Equality Now

A just world for all women and girls

Harmonisation of national sexual and reproductive health rights laws with Article 14 of the Maputo Protocol

October 2026

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List of acronyms and abbreviations

ACHPR	African Commission on Human and Peoples' Rights
AIDS	Acquired Immunodeficiency Syndrome
APH	Antepartum Haemorrhage
AU	African Union
CEDAW	Convention on / Committee on the Elimination of All Forms of Discrimination against Women
CEHURD	Centre for Health, Human Rights and Development
CEP	Community Empowerment Programme
CHPS	Community-based Health Planning and Services
CHW	Community Health Worker
CNGOB	National Association of Gynaecologists (Collège National des Gynécologues Obstétriciens du Bénin)
CNLPE	Comité National de Lutte Contre la Pratique de l'Excision (National Committee to Combat the Practice of Excision)
CNLS	National AIDS Council (Conseil National de Lutte contre le Sida)
CPF	Code of Persons and the Family
CRC	Convention on / Committee on the Rights of the Child
CSE	Comprehensive Sexuality Education
CSOs	Civil Society Organisations
EAC	East African Community
ECOWAS	Economic Community of West African States
FCT	Federal Capital Territory
FGM	Female Genital Mutilation
FIDA-K	Federation of Women Lawyers Kenya
GBV	Gender-Based Violence
GHS	Ghana Health Service
HIV	Human Immunodeficiency Virus
HRC	Human Rights Council

ICPD	International Conference on Population and Development
MOH	Ministry of Health
NGOs	Non-Governmental Organisations
NHIF	National Health Insurance Fund
NHIS	National Health Insurance Scheme
NRHP	National Reproductive Health Policy
ODA	Official Development Assistance
PAC	Post-Abortion Care
PPH	Postpartum Haemorrhage
RJIF	Reproductive Justice Initiative Foundation
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SADC	Southern African Development Community
SDGs	Sustainable Development Goals
SHI	Social Health Insurance
SNEEG	Stratégie Nationale pour l'Équité et l'Égalité de Genre (National Strategy for Gender Equity and Equality)
SRHR	Sexual and Reproductive Health and Rights
SRRWA	Special Rapporteur on the Rights of Women in Africa
STIs	Sexually Transmitted Infections
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VAPP	Violence Against Persons (Prohibition) Act
WHO	World Health Organization

Executive summary

Overview and purpose

This report delivers a comprehensive and detailed assessment of the degree to which the national SRHR laws in eight selected African nations, specifically **Benin, Burkina Faso, Ghana, Kenya, Nigeria, Rwanda, Senegal**, and **Uganda**, are aligned with **Article 14** of the **Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa** (the **Maputo Protocol**), as well as with broader regional SRHR frameworks. The **Maputo Protocol** stands as a landmark legal instrument for advancing women's rights across Africa, and its **Article 14** is particularly significant as it explicitly protects women's[1] right to comprehensive control over their sexual and reproductive health, including the right to abortion in certain circumstances.

The central objective of this study is to meticulously evaluate the existing legislative and policy landscapes on SRHR within these target countries to determine their respective levels of harmonisation with the **Maputo Protocol**. By systematically identifying the specific gaps and inconsistencies between international law and domestic legal realities, this report provides actionable insights. It is intended to be a valuable resource to support law and policy makers, civil society organisations and legal advocates in their ongoing efforts to strengthen the national legal frameworks that are essential for effectively safeguarding the health and fundamental rights of all women and girls.

Key findings

The comparative analysis of the eight target countries reveals significant insights into the harmonisation of national sexual and reproductive health and rights (SRHR) laws with **Article 14** of the **Maputo Protocol**. The following findings highlight areas of progress, successful initiatives, and persistent challenges that hinder full harmonisation.

- All eight countries have successfully enshrined the right to health and equality within their national constitutions. However, **Ghana** and **Nigeria** do so only partially or indirectly, rather than through a fully explicit, standalone right-to-health clause, as seen in other nations.
- Of the eight countries studied, **Benin, Ghana,** and **Rwanda** have established legal frameworks that are fully aligned with **Article 14** of the **Maputo Protocol.** This represents only 37.5% of the total group.
- Each of the eight countries has successfully embedded SRHR priorities in their national health policies.
- Furthermore, all eight countries have taken steps to strengthen their legal provisions against harmful traditional practices, specifically targeting issues such as FGM and child marriage.
- **Benin** is a regional leader, having enacted **Law No. 2021-12** to expand access to abortion beyond the minimum international standards. The country is also making ongoing efforts to improve services for contraception and prevention of gender-based violence. **Law No. 2021-12** significantly liberalised abortion access, aligning with **Article 14** by allowing pregnancy termination based on material, educational, professional or moral distress.
- **Ghana** stands out for its progressive abortion laws and robust reproductive health policies, setting a regional benchmark. Amendments to the **Criminal Offences Act** allow abortion in cases of rape, incest, or when the pregnancy poses a risk to physical or mental health.
- **Rwanda** and **Kenya** embed SRHR priorities into national health policies and insurance schemes, resulting in more integrated service delivery models.
- Reservations to **Article 14** of the **Maputo Protocol** remain a significant barrier in **Uganda** and **Kenya**. In contrast, **Senegal's** reservation-free ratification alone does not guarantee domestic alignment.
  - **Uganda** holds reservations to **Articles 14(1)(a)** and **14(2)(c)**.
  - **Kenya** maintains a reservation to **Article 14(2)(c)**.

- The three countries (**Nigeria, Senegal** and **Uganda**) maintain the most restrictive frameworks, permitting abortion only to save the woman's life or under similarly narrow conditions. None is fully aligned with **Article 14** of the **Maputo Protocol**.

- **Burkina Faso** and **Kenya** permit abortion on broader grounds but are only partially aligned with the **Maputo Protocol**. **Burkina Faso** allows abortion in cases of rape, incest, or when the pregnancy poses a grave risk to the health or life of the woman. However, it does not explicitly include the endangerment of the patient's mental health, as specified in **Article 14(2)(c)** of the **Maputo Protocol**. **Kenya**, on the other hand, allows abortion only if the mother's life or health is in danger, or if other written laws permit it.

- **Kenya** and **Rwanda** embed SRHR priorities into national health policies and insurance schemes, resulting in more integrated service delivery models.

- Despite having comprehensive legal frameworks, **Burkina Faso** has yet to achieve full alignment, with restrictive procedural rules and significant barriers for rural populations, compounded by a debilitating security crisis that undermines health infrastructure.

- **Nigeria** exemplifies the complex challenge of federal systems, where state-level inconsistencies and delays in adopting key laws, such as the **Violence Against Persons Prohibition (VAPP) Act** and the **Child Rights Act**, often hinder progressive federal policies.

- The harmonisation efforts of **Uganda** are hampered by conflicting provisions of the Penal Code and inadequate youth-focused SRHR interventions.

- **Senegal** remains the most restrictive of the target countries, with a Penal Code that severely limits access to safe abortion and insufficient measures to protect against harmful practices.

Critical gaps and barriers

Despite legal progress, significant obstacles continue to block access to essential SRHR services. The most critical gaps and barriers include the following:

- **The implementation gap:** A significant gap exists between legal commitments to SRHR and the actual delivery of services across the eight countries. The existence of a law does not guarantee its enforcement. Implementation is further hindered by resource constraints, such as shortages of trained health personnel, inadequate funding, and weak supply chains, especially in rural areas. Sociocultural barriers also contribute; practices such as FGM and child marriage persist due to deep-seated social norms. Additionally, a disconnect exists between the ratification of the **Maputo Protocol** and its domestic application. For instance, Senegal ratified the **Maputo Protocol** without reservations but still only permits abortion to save a woman's life. **Kenya** and **Uganda** also maintain reservations regarding specific articles related to abortion.

- **Contradictory legal frameworks:** Several key findings emerge from the analysis. Three types of contradictions are common: a mismatch between international ratification and domestic law, as seen in **Senegal**; the use of reservations to weaken treaty obligations, as seen in **Kenya** and **Uganda**; and internal inconsistencies between constitutional commitments and restrictive criminal codes, found in **Burkina Faso, Kenya,** and **Nigeria**. Notably, ratification without reservations does not ensure alignment, as the case of **Senegal** demonstrates that a full commitment can exist alongside a restrictive domestic framework. Constitutional rights in **Nigeria** are undermined because they are non-justiciable, meaning they cannot be enforced in court. Furthermore, issues such as federalism in **Nigeria** and family-law fragmentation in **Senegal** create contradictions that affect SRHR beyond abortion laws.

- **Cultural and societal stigma:** In all eight countries, patriarchal structures, conservative social norms, and religious opposition create significant barriers to SRHR. In **Benin, Nigeria,** and **Uganda**, patriarchal norms restrict discussions on adolescent sexuality and limit access to contraception. Religious opposition is also a major factor; in **Senegal**, powerful groups block abortion law reform, while similar opposition in **Nigeria** and **Rwanda** leads some Rwandan providers to deny legal services based on conscientious objection. This widespread stigma results in a lack of awareness among the public and healthcare providers. For instance, many providers in **Ghana** incorrectly believe that all abortions are illegal, and in **Uganda**, this stigma has a 'chilling effect,' discouraging them from offering legal services. In Kenya, an anti-rights movement backed by religious groups led to the withdrawal of the 2014 SRHR guidelines. These cultural and religious forces undermine the implementation of the existing SRHR.

- **Lack of education:** A widespread lack of standardised, age-appropriate comprehensive sexuality education (CSE) leaves adolescents uninformed and vulnerable across the region. In 2016, Uganda banned all forms of CSE, citing conflicts with national customs. Similarly, conservative cultural and religious values have stalled the implementation of CSE in **Ghana**, and **Benin** has no standardised national programme. This educational gap has direct consequences in **Ghana**: teenagers and women in their 20s are at a higher risk of unsafe abortions due to limited awareness and stigma. In **Rwanda**, knowledge gaps contribute to high rates of teenage pregnancy, whereas in **Uganda**, very few health facilities offer youth-friendly services. Even where progress exists, such as in **Burkina Faso**, which integrated CSE between 2015 and 2020, implementation remains uneven, particularly in rural areas. **Nigeria** lacks a standardised CSE curriculum, compounding individual knowledge gaps with social and religious pressures.

- **Resource constraints:** Chronic underfunding of health sectors severely hampers efforts to promote SRHR in several countries. This results in frequent stock-outs of contraceptives and staff shortages in **Benin** and **Ghana**, especially in rural areas. **Burkina Faso** faces a similar situation, which is worsened by a humanitarian crisis that has caused 426 health facilities to close and 363 to offer only minimal services, leading to the diversion of resources from SRHR initiatives. Additionally, youth-friendly services and trained personnel are scarce. **Uganda** has very limited youth-friendly health facilities, and in **Rwanda**, access to abortion is mostly restricted to doctors in district hospitals, creating barriers for rural women. **Kenya** must also expand its capacity to train providers in delivering youth-friendly SRHR services. These resource limitations consistently undermine policy implementation.

- **Bureaucratic and structural hurdles:** These obstacles create significant barriers to SRHR services. Unnecessary procedural obstacles delay time-sensitive care, whereas fragmented governance leads to inconsistent implementation. For example, **Burkina Faso** requires confirmation from three doctors for therapeutic abortions and a prosecutor's sign-off for rape survivors, making legal abortion almost inaccessible. Similarly, **Senegal** demands the opinion of three doctors to save the mother's life. Federal fragmentation also causes structural challenges. In **Nigeria**, the **Violence Against Persons (Prohibition) Act (VAPP)** and **Child Rights Act** only apply automatically in the Federal Capital Territory, requiring each of the 36 states to adopt them individually, creating a varied legal landscape. Devolution in **Kenya** has led to unequal resource allocation and care quality across counties. Coordination failures further complicate matters. **Uganda** suspended its *National guidelines for SRHR* in 2017, and in **Nigeria**, non-enforceable constitutional health rights make holding the government accountable for failures in maternal care difficult. These overlapping issues indicate that legal rights often do not result in accessible services.

Analysis across all eight countries identifies a widespread "implementation gap," where advances in law and policy have not yet translated into consistent or equitable service provision, particularly for adolescents, unmarried women, and rural populations. Cultural and religious norms, chronic underfunding, and lack of comprehensive standardised sexual education continue to undermine progress. The cumulative impact of these findings underscores that legal reforms, while essential, are not enough: practical access requires ongoing investment in health systems, public education, and political will to challenge social stigma and entrenched inequality and discrimination.

This comparative perspective highlights national strengths and innovative approaches and reinforces the need for coordinated regional and national action to ensure that the promise of **Article 14** becomes a lived reality for all women and girls in Africa.

Recommendations

These recommendations are general in nature and apply across all eight countries examined in this study. They are intended to identify shared priorities and collective actions required to advance regional harmonisation of SRHR. Country-specific recommendations, reflecting each country's distinct legal context, governance structure, and implementation challenges, are provided in the substantive country sections later in this report. The following targeted actions are required to bridge the gap between policy and practice:

Governments

- Increase public financing for SRHR services. In line with the **Abuja Declaration**, governments should work towards allocating at least 15% of national budgets to health, with a defined proportion specifically ring-fenced for reproductive health

commodities, contraceptive procurement, provider training, and facility upgrades.

- Strengthen national SRHR data systems to address data availability, fragmentation, and quality issues. This involves establishing standardised mechanisms for collecting, managing, and reporting on SRHR service delivery, financing, and health outcomes to support evidence-based policymaking and accountability.
- Develop and widely disseminate comprehensive clinical guidelines for safe abortion and family planning, ensuring that providers have clear, unambiguous directions on legally permissible procedures.
- Remove unnecessary procedural barriers that delay or effectively deny access to time-sensitive care, including multi-doctor approval requirements for lawful abortion procedures, and replace them with evidence-based, rights-respecting protocols.
- Harmonise conflicting penal codes and health laws to remove legal ambiguity for both providers and patients and ensure that domestic legislation is fully aligned with **Article 14** of the **Maputo Protocol**.
- Withdrawal of reservations to **Article 14** of the **Maputo Protocol**, which continues to limit domestic obligations on reproductive rights.
- Establish nationwide monitoring and evaluation systems to track the implementation of SRHR, identify regional disparities, and support continuous programme improvement.
- In countries with federal or devolved governance structures, the domestication and enforcement of national SRHR laws across all sub-national units should be actively coordinated to ensure consistent protection regardless of geography.

Civil society organisations (CSOs)

- Lead public education campaigns through schools, grassroots workshops, and community networks to increase awareness of legal SRHR under both national and regional frameworks.
- Mobilise community leaders, women's groups, and youth advocates to challenge cultural stigma, discriminatory norms, and harmful practices at the local level.
- Partner with governments to monitor policy implementation and hold duty-bearers accountable, with particular focus on the rollout of CSE and the availability of youth-friendly services.
- Advocate for law reform where SRHR protections remain insufficient or procedural and structural barriers continue to restrict access.
- Document and disseminate success stories, best practices, and lessons learned to support replication and scale-up in other countries.

Healthcare providers

- Participate in regular, mandatory values-clarification and human rights training to ensure the consistent, unbiased provision of safe and legal SRHR services.
- Establish robust referral pathways and inter-professional networks to ensure that women and adolescent girls can access appropriate care regardless of location, including rural and remote settings.
- Uphold client confidentiality, respectful care standards, and non-judgemental counselling in all SRHR-related interactions.
- Contribute practical, evidence-based feedback to policymakers on implementation challenges, service gaps, and barriers encountered at the facility level to inform continuous policy reform.
- Participate in community education and outreach, correct misinformation, and provide accurate, accessible information on SRHR entitlements and services.

Media and campaigns

- Develop sustained, coordinated public awareness campaigns on SRHR using a mix of traditional media, including radio, television, and print and digital platforms to reach diverse audiences across urban and rural settings.
- Leverage technology and digital channels, including social media platforms, mobile health (mHealth) applications, SMS-based health information services, and online educational content, as cost-effective tools for disseminating accurate SRHR information, particularly to young people and underserved communities.

- Work with media organisations to promote responsible, rights-based reporting on SRHR issues, countering misinformation, stigma, and the normalisation of harmful practices.
- Engage influencers, community communicators, and trusted public figures to amplify SRHR messaging and reduce cultural barriers that prevent individuals from seeking services or exercising their rights.
- Support the production and distribution of multilingual content, including local and indigenous languages, to ensure that information reaches populations who may be excluded by language barriers.
- Media platforms should be used to highlight positive legal reforms and regional progress, build public confidence in the health system, and reinforce the normalisation of SRHR as a fundamental right.

Regional bodies (AU, African Commission on Human and Peoples' Rights (ACHPR), Special Rapporteur on the Rights of Women in Africa (SRRWA), Office of the Legal Counsel of the African Union Commission, Regional Economic Communities (ECOWAS, EAC, SADC, etc.)

- Strengthening the monitoring of member states' compliance with **Article 14** of the **Maputo Protocol** through structured periodic reviews, standardised reporting requirements, and clear performance benchmarks.
- Facilitating cross-country learning exchanges and technical support, sharing model laws, implementation guides, and proven service delivery approaches across the continent.
- Support national-level legal harmonisation by providing policy templates, legal drafting assistance, and capacity building for reform teams working to align domestic law with the Protocol.
- Use regional platforms and diplomatic processes to apply collective pressure against regressive legal or policy trends and to sustain political commitment to SRHR harmonisation.
- Establish or strengthen regional investment mechanisms, including pooled procurement arrangements and dedicated SRHR funding windows to address resource shortfalls in low-income settings and reduce dependence on external donor financing.

Methodology

Research approach

This study employs a qualitative, desk-based legal and policy analysis to assess the level of harmonisation between national laws and the standards set forth in **Article 14** of the **Maputo Protocol**. The research adopts a comparative legal framework, examining the "law on the books" versus the target countries' regional obligations. This approach facilitates a systematic evaluation of how domestic legislative environments facilitate or hinder the realisation of SRHR as mandated by the Protocol.

The assessment focuses on eight specific jurisdictions: **Benin, Burkina Faso, Ghana, Kenya, Nigeria, Rwanda, Senegal**, and **Uganda**. These countries were selected to represent a diverse cross-section of legal traditions (common law, civil law, and mixed systems) and varying stages of SRHR policy implementation across West and Eastern Africa.

Data collection methods and sources

Data collection primarily relied on a comprehensive review of primary and secondary sources. The research team conducted a systematic search and analysis of the following documents:

- Primary legal sources:
  - **Constitutions:** The national constitutions were reviewed to identify provisions related to the right to health, non-discrimination, and specific rights of women.
  - **Statutory laws:** Penal codes, public health acts, reproductive health laws, and laws relating to sexual offences and domestic violence were examined.
  - **Case law:** Significant court judgments interpreting SRHR provisions were analysed to understand the judicial application of these laws where available.
- Secondary sources:
  - **Policy documents:** National health strategies, SRHR guidelines, and ministerial directives were reviewed to understand the laws' operational context.

- **Shadow reports and concluding observations:** Reports submitted to and observations made by the ACHPR and the CEDAW Committee were utilised to gauge international compliance.

- **Academic and civil society literature:** Peer-reviewed articles, legal commentaries, and reports from reputable NGOs and international organisations (e.g., UNFPA, WHO) provided context on the gaps in implementation and the de facto situation on the ground.

Although the primary research methodology for this analysis is desk-based, the findings have been significantly enriched and supplemented by insights gathered from a series of select stakeholder consultations. These consultations were strategically conducted in countries demonstrating low or partial alignment with **Article 14** of the **Maputo Protocol**, specifically **Burkina Faso, Kenya, Nigeria, Senegal**, and **Uganda**. Direct engagement with women's rights advocates within these target countries allowed for a crucial validation of the initial legal analysis. Furthermore, these interviews provided essential nuance and context, shedding light on the practical, real-world application of the laws and revealing the gaps between legislation on paper and its enforcement in practice.

- Validation process:

A validation process was conducted to ensure consistency and reliability across the eight countries. Participants were given the opportunity to review the findings and provide feedback as part of this process, helping to strengthen the accuracy and coherence of the study's overall findings.

Criteria for harmonisation assessment

The degree of harmonisation was assessed against specific indicators derived from **Article 14 (1) and (2)** of the **Maputo Protocol** to ensure consistency across the country-level analyses. The assessment criteria included the following:

- **Constitutional alignment:** Does the constitution explicitly recognise the right to health and reproductive rights of women?

- **Access to contraception:** Do national laws support the right to control fertility and access to family planning methods?

- **Abortion legislation:** To what extent does the national penal code or health law permit abortion in the specific circumstances outlined in **Article 14(2) (c)** (sexual assault, rape, incest, and danger to the mother's mental or physical health or the mother's life or the foetus)?

- **Elimination of harmful practices:** Are there specific laws and policies in place that explicitly prohibit harmful traditional or cultural practices known to negatively impact women and girls' SRHR?

Limitations of the study

- **Time and resource constraints:** Due to time and resource constraints, the study relied primarily on desk reviews of legal texts, policy documents, and secondary literature. This approach limited the ability to conduct widespread primary interviews with rural populations, local civil society, and frontline healthcare providers, meaning that the understanding of social context and lived experiences is based on secondary sources rather than direct testimony.

- **Data availability and quality:** Data on SRHR in several target countries are often fragmented, outdated, or unavailable. This includes unrecorded unsafe abortions and gaps in evidence on topics such as youth-friendly services, contraceptive availability, and conscientious objection among providers. The lack of reliable data makes measuring the gap between legal frameworks and their actual implementation difficult.

- **Focus on national frameworks:** This analysis focuses on national-level laws and policies, which means that local variations in implementation may not be fully captured, especially in countries with federal or decentralised systems, such as **Nigeria** and **Kenya**. For example, the report could not review all 36 states' laws in **Nigeria**. As a result, the findings might overlook local nuances that affect women and girls' daily access to SRHR services.

- **Dynamic and evolving legal landscapes:** The laws and policies regarding sexual and reproductive health and rights (SRHR) in the countries studied are constantly changing. Therefore, the report's findings might not include the latest reforms and should be viewed as a snapshot in time, not a definitive record.

- **Geographically restricted stakeholder consultations:** Stakeholder consultations were geographically restricted, focusing only on five countries with low or partial alignment (**Burkina Faso, Kenya, Nigeria, Senegal**, and **Uganda**). This

excluded **Benin, Ghana**, and **Rwanda**. Consequently, the insights for these three countries are based solely on secondary sources.

- **Gaps between law and practice:** Legal analysis may not fully reflect how services work in practice, especially when provider behaviour differs from the law. For example, healthcare providers' conscientious objection can create unrecorded service gaps, as observed in **Rwanda**. Additionally, some legal reforms have not been implemented, such as **Rwanda**'s 2024 Ministerial Order, **Kenya**'s withdrawal of the 2014 *Safe abortion guidelines*, and **Uganda**'s suspension of the *2017 SRHR guidelines*.

- **Cross-country comparability:** Direct comparison between the eight countries is complicated by their different legal traditions (common law, civil law, and mixed). Comparability is further reduced by reservations, such as **Uganda**'s reservations to **Articles 14(1)(a)** and **14(2)(c)** and **Kenya**'s reservations to **Article 14(2)(c)**. Additionally, variations in legal structure and drafting styles mean that similar provisions may have different practical implications in each country.

- **Language and translation:** The use of French legal instruments in **Benin**, **Burkina Faso**, and **Senegal** presents a risk of translation errors, which could alter subtle legal meanings and affect comparative interpretation accuracy.

- **Underrepresented voices:** The study did not include the perspectives of groups such as rural populations, frontline healthcare providers, and local civil society organisations due to limited time and resources. It also did not directly survey underserved groups, such as adolescents and unmarried women. The inability to access communities in conflict zones, particularly in **Burkina Faso**, created a significant gap in the literature.

Introduction

Sexual and reproductive health and rights (SRHR) occupy a central position in contemporary discourse on public health, gender equality, and sustainable development across the African continent. The scale of the challenge is considerable: the African region accounts for 69% of maternal deaths, 46% of neonatal deaths, 55% of deaths in children under five years of age, and 47% of stillbirths, half of which occur during labour.[2] These figures reflect deep structural inequalities in reproductive and maternal health service provision and underscore the urgency of reforms in legal and policy rights.

The **Maputo Protocol**, which constitutes a landmark legal instrument establishing a rights-based framework for advancing women's reproductive autonomy across Africa, is central to this reform agenda.[3] **Article 14**[4] of the **Maputo Protocol** enshrines a woman's right to control her fertility, access contraception, and protect herself against sexually transmitted infections. **Article 14(2)(c)** further obliges member states to authorise medical abortion in cases of sexual assault, rape, incest, and where a continued pregnancy endangers the mother's mental or physical health or the mother's life or that of the foetus. This baseline provides African nations with a clear standard against which to assess their domestic legislative frameworks.

Despite this normative foundation, persistent inequalities in SRHR provision endure across the continent, reflecting not merely a health-sector deficiency but a fundamental development and human rights imperative requiring coordinated policy, investment, and structural reform. Although numerous African states have expanded access to reproductive health services in recent decades, substantial disparities persist in terms of access to contraceptives, maternal survival, adolescent pregnancy, and protection from harmful practices.[5]

The broader context of SRHR in Africa is shaped by intersecting determinants including poverty, geographical remoteness, educational attainment, armed conflict, and entrenched gender norms that interact to produce markedly uneven outcomes. Adolescents, rural populations, and marginalised communities bear a disproportionate burden of unmet need.[6] Maternal mortality data illustrate the scale of this burden with particular clarity: in Sub-Saharan Africa, 448 women die per 100,000 live births from pregnancy-related causes, a figure that, whilst representing a significant improvement from 1,120 per 100,000 in 1985, remains considerably above the global average.[7] Adolescent reproductive health presents equally pressing concerns: in 2024, 92 of every 1,000 girls aged 15 to 19 gave birth in Sub-Saharan Africa, a rate that, despite declining since 2014, continues to exceed the global average, reflecting the limited reach of comprehensive sexuality education and youth-focused reproductive health services.[8] Compounding these health outcomes is a persistent implementation gap between regional SRHR commitments and domestic realities: advances in law and policy frequently fail to translate into consistent or equitable service provision, leaving rural populations, unmarried women, and adolescents especially vulnerable to preventable harm. Any analysis of SRHR in Africa must therefore account for both the aggregate continental picture and the pronounced variation that exists between and within individual countries.

Against this backdrop, the present study offers a systematic assessment of the extent to which a selection of African nations align their national health and SRHR legislation with **Article 14** of the **Maputo Protocol** and wider regional frameworks. By identifying the gaps and inconsistencies between international treaty obligations and domestic legal realities, this study evaluates the degree to which

national environments facilitate or obstruct the realisation of these fundamental rights. The analysis focuses on eight countries: Benin, Burkina Faso, Ghana, Kenya, Nigeria, Rwanda, Senegal, and Uganda. These countries represent a range of legal traditions, regional contexts, and levels of alignment with regional SRHR commitments.

The consequences of these deficits extend well beyond the individual. Inadequate SRHR provision contributes to preventable maternal death, unintended pregnancy, unsafe abortion, premature school dropout among girls, and the intergenerational transmission of poverty and inequality.[9] Such outcomes underscore the interdependence of reproductive health, gender equity, and socioeconomic progress. To examine these dynamics, the study employs a qualitative, desk-based legal and policy analysis, systematically comparing enacted law in each of the eight target countries against the regional obligations they have undertaken. Through this comparative framework, the report aims to provide actionable insights for lawmakers, policymakers, civil society organisations, and legal advocates, with the ultimate objective of supporting stakeholders in strengthening national legal frameworks so that the commitments enshrined in the **Maputo Protocol** are realised in practice for all African women and girls.

The evidence presented in this introduction compellingly supports the conclusion that strengthening SRHR in Africa constitutes a health and development priority, underpinned by an unambiguous human rights rationale. The need to strengthen national legal frameworks and close the persistent gap between the treaty obligations undertaken by African states and the realities of domestic implementation is central to this endeavour. Through sustained investment, legislative reform, and equitable service delivery, African states have a genuine opportunity to advance towards universal SRHR services. This study contends that translating the commitments enshrined in the **Maputo Protocol** from aspirational text into a lived reality for all women and girls across the continent demands urgent, coordinated, and rights-centred action from legislators, policymakers, civil society organisations, and legal advocates alike.

The regional and international context of SRHR in Africa

To understand the legal landscape of sexual and reproductive health and rights (SRHR) across Africa, it is important to consider the broader regional and international treaties and agreements that shape national laws. For the eight target countries of this audit, domestic laws and policies do not exist in a vacuum: Benin, Burkina Faso, Ghana, Kenya, Nigeria, Rwanda, Senegal, and Uganda. The legal and policy frameworks of each country are shaped by a network of cross-border commitments, most notably the **Maputo Protocol** and related human rights instruments, designed to protect human dignity and bodily autonomy.

Regional, continental, and international instruments on the SRHR

Regional instruments

- **The African Charter on Human and Peoples' Rights (the Charter):** This charter was adopted in 1981 and stands as the primary regional human rights treaty for Africa. It places a fundamental obligation on member states to protect and promote their populations' wellbeing. Specifically, it legally binds governments to guarantee the right to health, a broad concept that explicitly includes reproductive health services, as well as ensuring complete freedom from discrimination, as outlined in **Articles 16** and **18**.[10]

- **The Maputo Protocol:** The **Maputo Protocol**, formally known as the *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2003*), is a progressive legal instrument for women's rights in Africa. It has been ratified by all eight countries in the report. The Protocol is comprehensive, covering civil, political, economic, social, and cultural rights, including areas such as harmful traditional practices and the rights of widows and women with disabilities that are often unaddressed in other treaties. **Article 14** of the Protocol is crucial for SRHR. It guarantees women's rights to control their fertility, decide on having children, choose contraception, protect themselves from STIs (including HIV/AIDS), be informed of their and their partner's health status, and receive family planning education. **Article 14(2)** obliges states to provide accessible health services and, notably, to authorise medical abortion in cases of sexual assault, rape, incest, or when the mother's mental/physical health or life is threatened.[11] The African Commission on Human and Peoples' Rights (ACHPR) has issued general comments to clarify these obligations. General comment no. 2 specifies that states must actively ensure legal access to contraception, family planning, and safe abortion services, remove practical barriers, and ensure that services are free from coercion. Other general comments on **Article 14(1)(d)** and **(e)** detail state duties regarding HIV, including providing access to prevention, testing, treatment, and care while protecting confidentiality and addressing women's vulnerability to infection. These comments provide a clear framework for assessing whether the national laws and policies of the eight target countries comply with the Protocol's requirements.[12]

- **The Maputo Plan of Action:** The Maputo Plan of Action, launched by the African Union in 2006, serves as a framework for implementing the SRHR outlined in the **Maputo Protocol**. The plan aims to achieve universal access to comprehensive SRHR services across Africa by guiding member states to integrate SRHR into national health systems, reposition family planning, strengthen maternal health, and legally address unsafe abortions. It also includes accountability monitoring mechanisms. Recognising uneven progress, the plan was renewed as the *Maputo Plan of Action 2016–2030*, aligning it with the Sustainable Development Goals (SDGs) and **Agenda 2063.** This updated version emphasises sustained financing and political will.[13]

Continental strategies

- **The African Union's Policy Framework for Sexual and Reproductive Health and Rights:** This continental policy document builds on the *Maputo Plan of Action* and supports the integration of SRHR into health and development planning across Africa. It specifically targets the achievement of universal access to sexual and reproductive health by 2030, in tandem with global goals.[14]

International instruments

- **Convention on the Elimination of All Forms of Discrimination against Women (CEDAW):** Adopted in 1979, CEDAW is a comprehensive international treaty often referred to as the **International Bill of Rights for women**. It mandates that states eliminate healthcare discrimination and ensure equal access to SRHR services, including family planning and maternal healthcare **(Articles 12 and 16)**. The convention establishes a woman's right to health, which encompasses bodily autonomy and the right to decide the number and spacing of her children.[15]

- The CEDAW Committee, which oversees the implementation of the treaty, identifies unsafe abortion as a primary cause of maternal mortality and morbidity. Therefore, the committee recommends that states decriminalise abortion and legalise it in cases of rape, incest, severe foetal impairment, or when the pregnant woman's life or health is at risk. Access to safe, legal abortion and quality post-abortion care is framed as essential for reducing maternal deaths, preventing unwanted pregnancies, and upholding a woman's right to bodily autonomy.[16]

- **The International Conference on Population and Development (ICPD) Programme of Action:** Agreed in 1994, the ICPD Programme of Action represents a global consensus to advance SRHR, gender equality, and reproductive rights and is explicitly referenced in the Sustainable Development Goals (SDGs).[17]

- **SDGs: The SDGs,** adopted by UN member states in 2015, include Goal 3 (Good health and wellbeing) and Goal 5 (Gender equality). Goal 3 is to reduce maternal mortality and ensure universal access to SRHR services and health coverage. Goal 5 seeks to achieve gender equality and empower women, with specific targets for access to SRHR.[18]

- **The Convention on the Rights of the Child (CRC):** Ratified by all African states, the CRC mandates states to protect adolescents' health and access to health information **(Articles 6 and 24)**.[19]

- **Resolutions of the United Nations Human Rights Council (HRC):** The HRC regularly adopts resolutions addressing preventable maternal mortality, child marriage, and gender-based violence, calling upon states to align national laws with international standards for SRHR.[20]

These overlapping instruments provide normative standards and operational guidance. They form the legal, policy, and advocacy landscape for SRHR reform across Africa.

Factors influencing harmonisation

The process of harmonising national SRHR laws with **Article 14** of the **Maputo Protocol** is shaped by a variety of interlinked factors that influence the pace, quality, and sustainability of reform across countries.

Political will: Strong, sustained political leadership is the cornerstone of successful legal harmonisation. Where governments have demonstrated high-level commitment, such as in Benin, proactive legal reforms in alignment with **Article 14** have progressed quickly and comprehensively. Legislative champions, active parliamentary committees, and executive support all accelerate reform and drive efforts to domesticate international and regional treaties into national law. In contrast, countries operating under federal systems, such as Nigeria, face significant complexity. At the federal level, political will may not translate into state-level action, leading to inconsistent implementation, gaps between policy and practice, and disjointed progress across regions. Insecurity, political transitions, or changes in government can also stall reform processes, as seen in Burkina Faso and parts of Uganda.

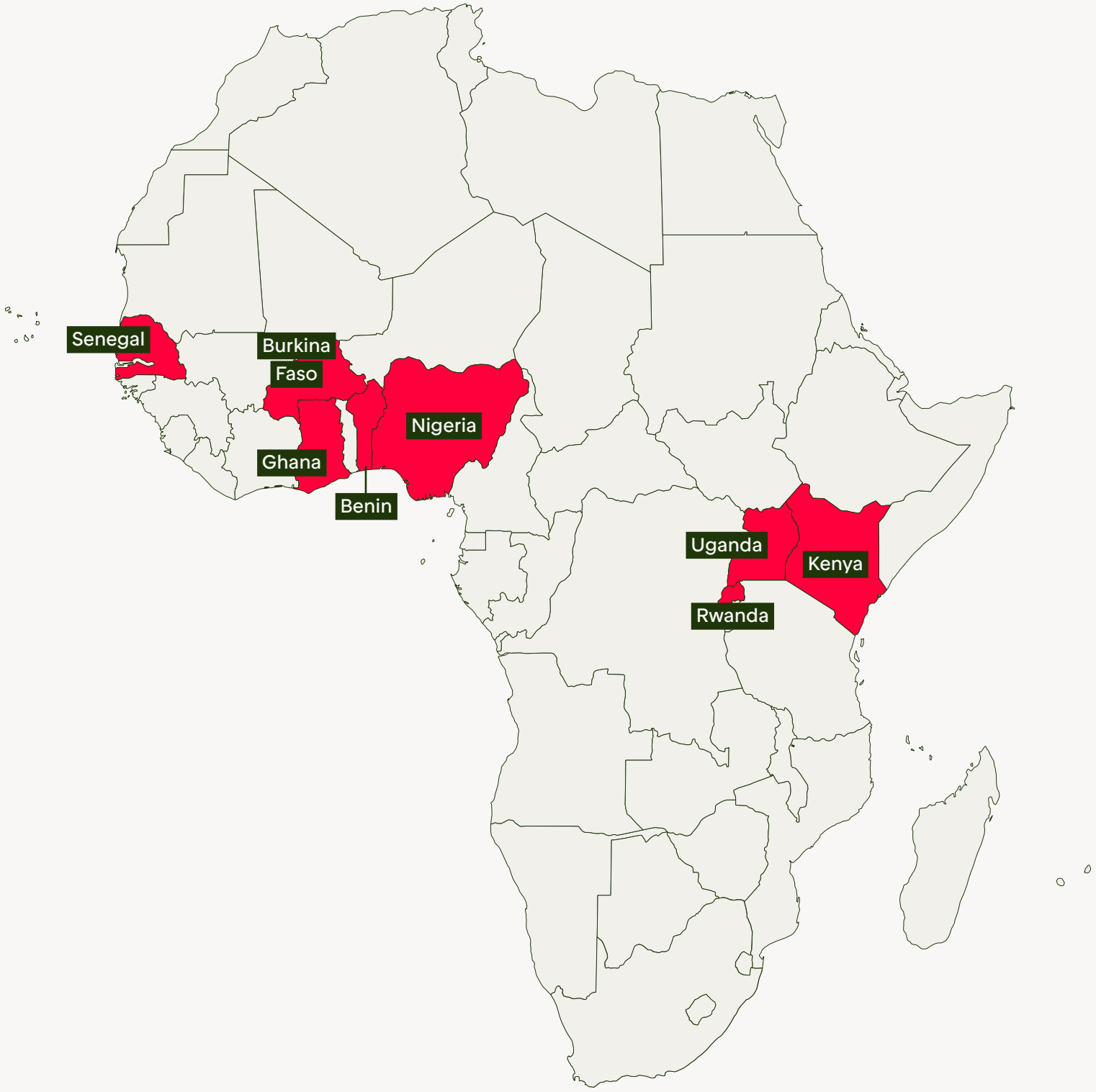
Patriarchal cultural and religious norms: Deeply ingrained social values, traditional customs, and religious beliefs remain among the most formidable barriers to full harmonisation. Taboos persist around sexuality, family planning, and abortion in many countries, with SRHR topics often considered culturally sensitive or morally contentious. This societal stigma not only prevents women and girls from seeking services but also discourages policy dialogue and open education efforts at the community level. Religious leaders frequently act as powerful gatekeepers, shaping the attitudes of healthcare providers, teachers, parents, and policymakers. In environments where religious and cultural pressures are strong, local

resistance, non-compliance, and a lack of public awareness often undermine progressive laws. Even newly enacted SRHR laws are sometimes ignored or actively opposed, resulting in limited uptake and low service utilisation.

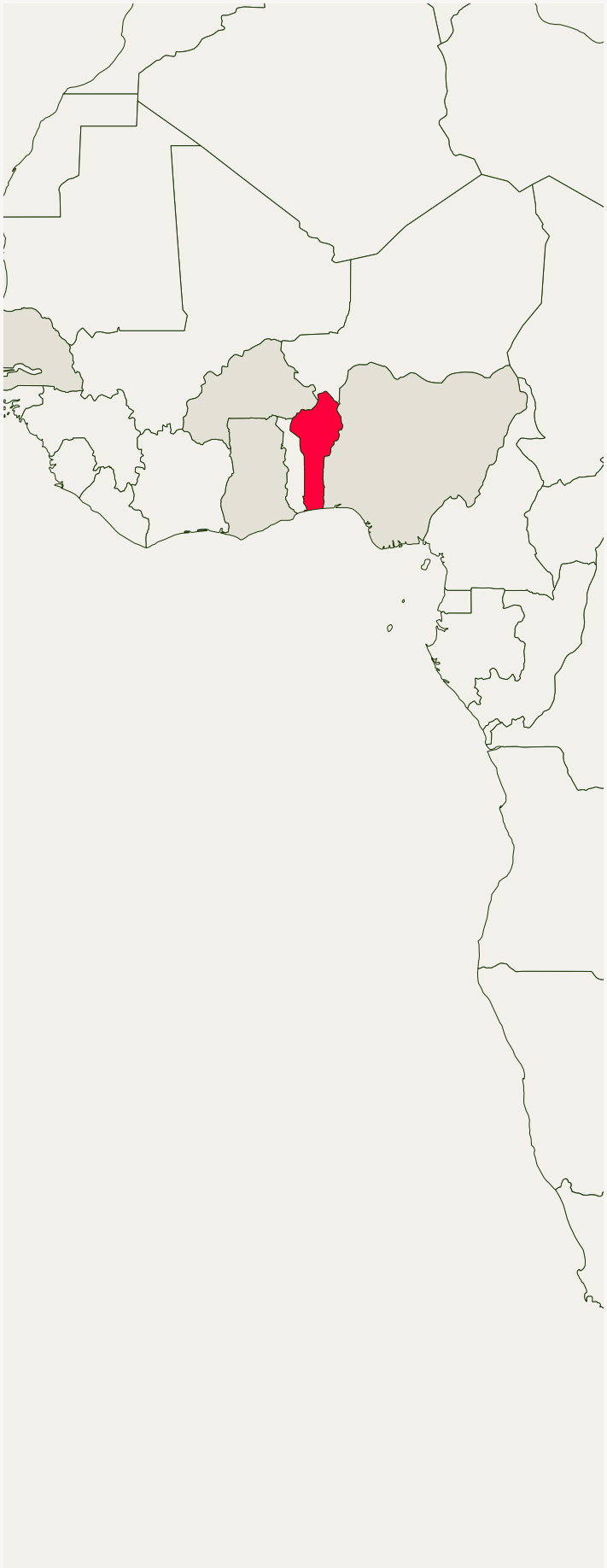
Resource availability: The financial, human, and infrastructural resources available to national health systems are a critical determinant of the outcomes of harmonisation. Most countries in the region struggle with chronic underfunding of health sectors, constraining efforts to implement national SRHR policies and deliver services equitably. Budgets for reproductive health commodities and training are frequently inadequate, causing recurrent shortages of contraceptives, limited stock of essential medicines, and a scarcity of trained personnel, especially in rural and hard-to-reach areas. Where political instability or humanitarian crises persist, such as in Burkina Faso, resources are often diverted to emergency needs, leaving SRHR initiatives underfunded or suspended altogether. Furthermore, weak planning systems and logistical inefficiencies can intensify supply chain bottlenecks, hindering the ability of service providers to meet community needs, regardless of supportive legal frameworks.

Taken together, these factors interact in complex ways: progress in one domain, such as political commitment, may be undermined by inertia in others, such as cultural opposition or funding constraints. Therefore, successful harmonisation requires not only legal reform but also multifaceted strategies that address leadership, social change, and investment in health system capacity.

Country-level analysis



Benin



Overview of the national health laws

Benin has built a strong legal framework to protect SRHR. The Benin Constitution is the foundation of this system. **Article 26** guarantees strict equality before the law for all citizens, regardless of their sex.[21]

Beyond the constitution, **Law No. 2003-04 on sexual and reproductive health** establishes the core legal structure for SRHR.[22] This law regulates access to contraception, family planning, and prenatal care. Originally, **Article 17** of this law only permitted abortion when the pregnancy posed a risk to the woman's life or health, resulted from rape or incest, or involved severe foetal abnormality. However, Benin took a massive step forward with **Law No. 2021-12**, which amended the 2003 framework.[23] This progressive amendment allows a pregnant woman to request a voluntary termination of pregnancy if the pregnancy is likely to cause material, educational, professional, or moral distress that conflicts with the interests of the woman or the unborn child.[24] In May 2023, the Government of Benin issued Decree No. 2023-151 to enact the 2021 amendment to the sexual and reproductive health law. This decree outlines the conditions for providing safe abortions, including facility authorisation, provider qualifications, and informed consent.[25]

Law No. 2011-26,[26] enacted on January 9, 2012, focuses on the comprehensive prevention and subsequent punishment of violence specifically targeting women, with relevant **Articles 3** and **21-26**. Additionally, **Law No. 2006-19** addresses the punishment of sexual harassment and ensures the protection of victims within the Republic of Benin, as outlined in **Articles 1, 8,** and **12**.[27]

Furthermore, the **Children's Code (Law No. 2015-08)**[28] prohibits child marriage by setting the minimum age at 18 years and entirely outlaws sexual exploitation of children and FGM. The **Code of Persons and the Family**, **Law No. 2004-020 of 8 August 2004,**[29] sets the minimum age for marriage at 18 years for both men and women. However, the law includes exceptions that allow minors with parental or judicial consent to marry before age 18. The code also prohibits forced marriage and grants equal legal capacity to spouses, including in family planning decisions.[30]

Law No. 2021-11 of October 2021 outlines special measures for the repression of sex-related offences and for protecting women in the Republic of Benin.[31]

Progressive policies and examples of best practices

Benin has enacted several progressive policies, including the National Strategic Plans on HIV/AIDS (*Plans Stratégiques Nationaux de Lutte contre le VIH/Sida*). These multi-year plans, coordinated by the national AIDS council (CNLS), address HIV/AIDS prevention, treatment, care, and support and include specific sexual and reproductive health components.[32]

Additionally, through its *national population policy, national reproductive health strategy*, and FP2020 commitment, the government pledged to revise its reproductive health task-sharing policies. It also committed to making modern contraceptives free of charge available to youth in public health facilities and increasing the contraceptive procurement budget to CFA 250 million by 2018.[33]

Benin provides an illustrative model for legislative reform through its 2021 expansion of access to abortion. This reform is a best practice in CSO-led advocacy. Between 2018 and 2021, a coalition including the Ministry of Health, the National Association of Gynaecologists (CNGOB), youth organisations, and women lawyers worked together to gather the first national-level data on abortion mortality.[34] Instead of relying solely on human rights arguments, this coalition addressed the national assembly with hard clinical evidence about the death toll of unsafe abortions. They trained healthcare providers and held national dialogues before the law was enacted, building the capacity necessary for immediate implementation. This evidence-based, coalition-driven approach is a prime example of successfully navigating complex SRHR reforms.

Assessment of alignment with Article 14

Benin's legal framework demonstrates substantial alignment with **Article 14** of the **Maputo Protocol**, which was ratified in 2004. Before 2021, the legal framework was only partially aligned with the **Maputo Protocol**, as it permitted abortion solely on the grounds of saving the pregnant woman's life. This was a significant restriction compared with the broader rights outlined in the Protocol. However, the introduction of the new **Law No. 2021-12** marked a substantial shift, bringing the country into much closer alignment with **Article 14(2)(c)** of the **Maputo Protocol**. The updated law significantly expanded the grounds for legal abortion. The procedure is now permitted within the first 12 weeks of pregnancy if the continuation of the pregnancy is likely to cause material, educational, professional, or moral distress to the woman or her family.

This expansion is noteworthy because it goes beyond the specific circumstances explicitly listed in **Article 14**, such as rape, incest, sexual assault, or danger to the mother's physical or mental health and life. Benin has adopted one of the most progressive legal stances on abortion rights in the region by including socioeconomic and moral distress as valid reasons, demonstrating a deep commitment to the spirit of the **Maputo Protocol**.

Benin's **Law No. 2003-04** directly aligns with **Article 14(1)(a)** of the **Maputo Protocol's** right to control fertility by guaranteeing the right to choose the number and spacing of children. National strategies promoting access to various contraceptive methods further support this right.

Benin's legal framework supports access to family planning services in relation to **Article 14(1)(b)** of the **Maputo Protocol** on the right to access contraceptives. Policies ensure the availability of contraceptives in public health facilities, demonstrating strong alignment with the Protocol's requirements for states to provide adequate and accessible family planning.[35]

Gaps, inconsistencies and challenges

Despite having one of the continent's most progressive legal frameworks, Benin faces significant challenges when translating these laws into everyday reality. The most significant gap is in the implementation of the new law on abortion. There is a critical need to develop and disseminate clear clinical guidelines, train healthcare providers, and equip health facilities to provide safe abortion services. Without these measures, the law only remains a right on paper.

Deep-seated cultural norms, religious beliefs, and social stigma continue to hinder access to SRHR services. This is particularly true for adolescents and unmarried women seeking contraception or safe abortion services. Stigma can also prevent open discussion and sexual education.

Chronic underfunding in the health sector leads to frequent stock-outs of contraceptive commodities, particularly in rural areas. Geographic and economic disparities mean that women and girls in remote or impoverished communities have far more limited access to SRHR services than their urban counterparts. Although policies may support reproductive health, there is no standardised, nationwide comprehensive sexuality education (CSE) programme in schools. This information gap leaves young people vulnerable to unintended pregnancies and STIs.

A major inconsistency exists between the legal right to modern contraceptives and their actual availability, particularly for rural women and adolescents. Social stigma, reliance on patriarchal family structures, and frequent stock-outs in public health facilities create barriers to care. Furthermore, while the 2021 abortion reform is legally binding, deep-rooted cultural resistance and a lack of clinical training among some rural healthcare providers mean that safe abortion access remains unequal across different regions.

Opportunities for improvement and reform

There are strong opportunities for Benin to strengthen its SRHR framework and close existing service gaps. First, the government has an opportunity to fully actualise its national commitment to make modern contraceptives available free of charge for youth in public health facilities. The Ministry of Health can eliminate the financial barriers that keep young people from accessing family planning by increasing the national budget for contraceptive procurement.

There is also a prime opportunity to leverage domestic jurisprudence to further advance gender equality. Benin's constitutional court has previously addressed discriminatory gender-based provisions in family law, such as unequal adultery and polygamy rules. By continuing to support strategic litigation, civil society can push the judiciary to dismantle remaining patriarchal norms that hinder women's reproductive autonomy in the home.

Recommendations

This matrix sets out actionable recommendations for advancing SRHR in Benin. Although Benin already holds one of the region's most progressive legal frameworks anchored by **Law No. 2021-12**, the central challenge lies in turning these legal gains into real, everyday access. The actions below are organised by a stakeholder group to support coordinated delivery.

Government

- Clear clinical guidelines for safe abortion services should be developed and disseminated so that the rights granted under **Law No. 2021-12** translate into practice rather than remaining a right on paper.
- Fully operationalise **Decree No. 2023-151** (May 2023), which enacts the 2021 amendment to the **Sexual and Reproductive Health Law**, by ensuring that its provisions on facility authorisation, provider qualifications and informed consent for safe abortion services are implemented consistently across all health facilities.
- Increase funding for the health sector and ring-fence budget lines for contraceptive procurement, preventing the recurring stock-outs that hit rural areas hardest.
- Honour the national commitment to make modern contraceptives available to young people in public health facilities free of charge.
- Equip health facilities with the necessary supplies, equipment, and trained staff to provide comprehensive SRHR care, particularly outside urban centres.
- Strengthen SRHR data systems by collecting reliable, disaggregated data on service delivery, funding, and clinical outcomes, addressing fragmented and outdated records that currently obscure the gap between law and practice.
- Remove administrative and procedural barriers that delay access to time-sensitive reproductive care.
- Establish a standardised, nationwide comprehensive sexuality education (CSE) programme in schools to close the information gap that exposes young people to unintended pregnancy and STIs.

- Review the exceptions in the **Code of Persons and the Family (Law No. 2004-020)** that allow minors to marry before age 18 with parental or judicial consent and work towards eliminating these exceptions to ensure full protection of girls' rights and reproductive autonomy.

Healthcare providers

- Complete thorough training to deliver safe, legal abortion services under **Law No. 2021-12** and **Decree No. 2023-151** without bias or judgement, including facility authorisation requirements and informed consent procedures.
- Participate in regular values-clarification and human rights training to support unbiased, respectful care for all patients, including adolescents and unmarried women who face heightened stigma.
- Build referral systems and professional networks so that women and adolescent girls can access appropriate care wherever they are, including in rural and remote regions.
- Uphold client confidentiality and provide non-judgemental counselling on all SRHR services.
- To inform continuous reform, share practical feedback with policymakers on implementation challenges, including barriers encountered during the rollout of the 2021 reform and **Decree No. 2023-151**.

Civil society organisations

- Launch community engagement programmes that address deep-seated cultural norms, religious beliefs, and social stigma around SRHR, particularly among adolescents and unmarried women.
- Lead education drives that normalise open discussion of sexual and reproductive health, reduce stigma and help communities understand the rights already guaranteed under **Law No. 2021-12**.
- Support strategic litigation to dismantle remaining patriarchal provisions in family law, including the exceptions to minimum marriage age, and to strengthen women's reproductive autonomy.
- Monitor the rollout of the 2021 abortion reform and **Decree No. 2023-151** and hold duty-bearers accountable for consistent delivery across all health facilities.
- Advocate for the removal of all exceptions that permit marriage under 18 years, building on the commitments of the **Children's Code (Law No. 2015-08)**.
- Document and share Benin's successes, such as the 2021 evidence-based, coalition-driven reform of 2021 to inspire replication elsewhere.

Regional bodies

- Monitoring Benin's progress on health-sector funding and the practical implementation of its progressive laws, including the operationalisation of **Decree No. 2023-151**.
- Technical assistance for clinical training programmes on safe abortion and family planning.
- Facilitate cross-country learning exchanges, positioning Benin's evidence-based, coalition-driven reform model as a regional benchmark.
- Offer policy templates and legal drafting support to help sustain and deepen alignment with **Article 14** of the **Maputo Protocol**.

Media, campaigns and technology

- Run sustained public awareness campaigns that explain the rights granted under **Law No. 2021-12** and wider SRHR entitlements, helping close the gap between what the law allows and what people know.
- Use media platforms to counter cultural stigma and challenge myths that discourage women and providers from using or offering legal services.
- Deploy digital platforms, mobile tools, and social media to share accurate SRHR information and extend youth-friendly outreach to underserved and rural communities.
- Partner with community leaders, women's groups, and youth advocates to amplify and broaden the reach of accurate messaging.
- Use technology to support confidential information channels, helping adolescents and unmarried women access guidance without fear of judgement.
- Produce and distribute multilingual and local-language content to low-literacy and rural populations who may be excluded by language barriers.

Addressing sociocultural and religious barriers

Deep-seated cultural norms, religious beliefs, and patriarchal structures remain among the most formidable obstacles to SRHR in Benin. These barriers cut across every stakeholder group and need dedicated, sustained attention even as the legal framework of the country leads the region. The following measures can help address these barriers:

- Engage religious and traditional leaders as partners in dialogue, acknowledging their significant gatekeeping role in shaping attitudes towards contraception, family planning, and abortion, and working with them rather than around them.
- Tackle the stigma that deters adolescents and unmarried women from seeking contraception or safe abortion services, normalising open conversation about SRHR through trusted community voices.
- Address patriarchal family structures that limit women's decision-making on family planning by fostering community-level dialogue that challenges discriminatory norms and promotes equal reproductive autonomy for women and girls.
- Replicate the evidence-based, coalition-driven approach that underpinned the 2021 abortion reform by bringing together health data, civil society, and trusted community messengers to drive sustained behavioural and norm change.
- Community education initiatives that explain the protections already in law, including the rights granted by **Law No. 2021-12**, to ensure that women and girls know they can act on their legal entitlements.
- Use trusted messengers, including healthcare workers, community leaders, and women's organisations, to normalise SRHR discussions in rural and conservative settings where stigma runs deepest.
- Frame outreach and reform advocacy around the concrete, documented toll of unsafe abortion, using hard clinical evidence to build credibility and win support among community and religious gatekeepers.

Burkina Faso

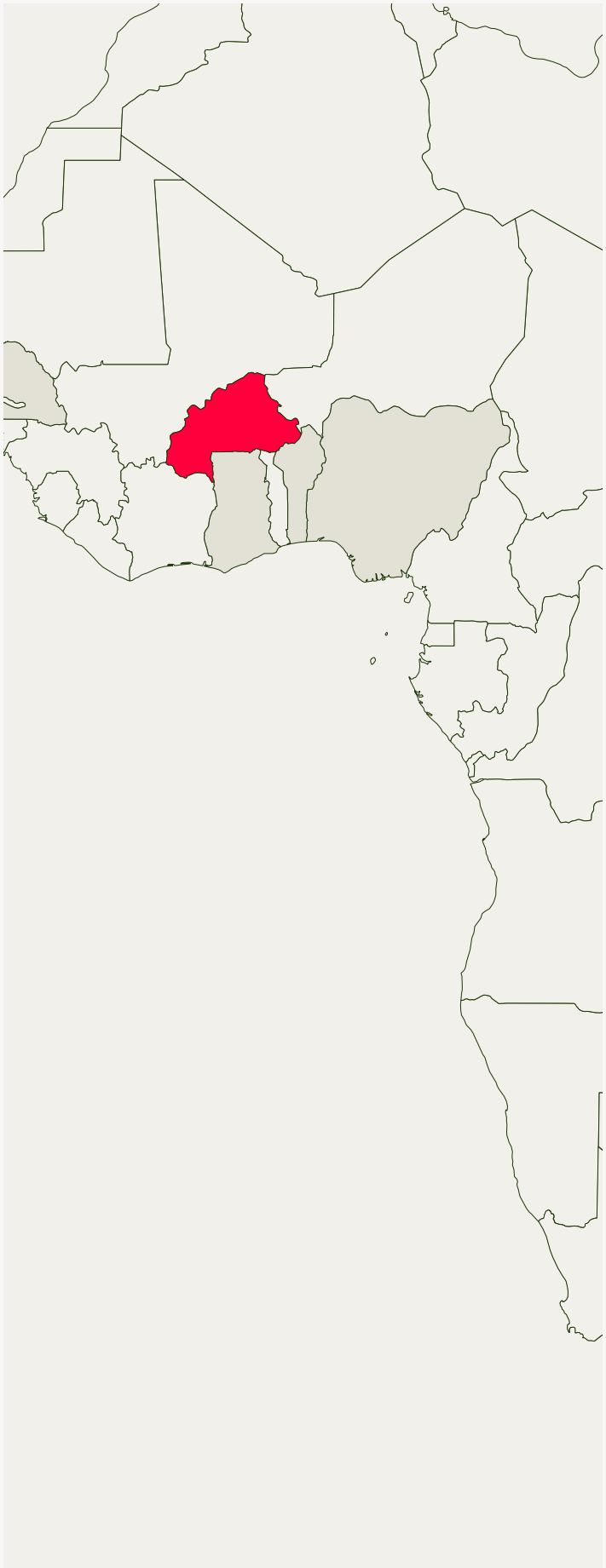
Overview of the national health laws

Burkina Faso has established a comprehensive legal framework to safeguard SRHR. The foundation of this system is the constitution of 2 June 1991.[36] **Article 1** guarantees equality and explicitly prohibits sex-based discrimination. **Article 2** protects physical integrity and forbids degrading treatment, offering constitutional support against harmful practices. **Article 18** officially recognises the right to health and mandates the state to promote it.[37]

Beyond the constitution, **Act No. 049-2005/AN on reproductive health**[38] serves as the primary legislation for SRHR. This law affirms the right to quality reproductive health services, establishing frameworks for family planning, safe motherhood, and the management of sexually transmitted infections. **Article 8** of **Law No. 049 2005 AN**[39] on reproductive health and sexual rights states that all individuals, including adolescents and children, have equal rights and dignity regarding reproductive health. No individual may be deprived of this right, which they enjoy without any discrimination based on age, sex, wealth, religion, ethnicity, marital status, or any other consideration.[40]

The criminal code heavily regulates reproductive autonomy. While **Article 386** prohibits elective abortion, **Article 387** permits it when the mother's life or health is in danger, in cases of severe foetal abnormality, or upon the woman's request following rape or incest (within the first ten weeks, pending public prosecutor confirmation). **Article 388** requires three doctors to confirm therapeutic abortions and sets penalties for infractions.[41]

Other notable legal provisions include the **Code of Persons and the Family (CPF),** which was amended and adopted in 2025 and replaced the 1989 version. The CPF recognises the equality of men and women, prohibits forced marriage and sets the minimum marriage age at 18 for both girls and boys.[42] Legislation against female genital mutilation (FGM) has evolved, with **Law 43/96/ADP of 1996** revised in 2018 and incorporated into the **Criminal Code (Articles 380–381)**, also severely punishing FGM, with enhanced penalties for medical professionals who perform it, imposing substantial penalties particularly for repeat and professional offenders.[43]



Progressive policies and examples of best practices

Burkina Faso has implemented several policies that serve as excellent models for advancing SRHR. The **National action plan to eliminate FGM (comité national de lutte contre la pratique de l'excision (CNLPE)),** established by Presidential Decree No. AN VII-318/FP/SANAS/SEAS of 18 May 1990[44] is a standout best practice. The government established the National Committee against the practice of FGM, created an anonymous national reporting hotline, deployed police to patrol villages, and integrated FGM education into primary and secondary school curricula. Educational campaigns on FGM in Burkina Faso reached more than 300 remote villages. This multi-pronged approach uses media and community engagement to enforce zero tolerance.[45] [46]

Another notable best practice is that since April 2016, Burkina Faso has implemented a national policy[47] known as "*la gratuité des soins,"* which provides free healthcare for pregnant and breastfeeding women and children under five. The policy also includes free screening and treatment for all women with cervical and breast cancer. This free care is available in all public and state-approved health facilities throughout the country.[48]

Burkina Faso has adopted a new **Persons and Family Code (CPF),** setting the minimum legal age for marriage at 18 for both girls and boys, an update from the previous ages of 17 for girls and 20 for boys. While this is seen as progress for girls' rights, whether judicial exceptions will still be permitted remains unclear.[49] However, the 2025 amendments to this code introduce regressive measures. **Article 210-3** criminalises same-sex conduct and its promotion, with penalties of two to five years' imprisonment and fines up to 10 million CFA francs. This amended code was adopted by the transitional legislature on 1 September 2025, and was signed into law by President Captain Ibrahim Traoré on 25 September 2025, replacing the 1989 version.[50]

The FP2030 commitment, which aims to increase the prevalence of contraceptives and service delivery, also stands out as a best practice in strengthening the policy-driven health system.[51] Between 2008 and 2010, Burkina Faso's Ministry of Social Action and National Solidarity ran a pilot project to combat early marriage across five regions. Titled "Eliminating early marriage in Burkina Faso: A community protection, empowerment, and intervention plan," this was the country's first state-led initiative to combine legal enforcement with community-based protection and psychosocial support for survivors. The project provided psychological help to 332 survivors of early and forced marriage. It also led to the prosecution of nine individuals for forced marriage, marking the first time Burkina Faso systematically used its laws against the practice.[52]

Assessment of alignment with Article 14

In June 2006, Burkina Faso ratified the **Maputo Protocol** without reservations, indicating its commitment to upholding the rights enshrined within it. The national framework's alignment with **Article 14** is partial, with areas of both progress and significant divergence.

Law No. 049-2005[53] on reproductive health aligns with the **Maputo Protocol**, specifically **Articles 14 (1a)** and **14 (1b)** regarding the right to control fertility and access to contraceptives. This law affirms the right to decide on the number and spacing of children and requires that the state provide access to family planning information and services. This alignment is further supported by national policies that promote free or subsidised contraception.

However, the legal framework of Burkina Faso is only partially aligned with **Article 14** of the **Maputo Protocol**. While the Penal Code authorises abortion in cases of rape, incest, or when the pregnancy poses a grave danger to the woman's health or life, it does not explicitly include endangerment of her mental health, as specified in the **Maputo Protocol Article 14 (2) (c)**. This omission creates a significant gap, limiting the legal scope of abortion access compared to the regional standard.

Gaps, inconsistencies and challenges

The most significant challenge is the ongoing security and humanitarian crisis that has unfolded since 2015. This protracted crisis has had severe consequences, most notably the mass internal displacement of an estimated two million people[54] and the collapse of health services across large parts of the country. By the end of January 2024, healthcare access in the most affected regions had been severely impacted. A total of 426 health facilities have closed, and another 363 are offering only minimal services, leaving millions without access to basic healthcare,[55] let alone SRHR services. Women and girls in conflict-affected regions are particularly vulnerable to sexual violence; however, access to post-rape care and legal abortion is virtually non-existent.[56]

Sociocultural barriers, including conservative norms and religious beliefs, create a stigma around contraception, especially for adolescents, leading to a high unmet need for family planning. Additionally, the health system faces challenges from funding and resource constraints, such as a shortage of trained staff, frequent stock-outs of

contraceptives, and poor infrastructure, particularly in rural areas. These existing weaknesses are exacerbated by the ongoing humanitarian crisis.

Access to family planning remains a substantial challenge. While **Act No. 049-2005/AN**[57] guarantees access to contraceptives, the country's FP2030 commitments reveal that modern contraceptive prevalence and product availability at rural service points still require massive expansion to meet public need.[58]

Another critical inconsistency lies within abortion provisions. Although the law permits abortion under specific circumstances, the procedural hurdles are severe. Requiring confirmation from three separate doctors for therapeutic abortions or a public prosecutor's sign-off within a strict ten-week window for rape survivors creates immense administrative barriers. These delays often render legal abortion inaccessible to vulnerable women.

In addition to these existing limitations, the Penal Code does not explicitly recognise the endangerment of a woman's mental health as a legally permissible justification for abortion. This means that while physical health risks might be considered, the severe psychological impact of a pregnancy is not clearly stated as a valid reason for termination.

Even in stable areas, the gap between law and practice is wide. The legal grounds for abortion are not widely known by the public or even by all healthcare providers. The process of obtaining a legal abortion is often slow and bureaucratic, requiring judicial and medical approvals that can be difficult to secure, pushing many women towards unsafe, clandestine procedures. Furthermore, while anti-FGM laws are strict, enforcing them in remote areas remains a persistent challenge due to deeply ingrained cultural norms.[59]

Opportunities for improvement and reform

We can identify several clear opportunities to strengthen the SRHR landscape in Burkina Faso. The government can drastically improve maternal health by streamlining the procedural requirements for legal abortion. Removing the three-doctor rule and simplifying the process of prosecutor confirmation would allow women to access time-sensitive emergency care without unnecessary administrative delays.

Additionally, there is a strong opportunity to expand access to family planning through the **FP2030 National Commitment**. By successfully establishing the planned multisectoral coordination body, Burkina Faso can efficiently direct resources to rural clinics, ensuring they reach their goal of 90% contraceptive availability at service delivery points by 2030.[60]

Following a successful pilot phase in 2013, Burkina Faso made significant strides by gradually mainstreaming CSE into its education system between 2015 and 2020. To build on this progress, the country should expand its current efforts. CSE is now officially integrated into all pre-school, primary, and post-primary curricula and new teacher training programmes.[61] The next crucial step is to broaden the reach of these initiatives throughout the country, with a special focus on ensuring access in more rural and remote areas where such resources are often limited.

Recommendations

This matrix sets out refined, actionable recommendations for advancing SRHR in Burkina Faso. Although the country has a comprehensive legal framework, it remains only partially aligned with **Article 14** of the **Maputo Protocol**. Restrictive procedural rules, an ongoing security crisis, contraceptive stock-outs, and deep sociocultural resistance hold back progress. The following recommendations are organised by stakeholder groups to support coordinated, practical delivery.

Government

- Remove the three-doctor rule for therapeutic abortion and simplify the public prosecutor confirmation process so that women can access time-sensitive care without crippling administrative delays.
- Amend the Penal Code to recognise endangerment of a woman's mental health as a valid ground for abortion, closing the gap with **Article 14 (2)(c)** of the **Maputo Protocol**.
- Establish the planned multisectoral FP2030 coordination body to direct resources to rural clinics and drive towards the goal of 90% contraceptive availability at service delivery points by 2030.
- Resolve recurring contraceptive stock-outs by ring-fencing budget lines for commodity procurement and strengthening supply-chain management, particularly for rural service points.
- Protect and adapt SRHR services within the humanitarian response, restoring care in conflict-affected regions where 426 health facilities have closed and a further 363 operate at minimal capacity.
- Prioritise post-rape care and emergency reproductive services for women and girls in displacement settings, who currently face near-total gaps in access.
- Build reliable, disaggregated SRHR data systems to track service delivery and needs, addressing the fragmented and unreliable records caused by the security crisis.
- Sustain the "gratuité des coins" policy of free or subsidised family planning should be maintained and expanded to reach displaced and rural populations.

Healthcare providers

- Complete training on the exact legal grounds for abortion so that providers can confidently deliver lawful services rather than turning women away through fear or uncertainty.
- Participate in regular values-clarification and human rights training to support unbiased, non-judgmental care.
- Build referral systems and inter-professional networks so that women and girls can access appropriate care wherever they are, including remote and conflict-affected areas.
- Maintain confidentiality and respectful counselling, especially for adolescents and unmarried women who face heightened stigma.
- Strengthen the capacity to deliver mobile and outreach services that reach displaced communities that are cut off from fixed facilities.
- Share practical feedback with policymakers on the procedural barriers that block legal care, helping to inform continuous reform.

Civil society organisations (CSOs)

- Advocate for the rapid removal of the three-doctor rule and other legal bottlenecks that delay access to abortion.
- Push for full nationwide rollout of comprehensive sexuality education (CSE), building on the 2015 to 2020 mainstreaming so that rural and remote areas are not left behind.
- Run public legal literacy drives so that women, girls, and providers understand the rights and services already granted by the law.
- Mobilise community leaders, women's groups and youth advocates to challenge the stigma around contraception and adolescent sexuality.
- Monitor implementation of national commitments, including FP2030 targets, and hold duty-bearers accountable for delivery.
- Document and share successful community models in Burkina Faso, such as the FGM elimination campaigns, to support replication and scale-up.

Regional bodies

- Facilitate cross-border sharing of effective CSE curricula and supply chain management strategies suited to fragile and crisis-affected settings.
- Provide technical support and legal drafting assistance to assist Burkina Faso in harmonising its Penal Code with **Article 14**, including the mental health grounds for abortion.
- Apply diplomatic engagement and offer policy templates to encourage the removal of restrictive procedural barriers.
- Pooled procurement or regional investment mechanisms to ease contraceptive shortfalls in low-resource and conflict-affected areas.
- Monitor progress against **Article 14** through periodic reviews and performance benchmarks, factoring in the humanitarian context.

Addressing sociocultural and religious barriers

Conservative norms, religious influence, and entrenched stigma remain among Burkina Faso's greatest obstacles to SRHR. These barriers cross every stakeholder group and require dedicated and sustained attention.

- The legal enforcement of anti-FGM laws is paired with well-funded, community-led education programmes, recognising that punitive measures alone risk pushing the practice underground or across borders.
- Build on the proven National Committee Against FGM (CNLPE) model to shift social norms from within, including community engagement, school-based education, and anonymous reporting hotlines.
- Engage religious and traditional leaders as dialogue partners, addressing the gatekeeping role they play in shaping attitudes towards contraception, family planning, and abortion.
- Tackle the stigma that deters adolescents and unmarried women from seeking contraception by normalising open conversations about SRHR through trusted community voices.

- Replicate the community-protection and psychosocial-support approach of the early-marriage pilot project, combining legal action with survivor support.
- Frame reform around hard evidence, such as the toll of unsafe abortion, to win support from the community and policymakers, as successful coalitions elsewhere in the region have done.

Media, campaigns and technology

- Run sustained public awareness campaigns that explain existing SRHR and the legal grounds for abortion and family planning, closing the gap between what the law allows and what people know.
- Use radio, community media, and local-language broadcasting to reach rural and low-literacy populations, building on the media-driven success of the FGM campaigns that reached over 300 remote villages.
- Deploy mobile platforms, SMS tools, and social media to share accurate SRHR information and extend youth-friendly outreach to underserved and displaced communities.
- Use digital channels to provide confidential information and referral pathways, thereby helping adolescents and unmarried women seek guidance without fear of judgement.
- Counter myths and misinformation about contraception and abortion through targeted messaging that directly challenges stigma.
- Partner with community leaders, youth advocates, and women's groups to amplify trusted, locally grounded messaging.
- Explore digital tools to map service availability and supply levels, supporting public awareness and stronger data on access.

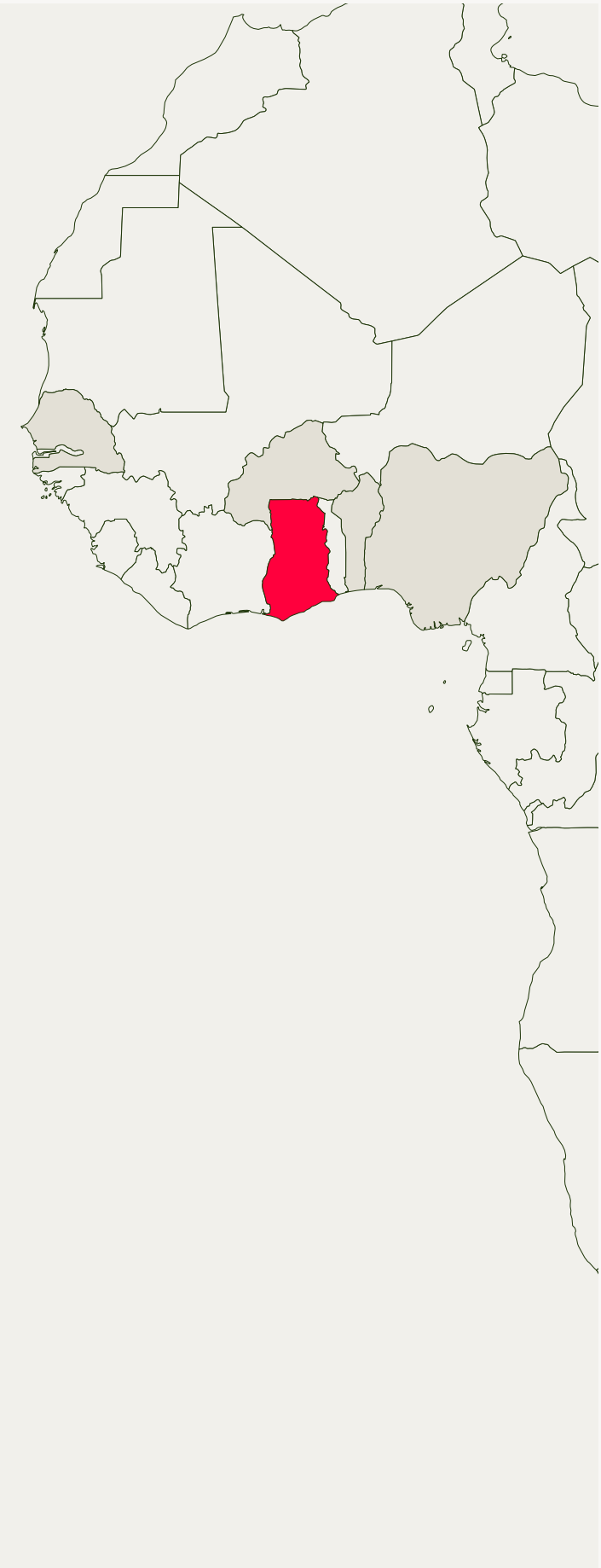
Ghana

Overview of the national health laws

Ghana has built a solid legal foundation to protect SRHR. The primary source of these protections is the **Constitution of the Republic of Ghana 1992**.[62] **Article 27** specifically protects maternity rights and the welfare of women.[63] Furthermore, **Article 30** provides explicit protection for vulnerable persons, extending vital safeguards to women across the country. While the Constitution does not have a standalone "right to health" clause, it is inferred from broader constitutional guarantees relating to dignity, social welfare, and protection of vulnerable persons. Ghana uses specific laws to regulate reproductive health beyond the constitution. A major piece of legislation is the **Criminal Offences Act 1960 (Act 29**). This law takes a relatively progressive stance for its time, allowing medical abortion in cases of rape, incest, foetal impairment, or when the pregnancy poses a risk to the woman's life or physical and mental health.[64] Ghana also enforces the **Domestic Violence Act 2007** and the **Human Trafficking Act 2005** to protect individuals from abuse and exploitation.[65] [66]

In 1994, a significant legal step was taken with the **Criminal Code (Amendment) Act**, which introduced **Article 69A** into the **Criminal Offences Act of 1960**. The primary purpose of this new article was to explicitly prohibit the practice then referred to as "female circumcision." Recognising the need for stronger measures and more accurate terminology, the law was further amended in 2007. This later amendment replaced the term "female circumcision" with "female genital mutilation" to better reflect the harmful nature of the act. Alongside this change in language, the penalties for performing the procedure were also increased to create a more robust deterrent.[67]

Together, these laws form a protective shield for vulnerable women and girls, ensuring they have legal recourse when faced with violence or coercion.



Progressive policies and examples of best practices

Ghana has pioneered several policies that serve as excellent models for the rest of the continent. The **Ghana Health Service and Teaching Hospitals Act, 1996 (Act 525)** establishes the Ghana Health Service (GHS), which is mandated to implement national health policies. The GHS has developed numerous policies and strategic documents, including the *National reproductive health service policy and standards* (2014) and the *National adolescent health service strategy*, to advance SRHR.[68] These policies aim to ensure access to a full range of reproductive health services, including family planning, maternal care, and post-abortion care.

Furthermore, Ghana has policies in place to promote access to contraceptives and integrate SRHR services into the primary healthcare system, often supported by the National Health Insurance Scheme (NHIS).

The most notable best practice is the community-based health planning and services (CHPS) programme. This initiative deliberately shifts healthcare delivery from hospitals to rural communities. By placing trained community health officers at the local level, the CHPS programme has drastically expanded access to family planning and maternal healthcare in remote areas.[69]

The nationwide rollout of safe motherhood programmes spearheaded by the family health division of the Ghana Health Service is another progressive step.[70] These initiatives include skilled birth attendance, antenatal care, and emergency obstetric support. Alongside the *National reproductive health service policy and standards*, these programmes have successfully reduced maternal mortality rates and improved the overall standard of reproductive healthcare across the country.[71]

Assessment of alignment with Article 14

Ghana shows strong alignment with key human rights instruments. It ratified the **Maputo Protocol** in June 2007 without reservations, signalling a commitment to its full implementation. Ghana's law is more liberal than that of many countries in the region and legally aligns with **Article 14(2)(c)** of the **Maputo Protocol**. **Article 14** of the **Maputo Protocol** requires African states to protect women's reproductive rights. Crucially, it asks states to authorise medical abortion in cases of sexual assault, rape, incest, and when a continued pregnancy endangers the mother's mental and physical health.

The **Criminal Offences Act 1960 (Act 29)**[72] explicitly includes these exact exceptions to abortion in cases of rape, incest, or defilement of a woman with a mental disability and when the pregnancy results from incest or poses a risk to the life or physical *or* mental health of the woman. The inclusion of mental health as a ground is progressive and aligns with the **Maputo Protocol**.

By providing a legal pathway for safe abortion in these specific circumstances, Ghana meets the continent's baseline for reproductive autonomy. Furthermore, the constitutional[73] protections for maternal welfare reflect the broader commitments found in the African Union health frameworks, showing that Ghana actively harmonises its domestic laws with regional expectations.

Gaps, inconsistencies and challenges

The provision under **Section 58(2)** of the **Criminal Offences Act of 1960** permits abortion where a pregnancy results specifically from rape, defilement of a person with a mental disability, or incest, rather than from sexual assault more broadly. This is an important distinction, as sexual assault encompasses a wider range of non-consensual acts than rape alone.[74] Consequently, a survivor of sexual assault falling outside the narrower definition of rape may have no clear legal pathway to lawful abortion under this ground.

Despite a progressive legal framework on paper, significant gaps exist when these laws meet reality. The most glaring challenge is access to safe abortion services. Even though **Act 29** permits abortion under several conditions, there is a widespread lack of awareness of its legal provisions among both the public and healthcare providers. Many women and girls do not know their legal rights. Furthermore, healthcare providers sometimes lack clarity on the law or allow personal beliefs to interfere with service delivery. Many believe that abortion is illegal under all circumstances. This, combined with the stigma attached to abortion, means that many qualified women are denied legal services and resort to unsafe methods. This gap drives many vulnerable women to seek unsafe, clandestine abortions, putting their lives at risk.

Compared with women aged 30 and older, teenagers and women in their 20s are at a higher risk of undergoing an unsafe abortion. This increased vulnerability can be attributed to several factors. For instance, younger women may lack awareness of safe and legal abortion services. They are also more likely to face financial barriers because they have less access to the necessary resources to cover the costs of a safe procedure. Furthermore, the social stigma surrounding abortion can have a more profound influence on younger individuals, potentially leading them to seek out clandestine and unsafe options.

Conservative cultural and religious values create significant resistance to open sexuality discussions. This has repeatedly stalled efforts to implement a national, age-appropriate CSE curriculum in schools, leaving young people without vital information. Stigma also limits access to contraception for adolescents and unmarried individuals.[75]

Access to sexual and reproductive health and rights (SRHR) services is highly unequal. Women in rural areas face greater barriers due to distance, cost, and a lack of trained providers. Although the National Health Insurance Scheme (NHIS) covers some services, out-of-pocket expenses for supplies and transportation remain a significant deterrent for the poorest populations.[76]

There are also major inconsistencies in rural healthcare delivery. Although urban centres often have better-equipped clinics, remote communities struggle to access basic reproductive health services. Staff shortages, frequent stock-outs of essential contraceptives, and poor road infrastructure mean that a woman's right to maternal healthcare often heavily depends on where she lives. Addressing these logistical and social barriers remains a major challenge for the health sector.[77]

Opportunities for improvement and reform

Ghana has clear opportunities to strengthen its SRHR framework and close existing service gaps. First, the Ministry of Health has a prime opportunity to run nationwide education campaigns. By openly teaching the public and healthcare providers about the legal allowances within **Act 29**, this can reduce stigma and ensure women access the safe care to which they are legally entitled.

There is also a great opportunity to improve service delivery by fully funding and implementing the *Family Planning Costed Implementation Plan 2016 to 2020*[78] and the *National Adolescent Health Service Strategy*.[79] By directing resources specifically to these plans, the Ghana Health Service can ensure that clinics have reliable contraceptive supplies. Additionally, the National Population Council can use its demographic insights to guide county-level leaders, helping them build youth-friendly health corners that specifically target adolescents' needs.

Recommendations

This matrix sets out recommendations for advancing SRHR in Ghana. The country holds one of the region's more progressive legal frameworks, with the **Criminal Offences Act 1960 (Act 29)** permitting abortion in cases of rape, incest, foetal impairment, and risks to a woman's physical or mental health. However, a wide gap remains between what the law allows and what women and girls can actually access. The following recommendations are organised by stakeholder groups to support coordinated, practical delivery.

Government

- Fully fund and execute the *Family Planning Costed Implementation Plan* and the *National Adolescent Health Service Strategy*, directing resources to translate policy commitments into reliable, on-the-ground services.
- Develop and widely disseminate clear clinical guidelines on the legal grounds for abortion under **Act 29**, so that providers and the public understand exactly when safe, legal services apply.
- Strengthen the National Health Insurance Scheme (NHIS) to cover a fuller range of SRHR services, reducing the out-of-pocket costs for supplies and transport that deter the poorest populations.
- Resolve recurring contraceptive stock-outs by ring-fencing budget lines for commodity procurement and improving supply-chain management, particularly for rural service points.
- Build youth-friendly health corners across all districts, drawing on the demographic insights of the National Population Council to target the specific needs of adolescents.
- Sustain and expand safe motherhood programmes and the *National Reproductive Health Service Policy and Standards* (2014), ensuring nationwide consistent quality of care.

Healthcare providers

- Complete regular values-clarification and human rights training to deliver safe, legal SRHR services without personal bias or judgement.
- Gain a clear understanding of the exact provisions of **Act 29**, correcting the common misbelief that abortion is illegal under all circumstances, and reducing the unlawful denial of care.
- Establish referral systems and inter-professional networks so that women and adolescent girls can access appropriate care wherever they are, including rural and remote areas.
- Uphold client confidentiality and provide non-judgmental counselling, especially for adolescents and unmarried women who face heightened stigma.
- Extend rural outreach through the community-based health planning and services (CHPS) programme, bringing family planning and maternal care directly into underserved communities.
- Share practical feedback with policymakers on implementation barriers to inform continuous reform.

Civil society organisations (CSOs)

- Run legal literacy campaigns that explain women's rights under **Act 29** so that more women understand the safe care they are legally entitled to receive.
- Monitor implementation of national plans and policies, holding duty-bearers accountable for the delivery of youth-friendly services and reliable commodity supplies.
- Pursue strategic litigation where SRHR protections fall short, using the courts to broaden the practical application of existing rights.
- Lead community engagement that partners with local leaders to dismantle the stigma surrounding abortion and contraception.
- Advocate for adopting a standardised, age-appropriate comprehensive sexuality education (CSE) curriculum in schools, countering the resistance that has repeatedly stalled progress.
- Document and share Ghana's successes, such as the CHPS model, to inspire replication and scale-up.

Regional bodies

- Highlight Ghana's progressive legal framework, particularly its alignment with **Article 14(2)(c**) of the **Maputo Protocol**, as a model for other West African states.
- Track Ghana's implementation of youth-friendly services and provide technical support to close the law–practice gap.
- Facilitate West African knowledge exchange by sharing Ghana's clinical guidelines, CHPS approach, and reproductive health policies across the sub-region.
- Offer policy templates and technical assistance to help sustain and deepen alignment with regional SRHR commitments.

Media, campaigns and technology

- Run nationwide awareness campaigns that explain the exact legal provisions of **Act 29**, closing the gap between what the law permits and what the public is aware of.
- Deploy digital and mobile platforms to extend youth-friendly outreach and share accurate SRHR information with adolescents and underserved rural communities.
- Use technology to provide confidential SRHR information channels, helping adolescents and unmarried women seek guidance without fear of judgement.
- Combat misinformation about abortion and contraception through targeted, evidence-based messaging that challenges the myths fuelling unsafe practices.
- Partner with community leaders, women's groups, and youth advocates to amplify trusted, locally grounded messaging.

Addressing sociocultural and religious barriers

Conservative cultural and religious values remain among some of the obstacles to SRHR in Ghana. They drive resistance to CSE, sustain stigma around abortion and contraception, and shape the attitudes of providers, parents, and policymakers. These barriers cross every stakeholder group and require dedicated and sustained attention.

- Tackle the resistance to a national CSE curriculum by engaging parents, teachers, and faith communities early, framing CSE around protecting young people from unintended pregnancy and STIs.
- Address the stigma that deters adolescents and unmarried women from seeking contraception by normalising open conversation through trusted community voices.
- Engage religious and traditional leaders as dialogue partners, recognising their gatekeeping role in shaping attitudes towards contraception, family planning, and abortion.
- Reduce abortion stigma by clarifying that **Act 29** already permits safe, legal services in defined circumstances for both communities and providers.
- Use trusted messengers, including community health officers within the CHPS network, to carry accurate information into rural and conservative settings.
- To win community and policymaker support, ground reform and outreach in hard evidence, such as the toll of unsafe abortion among teenagers and women in their twenties.

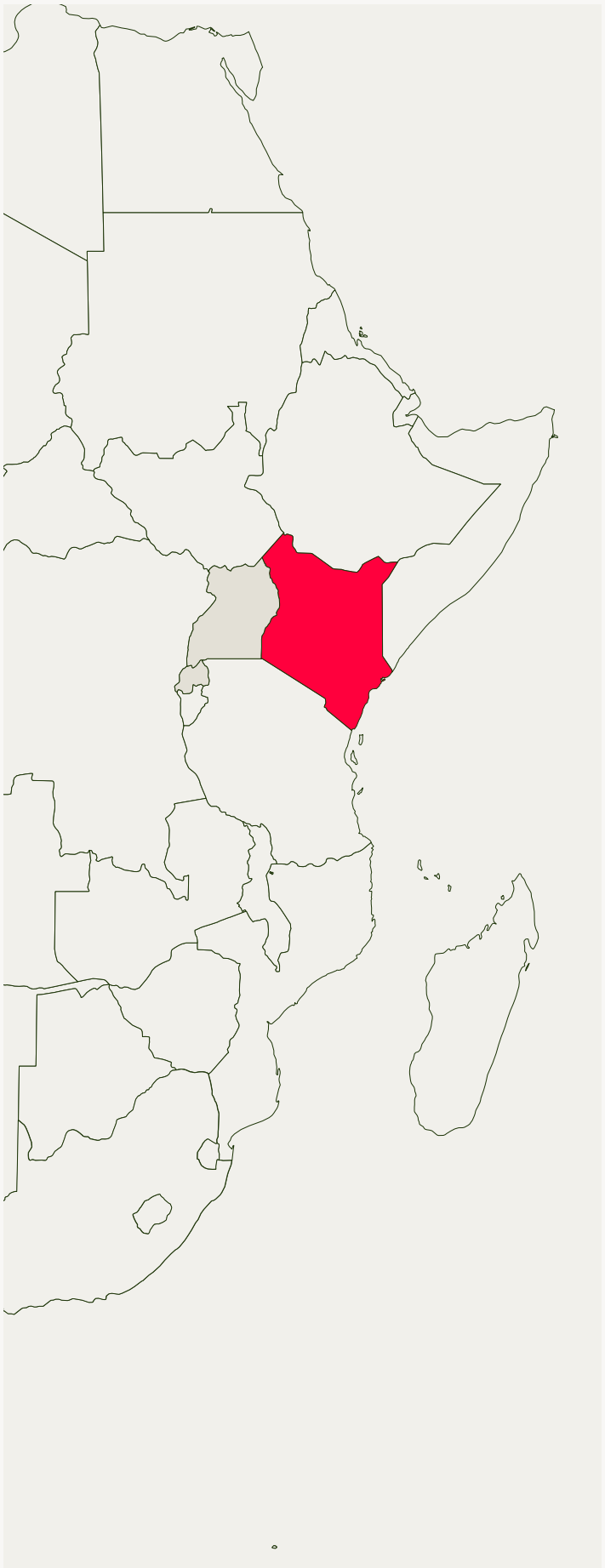
Kenya

Overview of the national health laws

Kenya has developed a robust legal framework to protect health and reproductive rights, anchored primarily by the **Constitution of Kenya 2010.**[80] **Article 43** of the Constitution is a cornerstone provision that guarantees every person the right to the highest attainable standard of health, including reproductive healthcare.[81] Furthermore, **Article 53** recognises and protects the specific rights of children to health and basic protection.[82] **Article 26(4)** provides a conditional right to abortion when it comes to pregnancy termination, permitting it only when a trained health professional determines there is a need for emergency treatment or if the life or health of the mother is in danger.[83]

Beyond the Constitution, several key acts form the foundation of the country's SRHR. The **Health Act 21 of 2017** establishes a unified framework for delivering health services, including reproductive care.[84] The **Sexual Offences Act 3 of 2006** addresses protection against sexual violence, which ensures survivors have access to justice and vital post-rape care.[85] Additionally, the **Prohibition of Female Genital Mutilation Act of 2011** explicitly outlaws the practice, protecting the physical and psychological integrity of women and girls.[86]

Other supporting legislative include the **HIV and AIDS Prevention and Control Act 2006**[87] and the **Children Act 29 of 2022**, which provide essential protections relevant to adolescent health.[88] However, the **Children Act** has been criticised for failing to provide comprehensive sexual education (CSE) and access to reproductive services for adolescents. **Section 16** of the Act mandates parental or guardian consent for children to receive these services, creating a major barrier for adolescents aged 10 to19 who often fear stigma and violence if they have to ask permission for things like contraceptives or STI testing.[89]



Progressive policies and examples of best practices

Over the past decade, the **Kenyan Ministry of Health (MOH)** has introduced several reforms to improve maternal healthcare. In 2013, the MOH launched a free maternity health programme that eliminated user fees at public facilities to remove financial barriers for women. In 2016, the programme was transitioned to the National Health Insurance Fund (NHIF), renamed the **"Linda Mama programme**," and expanded. The Linda Mama benefits package covers a mother's entire pregnancy and up to three months of postpartum care in public and private facilities. Pregnant women and mothers could register with the NHIF through various channels, including mobile phones or at health facilities. However, in 2023, the government enacted the **Social Health Insurance (SHI) Act**, abruptly ending the 57-year-old NHIF and the Linda Mama programme.[90]

The **Kenya Health Policy 2014 to 2030** and the **National Adolescent Sexual and Reproductive Health Policy (2015)**[91] stand out as progressive frameworks designed specifically to address the unique reproductive needs of young people, aiming to reduce teenage pregnancies and HIV transmission.[92]

In February 2019, the Kenyan Ministry of Health launched **the Obstetric Protocols** to standardise care and reduce maternal and neonatal mortality. These protocols focus on six key areas: postpartum haemorrhage (PPH), antepartum haemorrhage (APH), obstructed/prolonged labour, hypertensive disorders (eclampsia), sepsis, and abortion complications. [93]

The judiciary has also played a crucial role in establishing strong legal precedents that protect SRHR in Kenya. For instance, in the case of **Dr Tatu Kamau v The Hon. Attorney General**, the High Court's dismissal of the petition firmly upheld the unconstitutionality of female genital mutilation. This ruling reinforced the fundamental right to bodily autonomy and integrity, sending a clear message about the legal protections afforded to individuals against such harmful practices.[94]

In a significant ruling in 2022, the High Court of Kenya formally addressed the connection between reproductive healthcare and fundamental human rights. In the case of **PAK & Others v Attorney General (Petition No 266 of 2015)**, the court recognised that significant rights violations can indeed occur when individuals are denied access to safe abortion services. This decision established a crucial legal precedent, acknowledging that restricting access to such services is not merely a healthcare issue but can also constitute an infringement of an individual's basic rights.

Similarly, the landmark **AIDS Law Project v. Attorney General decision of 2015**[95] was another crucial step forward. This case clearly demonstrated Kenya's growing capacity for and commitment to rights-based legal progress within its judicial system by legally reinforcing the fundamental rights of individuals living with HIV.

Assessment of alignment with Article 14

Kenya's legal structure shows significant alignment with regional human rights instruments, particularly **Article 14** of the **Maputo Protocol**, which guarantees women's health and reproductive rights. **Article 43 of the Kenyan Constitution** directly mirrors the mandate of the **Maputo Protocol** to provide adequate, affordable, and accessible health services to women.[96] However, it is worth noting that although Kenya ratified the **Maputo Protocol**, it entered a reservation specifically to **Article 14(2)(c)**, which addresses access to safe abortion under specific circumstances such as sexual assault, rape, incest, or where the pregnancy endangers the mother's physical or mental health or the mother's or foetus's life. This reservation limits the extent to which Kenya is bound to implement the safe abortion provisions outlined in **Article 14(2)(c)**. Nonetheless, Kenya's domestic legal framework is, in many respects, well aligned with other aspects of **Article 14**.

Kenya's conditional abortion allowance under **Article 26(4)** represents a step towards aligning with **Article 14(2)(c)** of the **Maputo Protocol**. Although Kenya's Penal Code of 1963 under **Articles 158 -160** establishes a general prohibition on abortion, treating it as a criminal offence punishable by imprisonment,[97] subsequent constitutional provisions have resulted in a significantly more nuanced legal landscape surrounding reproductive rights. In particular, the 2010 Constitution introduces a critical exception through **Article 26(4).** This article permits abortion when, in the considered opinion of a trained health professional, there is a clear need for emergency treatment or if the continuation of the pregnancy is determined to endanger the mother's life or health. This constitutional clause effectively creates a legal pathway for abortion under specific, medically justified circumstances, establishing a crucial distinction between the blanket prohibition outlined in the older penal code and the conditional allowances granted in the more recent constitution. However, Kenya's alignment here remains partial, as the national law does not explicitly list rape or incest as standalone constitutional grounds for abortion, focusing

strictly on maternal life and health.

The 2011 Prohibition of Female Genital Mutilation Act 2011[98] serves as a strong domestic application of the Protocol's demand to eliminate harmful traditional practices.

Gaps, inconsistencies and challenges

Despite Kenya's progressive legal and constitutional framework for SRHR, significant gaps and challenges hinder its full implementation. Notably, Kenya entered a reservation to **Article 14(2)(c)** of the **Maputo Protocol**, limiting its obligation to ensure safe abortion. This discrepancy between the legal framework and its practical application creates significant challenges.

The primary challenge lies in the interpretation and implementation of **Article 26(4)** regarding safe abortion. Because abortion remains largely criminalised outside specific medical exceptions, health providers often fear prosecution. This ambiguity forces many women to seek unsafe, clandestine abortions. The High Court ruling in **PAK & Others v Attorney General (2022)** highlighted severe human rights violations arising from the denial of safe abortion services. This case emerged from policy gaps created by the arbitrary withdrawal of the *Standards and guidelines for reducing maternal mortality and morbidity from unsafe abortion*. The withdrawal left medical professionals without clinical guidance on when they could legally perform a termination. These gaps demonstrate reliance on reactive litigation rather than proactive policy changes, leaving the SRHR framework fragile.[99]

Prior to the **PAK case**, the withdrawal of the guidelines was challenged at the constitutional court in **the JMM case (Federation of Women Lawyers Kenya (FIDA-K) & 3 others v Attorney General & 2 others [2019] eKLR**). This ruling diluted the impact of the reservation by affirming that rape and sexual assault survivors have a right to access safe, legal abortion care under **Article 26(4)** of the Constitution.[100] On 25 March, 2022, the High Court of Kenya in Malindi ruled that abortion is a fundamental right under **Article 26(4)** of the Kenyan Constitution. The court deemed the arrest of PAK and Mohammed unlawful, affirmed the confidentiality of patient-provider communication, and stated that trained health professionals acting in good faith are not guilty of abortion offences under the Penal Code. It also ordered Parliament to create a legal and policy framework for access to abortion. However, the Kenya Court of Appeal reversed the 2022 High Court decision in **PAK & Salim Mohammed in April 2026. v. Attorney General**. The appellate court ruled that the Constitution does not grant a universal right to abortion, thereby criminalising the procedure except under the specific, narrow exceptions listed in **Article 26(4)**.[101]

Here are some other progressive judgments:

a) **Obstetric violence (Josephine Oundo Ongwen v. the Attorney General & 4 Others, 2018)**: In this case, upheld on appeal in 2024, the court found both national and county governments liable for failing to implement policies for respectful maternal care, specifically holding the Bungoma County Government responsible. While monetary compensation has been settled, policy implementation gaps remain.

b) **Unlawful detention of mothers (M.A.O and others) v. Attorney General and 4 others (2015):** This decision, known as the Pumwani case, led to a major policy shift, prompting the government to create and enforce the Linda Mama programme in 2013. However, the discontinuation of this programme is now a challenge.

Health protections for adolescents also face inconsistencies. While the **Children Act 2022** and the Constitution protect children's right to health, accessing contraceptive and reproductive health services remains difficult for unmarried adolescents due to cultural stigma, lack of provider training, and conflicting interpretations of age-of-consent laws.[102] Furthermore, while devolution has transferred health service delivery to county governments, this has led to unequal resource allocation and varying reproductive care quality across different regions.[103] Another significant challenge comes from a vocal anti-rights movement, often supported by influential religious groups. This movement actively campaigns against SRHR through organised opposition. The lobby exerts considerable political pressure, leading to setbacks such as the 2014 withdrawal of specific guidelines and stalling efforts to implement comprehensive sexuality education (CSE) in schools.[104]

Access to SRHR services, which is not equal for everyone, is another stark challenge; significant regional and economic disparities create major gaps in care. For instance, women living in rural and marginalised communities often face greater challenges in reaching skilled health providers. This means that they have much more limited access to essential services, such as contraception and safe abortions, than their urban counterparts. Furthermore, the cost of these services can be a prohibitive barrier for many individuals, forcing them to turn to cheaper alternatives.

Opportunities for improvement and reform

In October 2010, Kenya ratified the **Maputo Protocol** but with a reservation to **Article 14(2)(c),** which allows safe abortion in cases of sexual assault, rape, incest, or when the mother's health is at risk. Lifting this reservation would align Kenya with its own 2010 Constitution and international human rights standards, improving women and girls' access to critical healthcare. This would also reduce the stigma around abortion, allow for investment in comprehensive SRHR programmes, and position Kenya as a regional leader in women's health.

The current landscape presents several opportunities for systemic reform. First, the Ministry of Health can officially reinstate and disseminate clear, comprehensive *Guidelines on safe abortion care* to empower medical professionals and eliminate the chilling effect surrounding emergency reproductive care.

County governments, now responsible for local health service delivery, have the opportunity to ring-fence budgets specifically for family planning and maternal health, guided by the ***National family planning costed implementation plan 2017 to 2020*** and the ***Kenya RMNCAH investment framework 2016 to 2030***.[105] There is also significant room to expand the capacity of the Kenya Medical Practitioners and Dentists Council to train providers on youth-friendly SRHR services, bridging the gap in adolescent healthcare access.

Strategic litigation, like the work driven by civil society organisations (CSOs) in Kenya, is a vital tool for broadening the application of constitutional reproductive rights through judicial interpretation. Using the judiciary to progressively interpret the Constitution can compel executive action, serving as a model for advancing SRHR, particularly where political will is lacking. This approach demonstrates how a strong constitutional foundation can be leveraged to defend and advance the rights guaranteed under the **Maputo Protocol.**

Recommendations

Kenya's 2010 constitution offers a strong foundation through **Article 43** and the conditional abortion provision in **Article 26(4)**. However, a reservation to **Article 14(2)(c)** of the **Maputo Protocol**, the withdrawal of the 2014 safe abortion guidelines, and uneven county-level delivery continue to hold back progress.

Government

- Withdraw the reservation to **Article 14(2)(c)** of the **Maputo Protocol**, bringing national commitments into line with the 2010 constitution and reducing the legal ambiguity around safe abortion.
- Officially reinstate and disseminate clear guidelines on safe abortion care, ending the chilling effect created when the 2014 guidelines were withdrawn.
- Pass and operationalise comprehensive reproductive health legislation that gives full practical effect to the rights guaranteed under **Article 26(4).**
- Harmonise the 1963 Penal Code **(Articles 158–160)** with constitutional provisions so that lawful care providers are not criminalised.
- Support county governments to ring-fence budgets for family planning and maternal health, guided by the *National family planning costed implementation plan* and the *Kenya RMNCAH investment framework 2016 to 2030*.
- Build disaggregated SRHR data systems to track service delivery and address devolution-induced disparities.
- Ensure the full and timely implementation of all national and international SRHR decisions and commitments, translating policy into tangible action.

- Reinstate the Linda Mama free maternity programme under the new **Social Health Insurance Act**. Enacted in late 2023, the act abruptly replaced the 57-year-old National Health Insurance Fund (NHIF), dismantling the Linda Mama programme. The government must urgently restore equivalent protections for vulnerable women within the SHI framework to prevent any loss of access to skilled birth attendance and maternal health services.

Healthcare providers

- Complete regular values-clarification and human rights training to deliver lawful SRHR services without fear of prosecution or personal bias.
- Gain clarity on the exact scope of **Article 26(4)** so that emergency and life-saving care is provided promptly rather than withheld through uncertainty.
- Build referral systems and inter-professional networks so that women and adolescent girls can access appropriate care across county lines.
- Uphold confidentiality and offer non-judgemental counselling, particularly for unmarried adolescents facing stigma and conflicting age-of-consent interpretations.
- Share practical feedback with county and national policymakers on the barriers that prevent the provision of lawful care.

Civil society organisations (CSOs)

- Continue strategic litigation that builds on **PAK & Others v Attorney General (2022)**, using the courts to broaden the practical application of constitutional reproductive rights.
- Drive grassroots advocacy by holding county governments accountable for ring-fencing health budgets and providing youth-friendly services.
- Run legal literacy campaigns so that women understand their rights under the Constitution and the implications of **Article 26(4)**.
- Counter the organised anti-rights lobby with evidence-based advocacy and coalition-building.
- Document and share Kenyan successes, such as the Linda Mama programme and progressive court rulings, to support replication.

Regional bodies

- Provide East African platforms for Kenya to share strategies on constitutional SRHR alignment.
- Apply constructive engagement to encourage the withdrawal of the reservation to **Article 14(2)(c)** of the Maputo Protocol.
- Offer technical support and model guidelines to help reinstate safe abortion care standards.
- Monitor Kenya's progress against **Article 14** through periodic reviews and benchmarks.

Media, campaigns and technology

- Run public awareness campaigns to explain the rights and services available under **Article 26(4)**, closing the gap between law and public understanding.
- Counter misinformation spread by anti-rights groups with accurate, evidence-based messaging.
- Deploy digital and mobile platforms to extend youth-friendly outreach to adolescents and underserved rural communities.
- Use technology to provide confidential information channels for unmarried women and young people.
- Partner with trusted community voices to amplify locally grounded messaging.

Addressing sociocultural and religious barriers

Influential religious groups and an organised anti-rights movement shape political and social attitudes, stalling CSE and sustaining stigma. These barriers cut across every stakeholder group.

- Engage religious and community leaders as partners rather than treating them solely as opponents.
- Tackle the stigma that deters unmarried adolescents from seeking contraception using trusted local messengers.
- Counter the political pressure that led to the withdrawal of the 2014 guidelines and continues to stall CSE by framing reform around preventable maternal deaths and unsafe abortion.
- Ground advocacy in hard evidence, including the human rights findings of **PAK v. AG**, to build community and policymaker support.
- Pair anti-FGM enforcement with community-led education to shift norms from within.

Nigeria

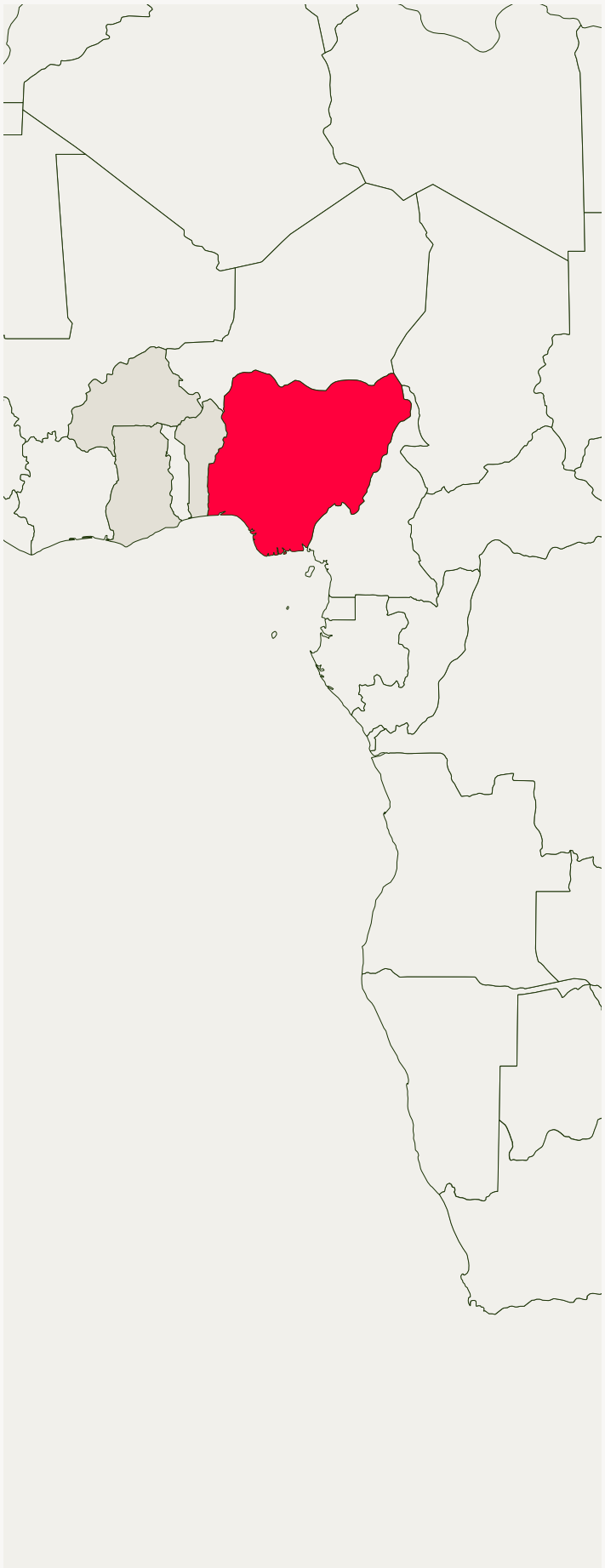
Overview of the national health laws

Nigeria has a complex legal landscape regarding sexual and reproductive health and rights (SRHR). The foundation of these rights sits within the **Constitution of the Federal Republic of Nigeria, 1999.**[106] Chapter IV guarantees fundamental human rights, including the right to life, human dignity, personal liberty, privacy, and freedom from discrimination. We draw upon these provisions to form the basis for claims of reproductive rights. However, while Chapter II directs the state to provide adequate medical facilities, these directives are legally non-justiciable, meaning that citizens cannot sue the government simply for failing to provide them.[107] Criminal law shows that a dual system governs the country.

In Southern Nigeria, **the Criminal Code Act** criminalises abortion. Section 228 states that a woman attempting to cause her own miscarriage faces up to seven years in prison. Anyone who helps induce a miscarriage faces up to 14 years, and anyone who supplies items for an abortion faces up to three years. These laws, outlined in sections 228-230, are based on intent, regardless of whether the woman is actually pregnant.[108] In Northern Nigeria, the **Penal Code Act** similarly criminalises abortion with heavy prison sentences of up to 14 years, operating alongside Sharia courts in 12 states.[109]

To protect vulnerable groups, Nigeria enacted the **Violence Against Persons (Prohibition) Act (VAPP Act)**[110] in 2015 and the **Child Rights Act in 2003**.[111] **The VAPP Act** criminalises rape, domestic violence, and FGM. The **Child Rights Act** sets the minimum marriage age at 18 years and prohibits child sexual abuse. However, this law and the **VAPP Act** only apply automatically in the Federal Capital Territory (FCT). For them to be effective elsewhere, each of Nigeria's 36 states must individually domesticate them.[112] Currently, 35 states have passed the **VAPP Act**, and 34 have passed the **Child Rights Act**.

The National Health Act, 2014[113] provides a framework for the development and management of a national health system. It mandates essential health services, including reproductive health and maternal care, and requires healthcare facilities to provide emergency care to all individuals regardless of their ability to pay. The **National Health Insurance Act, 2022 (replacing the NHIS Act of 1999)** provides a framework for universal health insurance coverage, including coverage for reproductive and maternal health services.[114]



Progressive policies and examples of best practices

Several progressive policies and landmark judicial decisions that serve as powerful best practices have been generated in Nigeria. The **National reproductive health policy** provides a strong, rights-based framework. It explicitly affirms that all Nigerians, regardless of age or gender, possess sexual and reproductive rights and deserve equal access to care.

The **Nigeria family planning blueprint (scale-up plan)** for scaling up access to family planning services, including contraception for adolescents, with targets for increasing modern contraceptive prevalence.[115] First adopted in 2001 and revised in 2009, the **National Reproductive Health Policy (NRHP)** from Nigeria's Federal Ministry of Health was first adopted in 2001 and revised in 2009. It is a rights-based framework that ensures that all citizens have access to sexual and reproductive health care. The policy addresses key areas, such as family planning, maternal health, HIV/AIDS, and gender-based violence.[116]

The judiciary has also delivered groundbreaking progress. In the landmark regional case of **Dorothy Njemanze & 3 Others v. (2017)**, the ECOWAS Community Court of Justice ruled that state agents unlawfully assaulted and discriminated against women. This was the first time an international treaty body found a violation of the **Maputo Protocol**, setting a massive sub-regional precedent.[117]

Domestic courts have recently begun to shift the narrative. In 2025, the Federal High Court in Abuja ruled against the **Reproductive Justice Initiative Foundation (RJIF).** The Attorney General stated that forcing survivors of sexual violence to carry unplanned pregnancies to term violates their fundamental right to physical and mental health. This decision represents a monumental first step in recognising reproductive healthcare for survivors not as a crime but as a fundamental human right.[118]

Assessment of alignment with Article 14

Nigeria ratified the **Maputo Protocol** in December 2004 without any reservations. However, the domestication and implementation of **Article 14** remain significant challenges. A stark misalignment exists between Nigeria's domestic legislation and its international commitments, specifically regarding **Article 14 (2) (c)** of the **Maputo Protocol**. While the country's **criminal code** permits abortion, it does so exclusively under the stringent condition of saving the woman's life. Similarly, the **Penal Code** restricts legal abortion to circumstances where it is necessary to preserve the life of the woman.

Neither of these legal frameworks acknowledges the broader grounds for safe abortion specified in **Article 14** of the **Maputo Protocol**. These grounds include cases of rape, incest, and sexual assault or situations where the pregnancy poses a significant risk to the woman's mental or physical health. This considerable gap means that Nigeria's laws are among the most restrictive in the region, placing them in direct conflict with the country's regional human rights commitments.

Nigeria demonstrates strong policy alignment with **Article 14 (1) (a) and 14 (1) (b)**, which cover the right to control fertility and access contraceptives of the **Maputo Protocol**. The nation's commitment is clearly evidenced by its participation in the Family Planning 2030 (FP2030) global partnership. Through this initiative, the government is actively working towards increasing the prevalence rate of modern contraceptives among its population. Furthermore, national policies support the free distribution of a range of contraceptives in public health facilities.[119] This strategic approach directly aligns with the Protocol's mandate to ensure that comprehensive and accessible family planning services are available to all.

Gaps, inconsistencies and challenges

The gap between federal policy and state-level implementation is the primary inconsistency in Nigeria, compounded by the conflict between SRHR policies and the penal laws.

Massive gaps can be seen between Nigeria's human rights commitments and the reality on the ground. The country's most glaring challenge is its highly restrictive abortion legislation. The law forces countless women to seek unsafe, clandestine abortions by threatening women and healthcare providers with long prison sentences. This legal barrier directly contributes to Nigeria's high maternal mortality rates.

The **Maputo Protocol** has not been domesticated into national law, as required by **Section 12** of the Constitution. This means that its provisions, including **Article 14**, are not directly enforceable in Nigerian courts.

In 2024, Nigeria's **Violence Against Persons Prohibition (VAPP) Act**, legislation that criminalises physical, sexual and emotional abuse, including domestic violence, rape, female genital mutilation, and child marriage, faced a significant threat. Senator Jibrin Isah (APC; Kogi) introduced a bill to repeal and re-enact the act, which was originally adopted in 2015. The bill, which passed its second reading in the Senate in September 2024, proposed replacing the **VAPP Act** with stronger legislation while

correcting certain technical errors in the existing law. However, it was met with considerable public opposition. Advocacy groups warned that the bill could weaken critical protections against sexual and gender-based violence (SGBV), and activists raised concerns about the lack of transparency and stakeholder consultation during the drafting process, fearing it could roll back key gains in the fight against gender-based violence.[120] [121]

Another major inconsistency stems from the federal structure of the country. While federal laws such as the **VAPP Act** and the **Child Rights Act** represent significant steps forward, their implementation varies locally.

The **Child Rights Act** was introduced as a federal law in 2003 and has since been adopted by all 36 states and the Federal Capital Territory (FCT). However, its formal enforcement is inconsistent. Bauchi was the last state to pass the act in late 2023, but several other states have not yet officially gazetted the law, thereby delaying its enforcement. This creates a fragmented legal landscape in which protection depends on geography.

A woman or child in a state that has fully domesticated these laws has strong legal protection against FGM and early marriage. In contrast, a person in a neighbouring state that has not adopted or gazetted the laws remains vulnerable. This fragmented system makes enforcing a unified national standard for reproductive health and safety incredibly difficult. Furthermore, because constitutional health rights are non-justiciable, citizens cannot easily hold the government accountable for failing to provide basic maternal care.

Nigeria is deeply religious and culturally diverse. Conservative norms regarding female sexuality often impede the implementation of SRHR initiatives, particularly comprehensive sexuality education (CSE) and access to contraceptives for adolescents.

Deeply ingrained religious beliefs and cultural norms are significant barriers to sexual and reproductive health and rights (SRHR) for young people. Discussions on adolescent sexuality are often taboo due to patriarchal structures, leading to stigma, low contraception use, and limited access to comprehensive sexuality education (CSE). Key obstacles include individual factors such as inadequate knowledge, social factors such as parental and religious influence, financial constraints, and health system factors such as poor provider attitudes and inconvenient clinic hours. Of these, social and religious pressures are the most significant, preventing adolescents from accessing reproductive health services.[122]

Health is on the concurrent legislative list. A progressive policy adopted at the federal level does not automatically apply to the 36 states. Advocates must repeat their efforts in every state legislature to secure adoption and funding.

Opportunities for improvement and reform

Despite these challenges, Nigeria has clear opportunities to strengthen its SRHR framework. The most immediate opportunity lies in sustained advocacy to ensure that all 36 states fully domesticate both the **VAPP Act** and the **Child Rights Act**. Achieving full domestication will create a consistent, nationwide shield against gender-based violence and child marriage.

Furthermore, the government can leverage the **National Health Act** of 2014 and the **National Health Insurance Act of 2022** to drastically improve maternal health outcomes. By fully funding and operationalising these frameworks, the state can guarantee emergency obstetric care and make modern contraceptives widely available. Lawmakers also have a pressing opportunity to amend the criminal and penal codes, expanding abortion exceptions to include survivors of rape and incest, thereby aligning domestic law with the **Maputo Protocol.**

Recommendations

Nigeria's federal structure, dual criminal code system, and the non-domestication of the **Maputo Protocol** create a deeply fragmented landscape. Progressive federal policies and recent court rulings offer openings, but state-by-state variation remains the central obstacle.

Government

- Domesticate the **Maputo Protocol** into national law as required by **Section 12** of the Constitution, so that **Article 14** becomes directly enforceable in Nigerian courts.
- Amend the Criminal Code (Southern Nigeria) and Penal Code (Northern Nigeria) to expand abortion exceptions to include survivors of rape and incest and risks to mental and physical health.
- Fully fund and operationalise the **National Health Act 2014** and the **National Health Insurance Act 2022** to guarantee emergency obstetric care and widen access to modern contraceptives.
- Build on the Family Planning 2030 (FP2030) partnership to raise the prevalence rate of modern contraceptives, sustaining free distribution in public facilities.
- Strengthen disaggregated data systems to track service delivery and maternal mortality across all 36 states.

Healthcare providers

- Complete values-clarification and human rights training to deliver lawful services without fear of the heavy penalties attached to the penal codes.
- Build referral systems so that women and girls can reach appropriate care regardless of their state of health.
- Provide emergency care to all patients, as required by the **National Health Act**, regardless of ability to pay.
- Maintain confidentiality and non-judgmental counselling, especially for adolescents facing conservative gatekeeping.
- Provide practical implementation challenges back to federal and state policymakers.

Civil society organisations (CSOs)

- Maintain sustained, state-by-state advocacy to secure the full domestication of the **VAPP Act** and the **Child Rights Act** across all 36 states.
- Build on the precedent set by the **Reproductive Justice Initiative Foundation (RJIF) v. Attorney General (2025**) and **Dorothy Njemanze v. Federal Republic of Nigeria (2017)** through continued strategic litigation.
- Educate communities on the provisions of the **National Health Insurance Act** and existing reproductive rights.
- Mobilise women's groups, youth advocates, and community leaders to challenge stigma at the local level.
- Document state-level successes to encourage adoption in lagging states.

Regional bodies

- Monitor Nigeria's state-by-state domestication progress and offer legislative drafting support.
- Use ECOWAS and continental platforms to reinforce the precedent of the Dorothy Njemanze ruling.
- Provide policy templates and technical assistance to support the harmonisation of the criminal and penal codes with **Article 14**.
- Apply diplomatic engagement to encourage the domestication of the **Maputo Protocol**.

Media, campaigns and technology

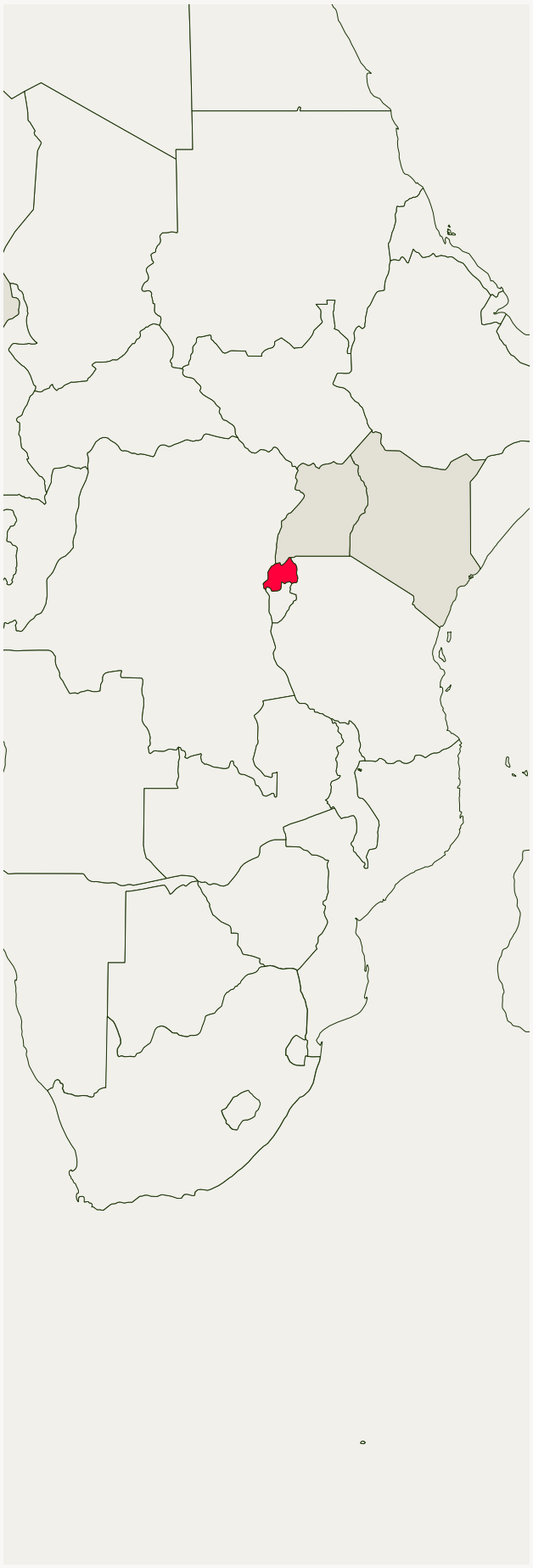
- Run awareness campaigns explaining rights under the **National Health Insurance Act** and existing federal reproductive health policies.
- Use digital and mobile platforms to extend youth-friendly outreach, navigating diverse cultural and religious contexts across states.
- Provide confidential digital information channels for adolescents and unmarried women.
- Counter misinformation about contraception and adolescent services using targeted, evidence-based messaging.
- Partner with trusted local and faith leaders to amplify accurate messaging in both the northern and southern contexts.

Addressing sociocultural and religious barriers

Deep religious and cultural diversity, patriarchal norms, and the influence of Sharia courts in 12 states make social and religious pressures the most significant barriers, particularly for adolescents.

- Engage religious leaders across Christian and Muslim communities as partners in shaping attitudes towards contraception and adolescent health.
- Address the taboo around adolescent sexuality that drives low contraceptive use and limited access to CSE.
- Tailor messaging to the distinct legal and cultural contexts of Northern and Southern Nigeria.
- Use trusted community messengers to carry accurate information into conservative settings.
- Ground reform advocacy in evidence on maternal mortality and unsafe abortion to win local support.

Rwanda



Overview of national health and SRHR laws

Rwanda has established a comprehensive legal foundation to protect SRHR. The **Constitution of the Republic of Rwanda 2003** (revised in 2015)[123] serves as the primary legal anchor. **Article 21** explicitly guarantees the right to health for all citizens, whereas **Article 15** emphasises strict equality between men and women. The Constitution also outlines a clear state obligation to protect and promote maternal and reproductive health.

To operationalise these constitutional guarantees, Rwanda enacted **Law No. 21/2016** relating to **human reproductive health.**[124] This law was later superseded by the new **Healthcare Services Law No. 26/2025** of 17 September 2025, which regulated healthcare services.[125] This progressive legislation provides a structured framework for the delivery of reproductive health services across the country.

A pivotal development occurred with the amendment of the **Penal Code in 2018 (Law No. 68/2018)**[126] to expand reproductive rights.[127] The revised Penal Code allows abortion under specific circumstances, including rape, incest, forced marriage, or when the pregnancy poses a risk to the woman's health.[128] This reform significantly expanded the legal grounds for abortion, removing the requirement for court authorisation and allowing medical doctors to perform the procedure in specific cases. Notably, **Article 125 of Law No. 68/2018**, which governs the exemption from criminal liability for abortion, remained entirely unaffected and was not altered by the legislative updates introduced in the 2023 amendment.

Ministerial Order No. 002/MoH/2024 (November 2024) further liberalised access, clarifying that mid-level providers (e.g. midwives and nurses) could deliver certain abortion services. However, implementation has faced regulatory hurdles[129]. As of June 2026, these obstacles remain largely unresolved, leaving an ongoing gap for follow-up advocacy.

Under the **2008 Law on the prevention and punishment of gender-based violence**, FGM is strictly prohibited in Rwanda. The law imposes a prison sentence of six months to five years for anyone who performs FGM. Penalties are more severe if the perpetrator is a medical professional or if the act results in death.[130] While Rwanda does not have a specific law for HIV/AIDS, **Article 29 of the gender-based violence law (N°59/2008)** addresses the intentional transmission of a "terminal disease."" The legal system interprets this to include HIV, making its wilful transmission a crime punishable by life imprisonment."[131] Further, this law provides legal recourse and protection for survivors, further strengthening the national SRHR framework.[132]

Progressive policies and examples of best practices

Rwanda is globally recognised for its highly effective and progressive health policies. One good example is the '**Mutuelles de Santé'**, a community-based health insurance, introduced in 2004. It was designed to give all citizens access to quality healthcare without financial hardship. It has helped reduce out-of-pocket health spending, particularly for rural and low-income communities. This programme has played a crucial role in expanding access to maternal healthcare, making essential services more affordable and reaching even low-income and rural populations.[133]

Additionally, the deployment of the community health worker (CHW) system is a standout best practice. This programme brings essential maternal and reproductive health services directly to the grassroots level, drastically reducing maternal mortality and significantly improving contraceptive uptake and overall family planning outcomes in rural communities.[134]

The *family planning and adolescent sexual and reproductive health strategic plan 2018 to 2024* serves as a model policy in terms of strategic planning.[135] It specifically targets the unique needs of young people to increase the prevalence of contraceptives and reduce teenage pregnancies. This is strongly supported by the Rwanda ***Health Sector Strategic Plan IV 2018 to 2024*** and the ***National Strategy for Maternal, Newborn, and Child Health,***[136] both of which integrate SRHR into the broader national health agenda. The coordinated effort between the Ministry of Health and the Rwanda Biomedical Centre ensures that these programmes are implemented effectively, making Rwanda a leader in the execution of progressive health policies.

One of the most outstanding best practices Rwanda offers as a model for other nations is its strategic withdrawal of the reservation to **Article 14(2)(c)** of the **Maputo Protocol**. This pivotal decision was not merely a symbolic gesture; it acted as a catalyst that sparked comprehensive and wide-ranging legislative and policy reform across the country. This formal change was accompanied by extensive public awareness campaigns and targeted professional training programmes for key societal actors, including healthcare providers, police officers, public prosecutors, and members of the media, to ensure that the reforms were effectively implemented and understood.[137]

Assessment of alignment with Article 14 and regional frameworks

Rwanda's legal and policy framework is strongly aligned with regional human rights standards, particularly **Article 14 of the Maputo Protocol**. **Article 14** mandates state parties to protect women's health and reproductive rights, including medical abortion in cases of sexual assault, rape, incest, and health endangerment.

By amending its Penal Code to explicitly permit abortion in these specific scenarios, Rwanda has taken a significant step in successfully harmonising its domestic laws with this critical regional human rights standard. This legislative change was a direct result of the country's decision to withdraw its reservation to **Article 14(2)(c)** of the **Maputo Protocol**, demonstrating a clear commitment to aligning national policy with international agreements on women's reproductive health rights.

The constitution's[138] focus on gender equality under **Article 15** further aligns with the **Maputo Protocol**'s broader principles of non-discrimination and women's empowerment. Furthermore, the constitutional obligation of the state to protect maternal health reflects the commitments outlined in various African Union health frameworks. Rwanda's proactive legislative approach demonstrates a clear commitment to domesticating regional human rights instruments and ensuring that they are translated into actionable national laws.

Regarding the right to control fertility and access to contraceptives, Rwanda exhibits a robust and commendable alignment as outlined in **Articles 14** (1) (a) and **14 (1) (b)** of the **Maputo Protocol**. The Rwandan government has taken a proactive and assertive approach to promoting family planning initiatives across the country. The successful integration of these services into the existing community health worker system has been a key strategy. This integration ensures that contraceptives are not only available in principle but are also practically accessible to individuals, including those residing in more remote rural areas. By doing so, the government directly supports and empowers citizens to exercise their right to decide on the number of children they have and the spacing between them, reflecting a strong commitment to the **Maputo Protocol**'s principles.[139]

Gaps, inconsistencies and challenges

Despite having a progressive legal framework, Rwanda faces practical challenges in fully achieving SRHR for all citizens.

A significant gap exists between the legal provision of safe abortion services and actual accessibility. While the Penal Code permits abortion under specific conditions, women and girls often face cultural stigma, complex administrative procedures, and a lack of awareness about their legal rights. Some healthcare providers also invoke conscientious objection, which can delay or deny access to time-sensitive care.

While the **2024 Ministerial Order**[140] intended to expand the provider base for abortion to include midwives and nurses, access remains largely restricted to doctors in district hospitals. This creates a bottleneck, particularly for rural women who may struggle to reach these facilities or afford the associated costs. This creates a real gap between legal rights and actual access.

Despite the availability of contraceptives, teenage pregnancy rates remain a concern. Gaps in comprehensive sexuality education (CSE) and cultural taboos around adolescent sexuality mean many young people lack the knowledge to protect themselves.

Until 2025, the law required parental consent for minors seeking abortion services, which was a significant barrier for adolescents who are victims of incest or who cannot safely disclose their pregnancy to their parents, driving them towards unsafe, clandestine methods despite the liberal law. However, as of August 2025, Rwanda's parliament has lowered the legal age for accessing reproductive healthcare from 18 to 15 years old. This change means that individuals aged 15 years will no longer need parental consent to obtain contraception from a medical facility.[141]

Rwanda is a deeply religious society. Moral opposition to abortion and contraception remains high in some communities and even among some healthcare providers. This "conscientious objection" by providers can lead to the denial of legal services or judgmental treatment of women seeking care.[142]

Gender-based violence (GBV) prevention is another area of concern. Although the law strictly punishes GBV, deeply rooted cultural norms and patriarchal attitudes sometimes discourage survivors from reporting abuse or seeking post-violence care.[143] Additionally, while national policies support adolescent reproductive health, young people, particularly in rural areas, still encounter barriers to accessing contraceptives and youth-friendly services due to social stigma and uneven resource distribution.[144]

Opportunities for improvement and reform

Rwanda has several clear opportunities to strengthen its SRHR framework and address existing service gaps. Working alongside the Rwanda Biomedical Centre, the Ministry of Health can launch nationwide public awareness campaigns to educate citizens, particularly women and girls, about their reproductive rights under **Law No. 21/2016**[145] and the amended **Penal Code**. Demystifying the legal grounds for abortion will help reduce stigma and improve access to safe abortion.

A significant opportunity exists to strengthen the capacity of the national gender monitoring office. Rwanda can improve the enforcement of gender-based violence laws and enhance community-level prevention programmes by providing more resources to this body. Furthermore, the government can invest in targeted training for healthcare providers to ensure that they deliver youth-friendly, non-judgemental SRHR services, bridging the gap between national policy and community-level access for adolescents.

Recommendations

Rwanda has one of the region's most progressive frameworks, with its 2018 Penal Code reform and strong SRHR integration into national health systems. The main challenges lie in closing the gap between liberal law and everyday access.

Government

- Resolve the regulatory hurdles blocking the **2024 Ministerial Order** so that mid-level providers, such as midwives and nurses, can deliver abortion services beyond district hospitals.
- Remove remaining administrative barriers that delay access to services permitted under **Law No. 21/2016** and the amended Penal Code.
- Ensure that rural and district hospitals receive consistent supplies of family planning commodities.
- Implement the August 2025 reform lowering the reproductive healthcare age to 15, ensuring that in practice, adolescents can access contraception without parental consent.
- Strengthen the national gender monitoring office to improve the enforcement of GBV laws.

Healthcare providers

- Address conscientious objection and personal bias through mandatory values-clarification training to ensure that legal services are not denied or delayed.
- Expand service delivery beyond doctors in district hospitals to reduce the bottleneck faced by rural women.
- Use the community health worker (CHW) system to extend family planning and counselling to the grassroots level.
- Maintain confidentiality and non-judgemental care, particularly for adolescents who can access services from age 15.
- Feed practical access barriers back to policymakers to inform continuous reform.

Civil society organisations (CSOs)

- Work with local health workers to build community trust and ensure women understand their rights under the recent reforms.
- Run legal literacy campaigns explaining the 2018 Penal Code grounds for abortion and the August 2025 age change.
- Monitor implementation of the 2024 **Ministerial Order** and hold duty-bearers accountable for provider expansion.
- Mobilise communities to challenge stigma around sexuality and contraception among adolescents.
- Document Rwanda's successes, such as its withdrawal of the reservation to **Article 14(2)(c)** of the **Maputo Protocol**, to share with neighbouring nations.

Regional bodies

- Document and share Rwanda's integration of SRHR into the Mutuelles de Santé community-based health insurance scheme as a regional model.
- The CHW system is a best practice for reaching rural populations.
- Provide technical support to help resolve regulatory hurdles around mid-level provider authorisation.
- Monitor progress against **Article 14** and facilitate cross-country learning exchanges.
- Actively showcase Rwanda's success in withdrawing its reservation to **Article 14(2)(c)** of the **Maputo Protocol**. By highlighting these positive outcomes and sharing lessons learned, Rwanda can serve as an influential example for neighbouring nations.

Media, campaigns and technology

- Run nationwide awareness campaigns in partnership with the Rwanda Biomedical Centre to demystify the legal grounds for abortion and reduce stigma.
- Publicise the August 2025 reproductive healthcare age change so that adolescents and providers understand the new entitlements.
- Deploy digital and mobile tools to extend youth-friendly information and outreach to rural areas.
- Provide confidential channels for adolescents who cannot safely disclose their pregnancies at home.
- Partner with CHWs and community leaders to carry trusted messages.

Addressing sociocultural and religious barriers

Despite progressive laws, Rwanda remains a deeply religious society where moral opposition to abortion and contraception persists among some communities and providers.

- Address conscientious objections directly, ensuring that personal beliefs do not translate into the denial of lawful care.
- Tackle the cultural taboos surrounding adolescent sexuality that maintain the high rates of teenage pregnancy.
- Engage religious and community leaders in dialogue to shift attitudes towards contraception and safe abortion.
- Use the trusted CHW network to normalise SRHR conversations in rural and conservative settings.
- Pair GBV law enforcement with community programmes that encourage survivors to report abuse and seek post-violence care.

Senegal



Overview of the national health laws

A comprehensive, though sometimes restrictive, legal framework governing sexual and reproductive health and rights (SRHR). The foundation of these rights is found in the 2001 **Constitution of the Republic of Senegal of 2001 (amended in 2009**).[146] The preamble firmly guarantees the human person's inviolability and the right to corporeal integrity, while **Article 7** recognises the right to life and the free development of personality, obliging the state to protect every individual.

The **Criminal Code (Law No. 65-60)**[147] stipulates that the rules surrounding reproductive autonomy become much stricter. **Article 305** strictly prohibits anyone from procuring or attempting to procure an abortion. Third parties can face up to five years in prison, while women who self-induce an abortion risk up to two years in prison. **Article 305 *bis*** goes further, penalising the distribution of abortifacients. The sole exception exists within **Article 35** of the **Code of Medical Ethics**, which permits therapeutic abortion only if it is the absolute only way to save the mother's life. This requires confirmation by three doctors, and a protocol must be sent to the president of the medical association by registered mail.[148]

Senegal takes a firm stance against female genital mutilation (FGM) to protect individuals from harmful practices. **Article 299 *bis*** of the **Criminal Code** heavily penalises FGM, imposing up to five years in prison or life imprisonment if the procedure results in death.[149] Additional protections come from **Law No. 2005-18** on Reproductive Health, **Article 4** requires the government to provide services that address FGM, sexual abuse, and other practices harmful to reproductive health. **Article 13** penalises all forms of violence and sexual abuse and entitles all women to family planning, obstetric care, and post-abortion care.[150]

However, **Article 111 of Senegal's Family Code (Law No. 72-61 of June 12, 1972**, as amended) sets the minimum legal age for marriage at 18 years for men and 16 years for women. Further, exceptions can be made by judicial authorisation for "serious reasons." This discrepancy has led to sustained advocacy from the CEDAW Committee, the CRC Committee and civil society, all calling for the minimum age for girls to be raised to 18 without exception to meet international standards.[151]

Progressive policies and examples of best practices

Despite the restrictive legal environment, Senegal has demonstrated innovation in policy implementation, particularly in family planning, such as **the National Reproductive Health Policy and National Population Policy**. The government has adopted a series of national population and reproductive health policies over time. These successive policies share common goals, including the reduction of maternal mortality rates, the expansion of family planning service coverage across the nation, and a focused effort to address the specific reproductive health needs of adolescents. As part of these initiatives, the government established a clear target to achieve a 45% family planning prevalence rate by the year 2020.[152]

We also see strong progressive intent in the national action plans for **FGM elimination and the strategy on gender equality (2016 to 2026**). In a separate but related effort, the government demonstrated its commitment to combating female genital mutilation (FGM) by adopting its third *National strategy for the elimination of FGM* in 2022. This comprehensive strategy outlines the country's approach for the period of 2022 to 2030 and is supported by a more detailed five-year action plan that covers the years 2022 through 2026.[153] Senegal has also developed a ***National Strategy for Gender Equity and Equality*** **(SNEEG) for 2016 to 2026**, indicating a broader commitment to addressing gender-based issues. The SNEEG strategic plan is designed to actively reduce gender-based inequalities by improving maternal health outcomes, ensuring greater access to family planning services, and implementing measures to reduce all forms of gender-based violence.[154] [155]

Senegal has used community-driven approaches to social change, including the **Tostan community empowerment programme (CEP)**. Since 1991, this initiative has delivered human rights and women's health education in local languages, aiming to support behavioural change through community dialogue. In 1997, the village of Malicounda Bambara made a public declaration to abandon FGM; the approach was later incorporated into Senegal's *National action plan for FGM abandonment*.[156] While public declarations have been associated with reduced practice in participating communities, sustained abandonment is not automatic and residual practice has been documented in some evaluations. Complementary legal enforcement remains essential.

Between 2007 and 2009, Senegal's 1999 law criminalising FGM was notably tested in the Kolda and Tambacounda regions. Several individuals, mainly traditional excisors, were convicted and imprisoned under **Article 299 *bis***. These prosecutions sent a strong deterrent signal that the law would be enforced and were supported by human rights organisations and some civil society groups. However, the prosecutions also had a significant unintended consequence: fear of legal action led some families to perform FGM on girls at younger ages, in greater secrecy, or across borders in countries like The Gambia and Guinea-Bissau where similar laws did not exist. This case demonstrates that while criminal law is essential, it is most effective when combined with community empowerment, education, and social norm change strategies.[157]

Assessment of alignment with Article 14

Senegal ratified the **Maputo Protocol** in December 2003 without any reservations. Senegal strongly aligns with the **Maputo Protocol** regarding the elimination of harmful traditional practices. Senegal effectively meets its obligations to protect women and girls from various forms of physical harm and abuse by explicitly criminalising female genital mutilation (FGM) and enacting comprehensive laws against gender-based violence (GBV).

Senegal is well aligned with **Articles 14 (1) (a) and 14 (1) (b)** of the **Maputo Protocol on the right to control fertility and access contraceptives. The law on reproductive health** and its national family planning strategies demonstrate a strong state commitment to ensuring access to contraceptives. Policies are in place to make a range of methods available through public health facilities.[158]

However, despite ratifying the **Maputo Protocol** without any reservation, Senegal's legal framework demonstrates a mixed alignment with **Article 14(2)** of the Protocol. The Protocol requires African states to authorise medical abortion in cases of sexual assault, rape, incest, and when the mother's mental or physical health is threatened by continued pregnancy. The domestic laws of Senegal do not align with this mandate. Because the **Criminal Code** severely restricts abortion and the law only permits abortion to save the life of the pregnant woman, even this requires the concurring opinion of three doctors, an almost impossible procedural barrier. The law does not recognise any of the other grounds specified in the **Maputo Protocol** (rape, incest, sexual assault, risk to health), placing Senegal in direct opposition to the regional standard.

Gaps, inconsistencies and challenges

Despite strong constitutional principles and having ratified the **Maputo Protocol** without any reservations, the country's highly restrictive abortion framework remains the most prominent challenge. By criminalising abortion without the exceptions for rape, incest, or foetal impairment that are explicitly stated in **Article 14 (2)** of the **Maputo Protocol**, the law creates a dangerous situation for women and girls. It signals a lack of political will to reform the Penal Code and harmonise national law with regional human rights standards, citing conflicts with national cultural and religious values. This restrictive legal environment ultimately forces many vulnerable individuals who find themselves in these desperate circumstances to seek unsafe, clandestine procedures, which pose significant health and wellbeing risks.

A significant legal inconsistency creates a difficult situation within the country's healthcare system. On the one hand, the Penal Code criminalises abortion, making it an illegal act. Policies from the Ministry of Health mandate that healthcare professionals must provide post-abortion care. This contradiction places healthcare providers in a precarious and ethically challenging position. They are professionally obligated to treat the often-life-threatening complications that arise from unsafe abortions, yet they are doing so for a condition that results from a practice that the law explicitly defines as a crime.

The sociocultural and religious context of the country presents a formidable obstacle.[159] Powerful and well-organised religious groups consistently and actively oppose any attempts to reform the existing abortion law. Their significant influence creates a challenging and often hostile political environment for advocates, civil society organisations, and policymakers who are working to address the high rates of unsafe abortion and maternal mortality. This entrenched opposition also fuels and perpetuates stigma surrounding SRHR, which in turn limits access to essential services, such as contraception, particularly for unmarried individuals and adolescents who may face judgement or care refusal.[160]

Another major inconsistency is in the **Family Code. Article 111** sets the minimum marriage age at 16 for women and 18 for men.[161] This legal disparity contradicts international standards and exposes young girls to early marriage, harming their reproductive autonomy and physical health.

Opportunities for improvement and reform

There are clear opportunities to strengthen Senegal's SRHR landscape. The most urgent reform is the amendment of **Articles 305 and 305 *bis*** of the **Criminal Code** to allow safe abortion in cases of rape, incest, and severe health risks.

Senegal also has a significant short-term opportunity to focus on its existing therapeutic abortion law's effective and consistent implementation. Although the law permits the procedure to save a pregnant woman's life, its practical application could be improved. Removing the burdensome three-doctor rule would protect women from the dangers of clandestine procedures and align Senegal's policy with regional standards.

There is also a prime opportunity to update the **Family Code**. By simply harmonising the legal marriage age to 18 for both boys and girls, lawmakers can instantly remove a major legal barrier to girls' education and reproductive autonomy.

Furthermore, health authorities can leverage **Law No. 2005-18** as a foundational tool. They can more heavily promote comprehensive family planning services and strategically expand the clinical capacity for essential post-abortion care by doing so. These combined efforts are crucial for creating a more robust healthcare system aimed at significantly reducing maternal mortality rates.

Finally, the government can improve its anti-FGM strategy by ensuring that strict legal enforcement is always paired with well-funded, community-led education programmes to change social norms from the ground up, rather than relying on punitive measures alone.

Recommendations

Senegal ratified the **Maputo Protocol** without reservation, yet its criminal code remains among the region's most restrictive. The gap between this commitment and non-compliance with **Article 14(2)(c)** defines the country's central challenge.

Government

- Amend **Articles 305 and 305 *bis*** of the criminal code to permit safe abortion in cases of rape, incest, and severe health risks, aligning national law with **Article 14(2)(c).**
- Remove the three-doctor rule and the registered-mail protocol that make accessing even life-saving therapeutic abortion almost impossible.
- Harmonise the family code by raising the minimum age of marriage for girls from 16 to 18, matching the age for boys, and meeting international standards.
- Leverage **Law No. 2005-18 on reproductive health** to expand family planning services and clinical capacity for post-abortion care.
- Resolve the contradiction between criminalised abortion and the mandate of the Ministry of Health to provide post-abortion care, protecting providers from legal jeopardy.

Healthcare providers

- Complete values-clarification and human rights training to deliver lawful care and post-abortion services without bias.
- Build referral networks so that women and girls can access appropriate care, including post-abortion treatment.
- Maintain confidentiality and non-judgmental counselling, especially for unmarried adolescents.
- Expand family planning and post-abortion care capacity under **Law No. 2005-18**.
- Share practical feedback on the impossible procedural barriers, thereby helping inform reform.

Civil society organisations (CSOs)

- Lead community dialogues with religious and traditional leaders to shift narratives around bodily autonomy, contraception, and maternal health.
- Sustain advocacy with the CEDAW and CRC committees to push for reform of the family code on marriage age.
- Run legal literacy campaigns to clarify what services the law already permits.
- Support community education and dialogue initiatives that complement legal enforcement, drawing on existing models such as the community empowerment programme where appropriate
- Document the human cost of unsafe abortion to strengthen the case for reform of the Penal Code.

Regional bodies

- Apply diplomatic engagement and provide legal templates to help Senegal harmonise its Penal Code with the **Maputo Protocol**, which it ratified without reservation.
- Highlight the gap between Senegal's reservation-free ratification and its non-compliance with **Article 14(2)(c)**.
- Provide technical and drafting support for reforming the criminal code and family code.
- Facilitate cross-country learning on community education approaches that support implementation of anti-FGM laws.
- Amplify accurate information on legal prohibitions and community experiences of abandonment, using trusted local voices.

Media, campaigns and technology

- Run awareness campaigns to clarify the existing therapeutic abortion provision and family planning entitlements under **Law No. 2005-18**.
- Use radio, community media, and local-language broadcasting to reach rural and low-literacy populations.
- Deploy digital and mobile tools to extend youth-friendly outreach and confidential information channels.
- Counter the stigma and misinformation fuelled by organised religious opposition with sensitive, evidence-based messaging.
- Amplify accurate information on legal prohibitions and community experiences of abandonment, using trusted local voices.
- Address sociocultural and religious barriers.

Addressing sociocultural and religious barriers

Powerful, well-organised religious groups actively oppose abortion law reform and sustain stigma, creating a hostile environment for advocates and limiting access to contraception.

- Engage religious and traditional leaders through dialogue.
- Support community education and dialogue processes that reinforce legal prohibitions on FGM.
- Pair robust enforcement of anti-FGM laws with well-funded community education, recognising that punitive measures alone can push the practice underground or across borders.
- Address the stigma that deters unmarried adolescents from seeking contraception.
- Frame reform around the toll of unsafe abortion and maternal mortality to build community and policymaker support

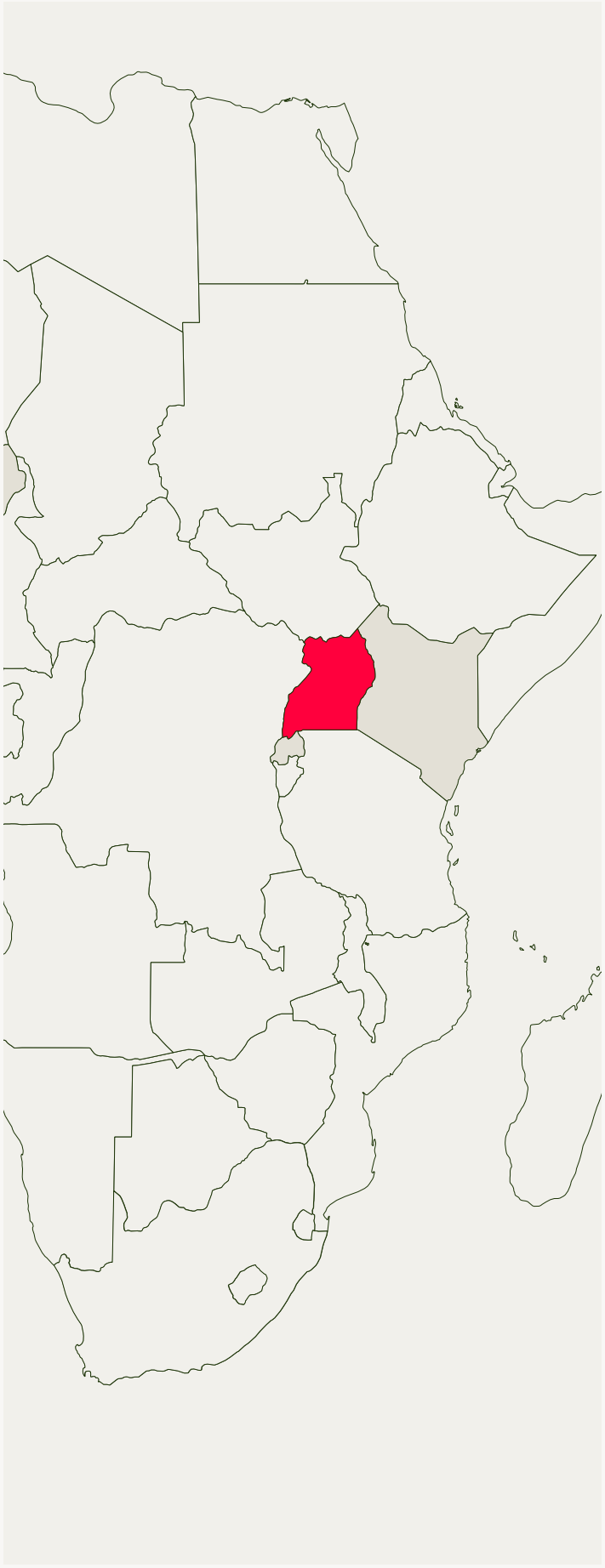
Uganda

Overview of the national health laws

Uganda has built a legal framework that addresses sexual and reproductive health and rights (SRHR) through its primary laws and national policies. The foundation of this system is the **Constitution of the Republic of Uganda 1995**. Within the Constitution, **national objectives XIV and XX** clearly emphasise the importance of healthcare access and the strict protection of women. Additionally, **Article 33** serves as a strong safeguard for women's rights, ensuring equal dignity and opportunities for women. **Article 22,** which protects the right to life, also holds critical implications for maternal health considerations, as it touches upon when life begins and how it is preserved.[162]

Several specific laws regulate reproductive health and protect vulnerable groups beyond the constitution. **The Penal Code Act, Cap. 120,** strictly regulates abortion, making it a criminal offence, except under very narrow circumstances.[163] To protect individuals from abuse, the government enacted the **Domestic Violence Act 2010**, which provides legal avenues for women facing domestic violence.[164] Furthermore, the **Prevention of Torture Act 2012** plays a vital role in ensuring humane treatment and care for survivors of extreme violence.[165] Finally, amendments to the **Children Act** offer essential legal protections for adolescent wellbeing and safety.[166] Under the provisions of the **Public Health Act (Cap 281)**, the Ministry of Health has a legal obligation to guarantee the effective and comprehensive delivery of health services to all citizens across the country. **The HIV and AIDS Prevention and Control Act (2014)** promotes universal access to HIV-related services, including prevention, testing, counselling, and care, while also outlining the responsibilities of the state and individuals.[167]

Uganda has taken a strong legal stance against FGM, in line with **Article 5(b)** of the **Maputo Protocol**. The practice is illegal under the **Prohibition of Female Genital Mutilation Act, 2010,** a comprehensive law enacted to protect the rights, health, and dignity of women and girls. The act criminalises all aspects of FGM, including performing the procedure, arranging for it, or promoting it.[168]



Progressive policies and examples of best practices

Despite these challenges, Uganda has introduced several progressive policies and established strong legal precedents. *The National policy guidelines and Service standards for sexual and reproductive health and rights (2012)* act as a comprehensive blueprint for delivering care, offering clear standards for health workers across the country.[169] Proactive planning is also seen in the *RMNCAH sharpened plan II 2017 to 2022*[170] and the *National family planning costed implementation plan*, which strategically directs funds towards reducing maternal and child mortality.[171] **The National Health Policy (2010)** identified reproductive health, maternal and child health, and HIV/AIDS prevention and treatment as national priorities.

Uganda also stands out for its progressive judicial decisions, which are often driven by the persistent efforts of civil society. A landmark example is the case of the **Centre for Health, Human Rights and Development & Others v Attorney General** (Constitutional Petition No. 16 of 2011). In this pivotal ruling, the courts closely examined the constitutional accountability of the government for preventable maternal deaths,[172] setting a significant precedent. This case, alongside the earlier **Law and Advocacy for Women in Uganda v. The Attorney General (2010)**[173] highlights a growing and influential legal trend. This trend firmly establishes that the state can be held responsible for its failure to provide essential services, such as emergency obstetric care, and for its duty to protect women's fundamental rights.

Assessment of alignment with Article 14

Uganda's ratification of the **Maputo Protocol** in July 2010 represents a significant step forward, yet it is accompanied by notable reservations that temper its potential impact. Specifically, the country has expressed reservations regarding the two critical components of **Article 14**. **Article 14 (1)(a)** asserts that women must have the fundamental right to control their own fertility. **Article 14 (2)(c)** aims to ensure that women have access to safe abortion services in select, harrowing circumstances, including cases of rape and incest. By making these reservations, Uganda essentially opts out of fully committing to these specific provisions. These reservations significantly weaken the protections that the **Maputo Protocol** offers women in Uganda.

When Uganda is compared to regional standards, a mixed picture emerges. **Article 14** of the **Maputo Protocol** requires African nations to protect women's reproductive rights, including authorising medical abortion in cases of sexual assault, rape, incest and when a pregnancy endangers the mother's health. While Uganda's constitution aligns with the Protocol's[174] goal of empowering women and protecting their health, the country falls short of full compliance regarding safe abortion. Specifically, Uganda's **Penal Code Act Cap 120** heavily restricts pregnancy termination,[175] creating a barrier that conflicts with the **Maputo Protocol's** broader reproductive freedoms. In addition to the specific laws mentioned, other legislative provisions present significant challenges to SRHR. For instance, the **Anti-Homosexuality Act 2023, Penal Code Act (cap 120, as amended),** and **HIV Prevention and Control Act** contain clauses that effectively criminalise the exercise of individual autonomy and personal choice. These laws create substantial legal and social barriers that directly impede the full enjoyment and realisation of fundamental SRHR for all individuals. Although Uganda's legal framework supports maternal health in principle, these restrictive penal provisions prevent it from fully meeting the progressive regional benchmarks for reproductive autonomy.

Under the **Maputo Protocol's** provisions for the **right to control fertility and access to contraceptives, Article 14 (1) (a) and 14 (1) (b),** Uganda's national policies and strategies are generally well-aligned. The government's dedication to family planning is evident in its detailed *National family planning costed implementation plans*[176] and the integration of these goals into broader national health strategies. Existing policies also support the provision of a comprehensive range of contraceptive methods through the country's public health facilities.

Gaps, inconsistencies and challenges

In Uganda, a fundamental contradiction between law and policy, compounded by political and social factors, presents a central challenge to SRHR.

The Penal Code criminalises abortion, which directly conflicts with the policies of the Ministry of Health that permit post-abortion care. This legal ambiguity creates a "chilling effect," deterring healthcare providers from offering legally permissible services, such as those needed to save a woman's life, due to fear of prosecution or social stigma; as a result, many women and girls are forced into seeking unsafe, back-alley procedures. This directly contributes to high maternal mortality and morbidity rates, exposing a severe inconsistency between the constitutional right to life and maternal healthcare.[177]

The restrictive abortion law in Uganda has led to high rates of associated maternal mortality and morbidity. Consequently, the country's legal and health landscape presents significant challenges for women's reproductive health.[178]

Efforts to advance SRHR in Uganda face considerable political and social opposition. This resistance is especially strong regarding initiatives aimed at adolescents and those concerning safe abortion access**.** In 2017, the Ugandan government suspended the launch of its *National guidelines and service standards for sexual and reproductive health and rights*. Weeks before the launch, some media outlets accused the Ministry of Health of planning to offer contraceptives to ten-year-olds. Following public outcry, the Ministry reviewed and revised the guidelines to clarify that contraceptives were intended for sexually active women of reproductive age (15 to49). However, some still objected, arguing that contraceptive services and supplies should be restricted to women aged 18 years.[179]

Health protection for adolescents is another major challenge. Despite the **Children's Act** and national guidelines, young people still struggle to access reproductive healthcare. Cultural stigma, a lack of youth-friendly services at district health centres, and confusing laws around the age of consent make it difficult for teens to obtain contraceptives or essential advice.

Furthermore, although laws such as the **Domestic Violence Act** exist, weak enforcement leaves many survivors without protection or post-violence care. Significant gaps exist between Uganda's adolescent health policies and service delivery, especially in rural areas. Health facilities that offer youth-friendly services are very limited, resulting in a high teenage pregnancy rate and an unmet need for contraceptives.[180]

Deeply entrenched patriarchal norms and religious beliefs present significant barriers to SRHR services access. The stigma surrounding premarital sex makes it difficult for adolescents and unmarried women to obtain contraception. Additionally, the lack of standardised comprehensive sexuality education (CSE) in schools leaves young people vulnerable to misinformation and unintended pregnancies. In 2016, the Ministry of Gender banned all forms of CSE, with lawmakers arguing that it went against Ugandan customs and values. Minister Janet Mukwaya stated that teaching sexual education was weakening national and moral principles.[181]

Opportunities for improvement and reform

There are several significant opportunities to improve the SRHR landscape in Uganda. First and foremost, withdrawing its reservation to **Article 14** of the **Maputo Protocol** would be a crucial step. This action is essential to ensure full compliance with the requirements of the instrument, thereby strengthening the legal framework for women's health and reproductive rights.

There is an opportunity to revise the **Penal Code Act Cap 120** to better align with the constitutional guarantees of maternal health. There is also a significant opportunity for the Uganda Human Rights Commission to take a more active role in monitoring SRHR compliance across district health systems, ensuring that local clinics implement national health directives.

The reproductive and child health division of the Ministry of Health has the power to issue clearer, binding guidelines that demystify when emergency obstetric care and legal abortion can be provided. This would give healthcare workers the confidence to save lives without fear of prosecution.

Finally, strategic litigation presents a powerful reform path. Public interest cases can force the government to answer for failing to provide basic maternal health services, pushing the judiciary to mandate better resource allocation and constitutional compliance.

Recommendations

Despite ratifying the **Maputo Protocol** in July 2010, Uganda maintains reservations on **Articles 14(1)(a)** and **14(2)(c)**, weakening women's reproductive rights. The Penal Code criminalises abortion unless the mother's life is at risk, which contradicts the policies of the Ministry of Health that allow post-abortion care. This legal conflict, combined with the suspension of the 2017 *National guidelines for SRHR*, the 2016 ban on comprehensive sexuality education (CSE), and the 2023 **Anti-Homosexuality Act**, have created a chilling effect on healthcare providers and limited access to safe procedures.

The following stakeholder recommendations are organised to support practical implementation.

Government

- Withdraw the reservations to **Articles 14(1)(a)** and **14(2)(c)** of the **Maputo Protocol**, ensuring full compliance and strengthening the legal basis for women's right to control their fertility and access safe abortion in cases such as rape and incest.
- Revise the **Penal Code Act Cap 120** to align with constitutional guarantees of maternal health, removing the legal ambiguity that conflicts with post-abortion care policies of the Ministry of Health.
- Issue clear, binding Ministry of Health guidelines through the reproductive and child health division, demystifying when emergency obstetric care and legal abortion can be provided so health workers can act without fear of prosecution.
- Reinstate and properly fund the suspended 2017 *National guidelines and service standards for SRHR*, resolving the coordination failures that left providers without clear direction.
- Finalise and fund national health insurance policies that explicitly cover comprehensive SRHR services.
- Use strategic litigation outcomes to drive reform, allowing cases of public interest to compel better resource allocation and constitutional compliance.
- Empower the Uganda Human Rights Commission to monitor SRHR compliance across district health systems, ensuring that local clinics implement national health directives.
- Develop targeted national interventions to address high rates of teenage pregnancy, including measures that allow pregnant girls to continue their education and access health services.

Healthcare providers

- Complete regular values-clarification and human rights training to deliver lawful SRHR services without personal bias or prosecution.
- Build referral systems and inter-professional networks so that women and adolescent girls can access appropriate care, including in rural and remote areas.
- Strengthen youth-friendly services at district health centres, addressing the scarcity that fuels high teenage pregnancy and unmet contraceptive needs.
- Uphold client confidentiality and provide non-judgmental counselling, particularly for adolescents and unmarried women who face heightened stigma.

- Counter the chilling effect created by ambiguity in the **Penal Code** by gaining clarity on the exact circumstances in which lawful care, including life-saving and post-abortion care, can be provided.
- Share practical feedback on the legal and service barriers encountered at the facility level with policymakers to inform continuous reform.

Civil society organisations (CSOs)

- Pursue strategic litigation that builds on the precedents set in **CEHURD & Others v. Attorney General (2011)** and **Law and Advocacy for Women in Uganda v. Attorney General (2010**), holding the state accountable for preventable maternal deaths and gaps in essential care.
- Advocate strongly for reinstating a standardised, age-appropriate CSE curriculum, countering the 2016 ban that left young people exposed to misinformation and unintended pregnancy.
- Monitor the treatment of young women in health facilities and document where youth-friendly services fall short.
- Campaign to remove parental consent requirements that block adolescents from seeking reproductive health care.
- Mobilise community leaders, women's groups, and youth advocates at the grassroots level to challenge stigma and discriminatory norms.
- Document and share success stories to support replication and sustain public pressure for reform.

Regional bodies

- Monitor Uganda's reservations to **Articles 14(1)(a)** and **14(2)(c)** through periodic reviews and clear performance benchmarks, tracking progress towards full compliance.
- Apply diplomatic engagement and collective pressure to encourage the withdrawal of these reservations and counter regressive legal trends.
- Provide technical support and legal drafting assistance for reforming the **Penal Code Act Cap 120** and harmonising conflicting health laws.
- Share regional best practices and model guidelines, drawing on neighbouring countries that have aligned their frameworks with **Article 14**.
- Provide robust monitoring to ensure that Uganda meets its commitments to reduce maternal mortality and expand family planning access under the framework of the African Union.

Media, campaigns and technology

- Run sustained public awareness campaigns explaining lawful SRHR services, helping close the gap between policy and public understanding.
- Deploy digital and mobile platforms to extend youth-friendly outreach to adolescents and underserved rural communities.

- Use technology to provide confidential information channels, helping young people and unmarried women seek guidance without fear of judgement.
- Counter the misinformation surrounding the suspended 2017 guidelines and the 2016 CSE ban with accurate, evidence-based messaging.
- Promote responsible, rights-based reporting on SRHR issues to reduce stigma and normalise harmful practices.
- Partner with trusted community communicators and public figures to amplify and broaden the reach of accurate messaging.

Addressing sociocultural and religious barriers

Deeply entrenched patriarchal norms and religious beliefs remain among Uganda's most pressing obstacles to SRHR. They sustain stigma, fuel political opposition, and shape the attitudes of providers, parents, and policymakers. These barriers cross every stakeholder group and require dedicated and sustained attention.

- Engage religious and traditional leaders as dialogue partners, recognising their gatekeeping role in shaping attitudes towards contraception, family planning, and adolescent sexuality.
- Confront the impact of the 2016 CSE ban by framing sexual education around protecting young people from unintended pregnancy and STIs, building support among parents and faith communities.
- Tackle the stigma surrounding premarital sex that makes it difficult for adolescents and unmarried women to obtain contraception.
- Learn from the public outcry that suspended the 2017 guidelines by engaging communities early and transparently before launching new SRHR initiatives.
- Prioritise outreach to rural areas where youth-friendly services are scarce and adolescent access gaps are widest.
- Use trusted community voices to normalise open conversations about SRHR and carry accurate information into conservative settings.

Conclusion

A law is only as powerful as the lives it impacts. Across the eight countries examined in this report (Benin, Burkina Faso, Ghana, Kenya, Nigeria, Rwanda, Senegal, and Uganda), the landscape is rich in promise yet weighed down by a stubborn truth: a progressive law on paper does not automatically become safe care in a clinic. This gap between what the statute books say and what women and girls experience is the defining challenge of harmonising national SRHR frameworks with **Article 14** of the **Maputo Protocol**.

The progress is real and deserves recognition. Every country in this study has enshrined the right to health within its constitution and has embedded SRHR priorities in its national health policy. Benin stands out as a regional trailblazer, expanding abortion access through **Law No. 2021-12** well beyond the minimum standard and backing it with the practical machinery to deliver. Rwanda has matched bold reform with implementation, withdrawing its reservation to **Article 14(2)(c)** and weaving reproductive health into its community health worker system and national insurance scheme. Ghana's long-standing legal openness shows that early reform can endure. These are not abstract victories but blueprints that prove that change is both possible and replicable.

However, the contrast across the region is stark. While Benin and Rwanda lead, Senegal remains bound by one of the continent's most restrictive penal codes, criminalising abortion despite ratifying the Protocol without reservation. Kenya holds a reservation to **Article 14(2)(c),** limiting its obligation to ensure safe abortion. Uganda holds reservations to **Articles 14(1)(a)** and **14(2)(c)**, with its conflicting penal provisions casting a chilling effect on providers and pushing women towards unsafe procedures. Nigeria's federal structure fragments protection state by state, and Burkina Faso's comprehensive framework buckles under a humanitarian crisis that has shuttered hundreds of health facilities. The lesson is sobering: ratification alone is not enough, and reservations actively erode the enjoyment of rights.

A common thread lies beneath these legal differences. Deeply rooted cultural, religious, and patriarchal norms remain the most formidable barriers to progress. They sustain stigma, silence open conversations, and empower gatekeepers who block adolescents and unmarried women from receiving the care they need. They stall comprehensive sexuality education, banned outright in Uganda, repeatedly delayed in Ghana, and absent as a national standard in Benin and Nigeria. Where these forces go unchallenged, even the boldest reforms gather dust.

Therefore, the path forward is clear and demands more than legislation. It demands sustained political will to withdraw reservations and harmonise contradictory codes. It demands ring-fenced funding to end the stock-outs and staff shortages that cripple rural clinics. It demands the rollout of comprehensive sexuality education and genuinely youth-friendly services so that young people are informed rather than left vulnerable; it demands that communities be treated not as obstacles but as partners, engage religious and traditional leaders in honest dialogue, and ground reform in the hard evidence of preventable maternal deaths.

No single country can bear this burden alone. The strongest results emerge when nations learn from one another, when Benin's evidence-driven coalition model, Rwanda's integrated service delivery, and Senegal's experience with community education approaches alongside legal measures can inform cross-border learning. Regional bodies must move beyond passive monitoring to active leadership: applying diplomatic pressure, sharing model laws, pooling procurement, and holding states accountable against clear benchmarks. Coordinated regional action is not a luxury; it is the engine that converts isolated wins into continental momentum.

Article 14 sets out a bold promise: that every woman and girl in Africa has the right to control her body, her health, and her future. That promise was never meant to live only in the treaty text. The findings of this report are an invitation to policymakers, civil society, and legal advocates alike to close the gap, challenge the silence, and act with the urgency this moment demands. The laws are largely in place. The task now is to make them real. African women and girls have waited long enough. This report presents an opportunity for coordinated action by governments, regional institutions, civil society, and development partners to advance harmonisation and implementation of **Article 14** of the **Maputo Protocol**, which in turn will directly help accelerate achievement of the 2030 Sustainable Development Goals and Agenda 2063 to the benefit of women, their families and communities.

Endnotes

1 1. States Parties shall ensure that the right to health of women, including sexual and reproductive health is

respected and promoted. This includes: (a) the right to control their fertility; (b) the right to decide whether to have children, the number of children and the spacing of children; (c) the right to choose any method of contraception; (d) the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS; (e) the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices; (f) the right to have family planning education.

2. States Parties shall take all appropriate measures to: (a) provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas; (b) establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breastfeeding; (c) protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.

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3 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. https://au.int/en/treaties/protocol-african-charter-human-and-peoples-rights-rights-women-africa

4 1. States Parties shall ensure that the right of women, including sexual and reproductive health, is respected and promoted. This includes: (a) the right to control their fertility; (b) the right to decide whether to have children, the number of children, and the spacing of children; (c) the right to choose any method of contraception; (d) the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS; (e) the right to be informed on one's health status and on the health status of one's partner, particularly if affected by sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices; and (f) the right to have family planning education.

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