teenage pregnancies; health systems; enabling environment; and barriers.

8.1.1.2 Policy indicators and domestication progress

Policy indicators were isolated from the SADC SRHR Scorecard to assess the extent to which these policy indicators have been realized or provided for in the national policy frameworks of SADC countries. This was achieved by reviewing SRHR-related policy frameworks from SADC Member States. The list of these policy frameworks is included in the Appendices. Table 7 shows the extent to which the SADC SRHR Scorecard policy indicators have been realized.[17] As can be noted, apart from Zambia and Zimbabwe, all countries in SADC have policies that allow adolescents to access SRH services without third party authorization, although this may not be matched by practice and other laws.

Almost all countries in SADC set minimum legal age of consent to marriage at 18 years. This, however, is hampered by the challenge of reconciling local customs and religious practices with international standards and formal law. Even in countries with formal laws to end child marriage like Malawi, child marriage is still common, especially in rural areas. In Botswana, the Marriage Act (2001) sets minimum marriage age at 21 years, although the law explicitly indicates that this does not apply to customary or religious unions (Section 2 of the Act).

Apart from South Africa where abortion is legal, abortion in SADC countries is either not permitted or only allowed under specific conditions, such as when the life of the mother is in danger.

Table 7: Extent of realization of Southern African Development Community sexual and reproductive health and rights policy indicators[17]

SADC Scorecard Policy Indicator	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Policies that allow adolescents to access SRH services without third party authorization	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
Minimum legal age of consent to marriage, 18 years for all irrespective of age	Yes	Partial	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Partial	Yes	Yes
Legal status of abortion	Partial	Partial	No	Partial	Partial	Partial	No	Partial	Partial	Partial	Partial	Partial	Yes	Partial	Partial	Partial

Yes Partial No

[17] The table uses the 'traffic light' system where green denotes that a specific parameter is incorporated into the national framework; yellow denotes that the specific parameter is partially incorporated; and red denotes that the specific parameter is not incorporated.

8.1.2. Minimum Standards for the Integration of HIV and Sexual and Reproductive Health in the SADC Region (2015)

8.1.2.1 Background and context

The Minimum Standards for the Integration of HIV and SRH in the SADC Region (2015) are aligned to, and seek to operationalize, other SADC SRH and HIV-related strategies, policies and guidelines. These Minimum Standards were developed following an extensive consultative process with Member States, development partners, civil society organizations (CSOs) working on HIV and/or SRH streams, and other stakeholders including representatives from youth-focused organizations. The Minimum Standards promote and harmonize integrated SRH and HIV services, policies and strategies of Member States.

8.1.2.2 Policy Minimum Standards and domestication progress

Policy indicators were isolated from the Minimum Standards and the extend to which they have been realized in SADC countries was assessed. This entailed a review of SRHR and HIV-related policy frameworks from SADC countries. A list of these policy frameworks is listed in the Appendices. Table 8 shows the status.

Table 8: Extent to which Southern African Development Community policy Minimum Standards have been realized[18]

SADC Minimum Standards Policy Indicators	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Review and revise relevant SRH and HIV policies to ensure integration of the two streams.	Yes	Yes	Yes	Yes	Yes	Yes	No data	Yes	Yes	Yes	Partial	Yes	Yes	Yes	Yes	Yes
Develop policies which address presentation of mother-to-child transmission and child survival using the double divided approach.	Yes	Yes	Yes	Yes	Yes	Yes	No data	Yes	No data	Yes	No data	Partial	Yes	Yes	No data	No data
Review and develop policies that integrate SRH and non-communicable disease issues.	Yes	Yes	Yes	Yes	Yes	No data	Yes	Yes	Yes	Yes	Yes	No	No data	Yes	Yes	Yes
Develop policies that support the provision of essential reproductive health commodities, age-appropriate services to adolescents and youth.	Yes	Yes	No data	No data	Yes	Yes	No data	Yes	No data	Yes	No data	Yes	Yes	Yes	No data	Yes
Review and revise Ministry of Education and other related polices to integrate SRH and HIV and provide CSE.	Yes	No	No data	Yes	Yes	Yes	No data	Yes	Yes	Yes	Yes	Yes	Yes	Partial	Yes	Yes
Review and revise or develop new policies that support access to integrated SRH and HIV services for key populations.	Yes	Partial	No data	No data	Yes	Yes	No data	Partial	No data	Partial	Yes	Partial	Yes	Partial	No data	No data
Review and revise national youth policies to ensure responsiveness to SRH and HIV integration for adolescents and youth.	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Partial	Yes	Yes	Partial	Yes	Yes	No data	No data
Develop policies which address the issue of SRH and HIV among the elderly.	Yes	Yes	Yes	Yes	Yes	Partial	No data	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No data
Review/develop legal frameworks based on assessment of legal frameworks which impact on key populations' access to SRH/HIV services.	Yes	Partial	No data	No data	No data	No data	No data	Yes	No data	Yes	No data	Partial	No data	Partial	No data	No data
Review/develop legal frameworks that promote zero rate taxation on importation of essential sexual, reproductive, maternal, newborn and child health and HIV life-saving commodities.	No data	No data	No data	No data	Partial	No data	No data	No data	No data	No data	No data	No	No data	No data	No data	No data
Review improve or/and enact new laws that address negative cultural practices that hinder optimal access to SRH and HIV services.	Yes	Partial	No data	No data	Partial	Yes	No data	Yes	No data	Yes	Yes	No	No data	Partial	Partial	Partial
Review improve or enact new laws to address GBV (and SGBV) against women, men, children, adolescents and youth.	Yes	Yes	Yes	No data	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Develop or enact laws that ensure access to and vitalization of SRH and HIV services by key populations.	Yes	Partial	No	No	Partial	No data	No	Partial	No	Partial	No data	Yes	Yes	Partial	No data	No data

Yes Partial No Not clear/no data

[18] The table uses the 'traffic light' system where green denotes that a specific parameter is incorporated into the national policy framework or practice; yellow denotes that the specific parameter is partially incorporated; and red denotes that the specific parameter is not incorporated.

As Table 8 shows, there is remarkable progress in review and integration of SRH and HIV policies (15 out of 16 countries), integration of SRH and non-communicable diseases (13 out of 16 countries), and review and enactment of laws to address GBV (14 out of 16 countries).

All policy provisions related to key populations have limited operationalization and applicability in SADC because same-sex sexual activity is illegal in all countries except Angola, Seychelles and South Africa. This implies that the lesbian, gay, bisexual, transgender, intersex or queer (LGBTIQ) community (as part of key populations) is often excluded from policy and practice.

There was a lack of data to meaningfully assess the extent of domestication of legal frameworks that promote zero rate taxation on importation of essential sexual, reproductive, maternal, newborn and child health and HIV life-saving commodities.

Angola, Eswatini, Malawi, Mozambique and Tanzania are among the SADC countries that have realized most policy indicators (at least 70 per cent) from the SADC SRHR Minimum Standards. There was insufficient data available for Comoros, DRC, Lesotho, Madagascar and Mauritius to make a meaningful conclusion.

8.1.3. SADC Regional Strategy for HIV Prevention, Treatment and Care and Sexual and Reproductive Health and Rights among Key Populations

8.1.3.1 Background and context

The KP Regional Strategy is designed to guide the adoption and institutionalization of a standard, comprehensive package that addresses the unique challenges in providing equitable and effective HIV and SRH rights and services to KPs in SADC. Additionally, the KP Regional Strategy aims to guide Member States in designing and implementing appropriate SRH and HIV prevention, treatment and care programmes for KPs, focusing on the major issues that need to be addressed at policy, legal, institutional and facility levels. The strategy was developed to address stigma, provide justice for KPs who are victims of violence, and improve access to quality services for KPs, among others.

8.1.3.2 Domestication progress

As part of assessing the extent to which the KP Regional Strategy has been incorporated in national policies in SADC countries, policy indicators were isolated from the Strategy and used as a benchmark to review SRHR-related national policies in SADC countries. A list of the policies is included in the Appendices. As can be observed from Table 9,[19] this is the least domesticated SRHR framework in SADC among the three reviewed in this assessment. In part, this is due to sparse and inconsistent data. As observed in section 8.1.2 above, all policy provisions related to KPs have limited applicability in SADC because same-sex sexual activity is illegal in all countries except Angola, Seychelles and South Africa. This implies the envisaged key population excluding the LGBTIQ community.

Table 9: Extent to which HIV and sexual and reproductive health and rights policy indicators on key populations have been realized

SADC HIV SRHR Key Population Policy indicator	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Member States with institutionalized mechanisms to address stigma against key populations.	Yes	Partial	Partial		Partial	Partial	Partial		Yes	Partial	Yes		Yes	Partial		Yes
Member States who have produced or updated a national key population stigma index.		Yes	No	Yes	Yes			No	Yes		Yes	No			Partial	Yes
Member States providing legal aid services to key populations.	Yes	Partial	Partial	Partial		Partial	Partial	Yes	Yes	Partial		Partial		Partial	Partial	
Member States implementing minimum basic package of service for key populations.	Yes	Partial		Yes	Yes	Partial	Partial		Yes	Partial	Yes	Partial				Yes
Member States with functional Technical Working Groups representing key populations.	Yes	Partial			Yes	Yes	Partial		Yes	Partial	Yes	Yes	Yes	Partial		
Member States having specific budgets allocations for key population interventions.						Partial						No				
Member States mobilizing additional financial resources from development partners for key population interventions.		Partial				Yes	Partial			Partial	Yes			Partial		
Member States conducting Integrated HIV Bio-Behavioural Surveillance Studies of key population groups.	Partial	Partial			Partial					Partial	Yes	Yes			Yes	Yes
Member States with mechanisms to ensure participation of key populations in the design and implement of programmes.	Yes	Partial			Yes	Yes	Partial			Yes	Yes		Yes	Partial	Partial	
Member States with nationally validated legal environment assessments on HIV and SRH.								Yes	Yes		Yes	Yes			Yes	Yes
Best practices on removing legal and policy barriers for key populations documented and shared.	Yes											Yes				Yes

Yes Partial No Not clear/no data

[19] The table uses the 'traffic light' system where green denotes that a specific parameter is incorporated into the national policy framework or practice; yellow denotes that the specific parameter is partially incorporated; and red denotes that the specific parameter is not incorporated.

There is, however, a growing recognition among policy makers to include the LGBTIQ community in SRHR and HIV policy and interventions, even in countries where same-sex sexual activity is illegal. For example, in Zimbabwe, a delegation of 70 Members of Parliament (MPs), led by the Parliamentary Committee on Health, visited an LGBTIQ drop-in centre in Mutare. It is therefore encouraging that some Parliamentarians are actively engaged in promoting the rights of KPs within SADC.

8.2. East African Community sexual and reproductive health and rights policy domestication

The EAC is made up of seven countries, namely Burundi, DRC, Kenya, Rwanda, South Sudan, Tanzania and Uganda. The mission of the EAC is to widen and deepen economic, political, social and cultural integration in order to improve the quality of life of the people of East Africa through increased competitiveness, value added production, trade and investments.[20]

Figure 4: East African Community Partner States[20]

[20] https://www.eac.int/about-eac.

8.2.1. EAC Integrated Reproductive Maternal Newborn Child and Adolescent Health (RMNCAH) Policy Guideline (2016–2030) and EAC RMNCAH Scorecard

8.2.1.1 Background and context

The EAC Integrated RMNCAH Policy Guideline (2016–2030) seeks to build on the momentum for women's and children's health. It articulates regional policy positions that will potentially accelerate elimination of preventable maternal, under-five and adolescent deaths in the EAC Partner States by 2030. This is in line with the SDGs and the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030).

The EAC Integrated RMNCAH Policy Guideline focuses on:

Harmonization and integration of packages of essential RMNCAH services

Strengthening of health systems towards universal coverage of RMNCAH

Building of high impact partnership models for RMNCAH

Strengthening of RMNCAH research, innovations in the EAC

8.2.1.2 Domestication progress

No policy framework reviewed in the seven EAC countries in the areas of SRHR, HIV and GBV makes direct reference to the EAC Integrated RMNCAH Policy Guideline. There is, however, reference to the EAC Treaty in Uganda's Ministry of Health Strategic Plan 2021–2025 and Tanzania's Health Sector Strategic Plan V, 2021–2026. The Uganda Ministry of Health Strategic Plan 2021–2025 indicates that one of its premises is the Treaty for the establishment of the EAC (Article 118) which seeks to promote joint action towards the prevention and control of communicable and non-communicable diseases.

Despite the Integrated RMNCAH Policy Guideline not being explicitly reflected in key policy frameworks in SRHR, HIV and GBV, there have been efforts at implementation level to realize the EAC RMNCAH Policy. For instance, Uganda finalized and disseminated its reporting on the EAC RMNCAH Scorecard and used it to develop action points to strengthen programme implementation (UNAIDS, UNFPA, UNICEF and WHO, 2020). It should also be noted that all Partner States of the EAC have reported on the EAC Integrated RMNCAH Scorecard since its inception in 2014. Realization of the policy frameworks at programme level is, however, outside the scope of this assessment.

9 Discussion

This desk review shows that countries in ESA are making varying efforts and progress in domesticating global, continental and regional frameworks. This progress notwithstanding, analysis of selected national policies in SRHR, HIV and AIDS and GBV in the 23 countries reveals there is a deliberate effort to align national policy frameworks to relevant global, continental and regional standards, as well as to other national policies and priorities. At least one policy analysed in each of the 23 countries made direct reference to being guided by a global, continental or regional SRHR framework.

Since domestication depends largely on a country's legal and political context, the global, continental and regional frameworks often do not provide comprehensive guidance on procedural domestication, other than providing guidance on focus areas and generic monitoring in some cases. Further, enforcing compliance to international standards and norms becomes a challenge. Motivating countries to report back to international fora on the progress of domestication of specific standards (as is the case with the Maputo Protocol reporting at the African Union for instance), is one way of creating a community of practice and accelerating domestication. The RECs' capacities need to be strengthened to play the required leadership and coordination role in monitoring the domestication of the frameworks and ensuring reporting by Member States. Longer term sustainability strategies are required where this role is integrated into the overall mandate of the RECs. Collaboration between the RECs and such international bodies as the United Nations can enhance the technical and financial capacity to accelerate and monitor domestication and reporting. The evidence-based advocacy role of the civil society in this regard also plays a significant role to ensure that frameworks are aligned to government commitments, and to hold governments to account for progress made. This includes working in partnership with governments to find common solutions.

While good progress has been made at the policy level, lack of enabling laws and practices remain a challenge. Challenges to implementation of the SRHR policies at national level have further negative implication on full and effective domestication of international standards. These challenges include cultural norms and practices that are opposed to set policy standards, such as the prevalence on child marriages amidst policies; inconsistency in law and the application of the law regarding the age of consent to marriage that in most countries is set at 18 years; laws and policies that limit adolescents' and women's access to information, education and services on key SRH services and in turn, limit their ability to exercise their right to bodily autonomy; and laws that limit the liberty of certain population groups and in so doing, undermines SRH outcomes. Such policy and behavioural barriers may be resolved through the use of carefully planned social and behaviour change strategies. Most of these factors are expounded in the companion report on facilitators and barriers to domestication that has been presented separately.[21]

[21] Jana, M., Sisimayi,T., Madondo, T., Nkubizi, C., Weiner, R., Clacherty, J. and Monteiro, M. (2023). Assessment of the Domestication of Global, Continental and Regional Framework into National Policies, Strategies and Frameworks in East and Southern Africa: Facilitators and Barriers. Johannesburg: Research and Training for Health and Development.

10 Recommendations

Based on this desk review, the following recommendations are made:

10.1. Maputo Plan of Action domestication

No.	Issue	Recommendation
1.	Budget allocation to health, let alone RMNCAH, is low, unclear and rarely monitored.	Support countries to strengthen data collection on the proportion of health budget allocated to health and to track progress on expenditure related to SRHR in health budgets. Additionally, in countries where the budgets are lower than the 15% target as per the African Union Abuja Declaration, countries must be capacitated to advocate for increase budget allocation to health to meet this target. Capacity strengthening could involve working with government, government-allied institutions and civil society to develop and present policy dialogue and policy papers to duty bearers advocating for an increase in health budgets.
2.	Only 24% of countries have developed status reports on unsafe abortion.	Support countries to undertake and develop status reports on unsafe abortion which should include: • A focus on both the demand side and supply side (formal and informal) of unsafe abortion. • A cost-benefit analysis of the unsafe abortion and estimates on the potentially avoidable costs. • Recommendations on the strategic approaches for advocacy for provision of safe abortion and post abortion care services.
3.	Only 15% of countries implementing communication strategies for RMNCAH that integrates gender, harmful traditional practices and GBV.	Support countries to develop integrated communication strategies for RMNCAH. This process can be expedited by engaging experts to lead the processes, ensuring in-depth stakeholder participation.
4.	Only 28% of countries have integrated national research, innovation and M&E systems that incorporate tracking financial resources for RMNCAH.	Support countries to develop integrated M&E strategies and mechanisms for reporting on SRHR and RMNCAH.
5.	Even in countries where the minimum age for marriage is 18 years, customary law and/or practices still promote child marriage.	Advocate for alignment between formal law, customary law and cultural practices (especially in rural areas) to end child marriage.
6.	No clear communication and implementation strategy for MPoA at country level.	Support Member States to develop communication and implementation strategies for MPoA. The strategies must be developed in close consultation with relevant stakeholders, be widely disseminated and periodically reviewed and updated in response to changing context. This process can be expedited by engaging experts to lead the processes, ensuring in-depth stakeholder participation.
7.	Comoros, Eritrea, Madagascar, Seychelles and South Sudan have achieved less than 50% of MPoA policy indicators.	Engage and provide technical support to Comoros, Eritrea, Madagascar, Seychelles and South Sudan to accelerate domestication of MPoA.

10.2. Maputo Protocol domestication

No.	Issue	Recommendation	Remarks
8.	In ESA, 17 out of 23 countries have missed their reporting to the African Union on Maputo Protocol domestication.	Advocate for countries to report to African Union on Maputo Protocol domestication progress as required by Article 62 of the African Charter on Human and Peoples' Rights, to promote accountability and motivate domestication of the Protocol. Advocate for countries to act on recommendations from African Union observations on Maputo Protocol domestication progress.	The practice of countries reporting back to international fora on domestication progress of specific international standards should be encouraged across all international standards of interest.
9.	Countries' reservations on specific provisions of the Protocol are hampering full and effective domestication of the Protocol.	Advocate for countries to work on and address reservations to the Protocol with a view to lifting the reservations, full adoption and domestication of the Protocol.	
10.	Continued contestations related to women's and girls' rights, and culture and patriarchal norms and structures which are frequently invoked to justify violations of women's and girls' rights.	Design and implement social and behaviour change communication strategies aimed at addressing norms and cultural practices that violate women's and girls' rights at country level.	
11.	National legislation often does not fully and clearly articulate women's and girls' reproductive freedoms, including their rights to control fertility, to decide on the number, timing and spacing of pregnancies, and to choose a method of contraception. Instead, these issues are only reflected in policy or strategic frameworks which may not be enforceable in the absence of an enabling Act.	Advocate for formulation, passing and implementation of laws to give effect to policies and strategies that fully and clearly articulate women's and girls' reproductive freedoms.	

10.3. SADC SRHR Strategy and Scorecard (2019–2030)

No.	Issue	Recommendation	Remarks
12.	Budget allocation to health is low.	Advocate for increase in budget allocation to health to meet the African Union Abuja Declaration target of 15%.	As per the detailed recommendations in 10.1 (No.1).
13.	Even in countries where the minimum age for marriage is 18 years, customary law and/or practices still promote child marriage.	Advocate for alignment between formal law, customary law and cultural practices (especially in rural areas) to end child marriage.	

10.4. Minimum Standards for the Integration of HIV and Sexual and Reproductive Health in the SADC Region (2015) and SADC Regional Strategy for HIV Prevention, Treatment and Care and Sexual and Reproductive Health and Rights among Key Populations

No.	Issue	Recommendation	Remarks
14.	All policy provisions related to KPs have limited operationalization and applicability in SADC because same-sex sexual activity is illegal in all countries except Angola, Namibia, Seychelles and South Africa. This implies that the LGBTIQ community (a key population) is often excluded from policy and interventions.	Advocate for the recognition and inclusion of key populations (including the LGBTIQ community) in policies, laws and interventions.	As per the detailed recommendations in 10.1 (No.1).

10.5. EAC Integrated Reproductive Maternal Newborn Child and Adolescent Health (RMNCAH) Policy Guideline (2016–2030)

No.	Issue	Recommendation
15.	No policy framework reviewed in the seven EAC countries in the areas of SRHR, HIV and GBV makes direct reference to the EAC Integrated RMNCAH Policy Guideline.	Advocate for the recognition and alignment of national SRHR strategies to the EAC Integrated RMNCAH Policy Guideline.

Appendices

11.1. List of policy documents reviewed

11.1.1. Global level

- Sustainable Development Goals (SDGs); https://sustainabledevelopment.un.org/content/documents/21252030%20Agenda%20for%20Sustainable%20Development%20web.pdf
- International Conference on Population and Development (ICPD) Programme of Action; https://www.unfpa.org/sites/default/files/pub-pdf/programme_of_action_Web%20ENGLISH.pdf

11.1.2. Continental level

- Maputo Plan of Action (2016–2030) for the Operationalisation of the Continental Policy Framework for SRHR
- Maputo Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2005)
- Continental Policy Framework on SRHR (2006)
- Africa Health Strategy 2016–2030
- African Union Humanitarian Policy Framework (2016–2030)
- Migration policy framework for Africa and plan of action (2018–2030)

11.1.3. Regional level

Southern African Development Community

- SADC SRHR Strategy and Scorecard (2019–2030)
- Minimum Standards for the Integration of HIV and Sexual and Reproductive Health in the SADC Region (2015)
- SADC Regional Strategy for HIV Prevention, Treatment and Care and Sexual and Reproductive Health and Rights among Key Populations
- SADC Disaster Preparedness and Response Strategy and Fund (2016–2030)

East African Community

- EAC Integrated Reproductive Maternal Newborn Child And Adolescent Health (RMNCAH) Policy Guideline (2016–2030) and EAC RMNCAH Scorecard
- EAC Minimum Standards for Reproductive, Maternal, Newborn, Child and Adolescent Health and HIV Integration and Linkages
- East and Horn of Africa Regional Strategy (migration) (2020–2024)
- Joint Interim Guidance on Continuity of Essential Health and Nutrition Services during the COVID-19 Pandemic (2020)

11.1.4. Country Level

11.1.4.1 Angola

- Governo de Angola. 2018. Plano de Desenvolvimento Nacional 2018–2022. Luanda: Ministério da Economia e Planeamento
- República de Angola. 2010. Decreto Presidencial nº. 262/10, de 24 de Novembro. Aprova a Política Nacional de Saúde. D.R. nº 222, I série. Luanda: Diário da República
- República de Angola. 2012. Plano Nacional de Desenvolvimento Sanitário 2012–2025. Vol. 1. Luanda: Ministério da Saúde
- República de Angola. 2012. Plano Nacional de Desenvolvimento Sanitário 2012–2025. Vol. 2. Luanda: Ministério da Saúde
- República de Angola. 2012. Plano Nacional de Desenvolvimento Sanitário 2012–2025. Vol. 3. Luanda: Ministério da Saúde
- República de Angola. 1992. Lei de Bases do Sistema Nacional de Saúde (Lei 21-B/92, de 21 de Fevereiro de 1992). Luanda
- República de Angola. 2020. Lei 38/20, de 11 de Novembro de 2020 (Lei do Código Penal). Luanda: Diário da República
- República de Angola. 2013. Decreto Presidencial n.º 222-13 – Política Nacional para Igualdade e Equidade de Gênero. Luanda: Diário da República
- República de Angola. 2011. Lei n.º 25/11, de 14 de Julho de 2011 (Lei Contra a Violência Doméstica). Luanda: Diário da República
- República de Angola. 2013. Decreto Presidencial n.º 26/13 – Plano Executivo Contra a Violência Doméstica. Luanda: Diário da República
- Ministério da Saúde – Direcção Nacional de Saúde Pública. 2011. Roteiro Nacional para Acelerar a Redução da Mortalidade Materna e Neonatal. Luanda: MINSA–DNSP
- Ministério da Saúde de Angola – Direcção Nacional de Saúde Pública. 2008. Plano Estratégico Nacional de Saúde Sexual e Reprodutiva 2008–2015. Luanda: MINSA–DNSP
- República de Angola. 2004. Lei nº 8/04 sobre o Vírus da Imunodeficiência Humana (VIH) e a Síndroma de Imunodeficiência Adquirida (SIDA). Luanda: Diário da República
- Ministério da Saúde de Angola. 2014. V Plano Estratégico Nacional de Resposta às ITS-VIH/SIDA e Hepatites Virais 2015–2018. Luanda: Instituto Nacional de Luta contra a SIDA

11.1.4.2 Botswana

- Government of Botswana (GOB) (2011), National Health Policy 2011
- GOB (2021), National Guidelines for Health Services Integration 2021: Reproductive, Maternal, Neonatal, Child and Adolescent Health plus Nutrition, Non-communicable diseases and other services
- GOB (2008), Policy Guidance on Male involvement in SRH, HIV/AIDS and GBV Prevention and Management: An Addendum to SRH Policy Guidelines and Service Standards 2008
- GOB (2010), Essential Health Service Package (2010–2020)
- GOB (2001), Marriage Act
- GOB, Integrated Health Service plan
- GOB (2012), National cervical cancer prevention strategic plan (2012–2016)
- GOB, Integrated Diseases Surveillance and Response Strategy
- GOB (2005), National Drugs (Medicine) Policy 2005
- https://abortion-policies.srhr.org/country/botswana/
- https://www.who.int/news-room/feature-stories/detail/botswana-award-feature
- https://botswana.unfpa.org/sites/default/files/pub-pdf/Botswana%20CPD.pdf
- https://www.theguardian.com/global-development/2021/nov/29/botswana-upholds-ruling-decriminalising-same-sex-relationships
- GOB (2014), National AIDS Coordinating Agency 2014
- EANNASO (2017), https://eannaso.org/?mdocs-file=9610

11.1.4.3 Burundi

- Republic of Burundi (2016), National Health Policy (2016–2025)
- Burundi RMNCAH Scorecard Tool
- Republic of Burundi (2012), National Gender Policy (2012–2025)
- Republic of Burundi, Ministry of Environment, Agriculture and Livestock Gender Strategy 2020
- Republic of Burundi (2018), National Development Plan (2018–2027)
- Republic of Burundi 2018 Constitution.
- Republic of Burundi (2019), National Strategic Plan for Sexual Reproductive, Maternal, Neonatal, Infant and Adolescents health (2019–2023).
- Republic of Burundi (2007), Sexual Reproductive Health National Policy (2007).
- Republic of Burundi (2013), Sexual Reproductive Health Strategic Plan (2013–2015)
- Republic of Burundi (2016), The National Youth Policy: 2016–2026.
- Burundi Humanitarian Response Plan 2019, 2020, 2021, 2022.
- Gender and Community Development Analysis in Burundi 2009 (study conducted by East African Community)

- ALMA Scorecard Hub: RMNCAH scorecard tool supports accountability and action as countries prioritise adolescent health
- Lagarde, L., 2020. Burundi Bibliography 2019. The University of Texas. Available at: https://medialibrary.uantwerpen.be/oldcontent/container49545/files/DPP/BibGenBdi2019.pdf
- Unicef Burundi Health Budget Brief 2021–2022. Available at Burundi Budget Briefs 2021/22. UNICEF Eastern and Southern Africa
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United Nations Population Fund
East and Southern Africa
9 Simba Road / PO Box 2980,
Sunninghill, Johannesburg,
2191 / 2157, South Africa

Tel: +27 11 603 5300
Website: esaro.unfpa.org
Email: comms-team-esaro@unfpa.org
Twitter: @UNFPA_ESARO
Facebook: UNFPA East and Southern Africa
LinkedIn: UNFPA East and Southern Africa
Instagram: unfpaesaro

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