



The African Women's
Development and
Communication Network



QUALITATIVE STUDY ON THE IMPACT OF COVID-19 ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR) OF WOMEN AND GIRLS IN AFRICA



CONTENTS

ACKNOWLEDGMENT	4
EXECUTIVE SUMMARY	5
INTRODUCTION	7
<u>Background to the Study</u>	5
<u>Context to the Study</u>	8
<u>The Study</u>	7
<u>Methodology of the Study</u>	9
<u>Conceptual Approach to Assessing the impact of COVID 19 on SRHR</u>	11
THE STUDY FINDINGS	10
<u>Overall Impact of COVID 19</u>	11
COUNTRY CASE STUDIES	11
<u>Country Case Study 1: Guinea</u>	12
<u>Country Case Study 2: Liberia</u>	16
<u>Country Case Study 3: Mozambique</u>	20
<u>Country Case Study 4: Rwanda</u>	24
<u>Country Case Study 5: Tanzania</u>	28
<u>Country Case Study 6: Zambia</u>	32
CONCLUSIONS AND RECOMMENDATIONS	37
ANNEXES	39
<u>Annex 1: The analysis dimensions and indicators used to capture country status</u>	39
<u>Annex 2: Partner Country Key Informant Interview /Discussion Guide</u>	40

ACKNOWLEDGMENTS

The African Women's Development and Communication Network (FEMNET) and the Swedish Development Swedish International Development Cooperation Agency (SIDA) acknowledge and are grateful for the contribution and support of the following individuals and teams.

AUTHOR AND TECHNICAL EXPERT

Justus Aungo (Ph.D.)

Lead Researcher

JB Aungo & Company

FEMNET TEAM

Jill Anami, Josephine Ileri and Maureen Olyaro

STAKEHOLDERS INTERVIEWED AND CONSULTED

FEMNET and SIDA would like to thank everyone who offered comments and feedback on the research. We are grateful for all your input.

FUNDING PARTNER

Swedish Development Swedish International Development Cooperation Agency (SIDA)

EXECUTIVE SUMMARY

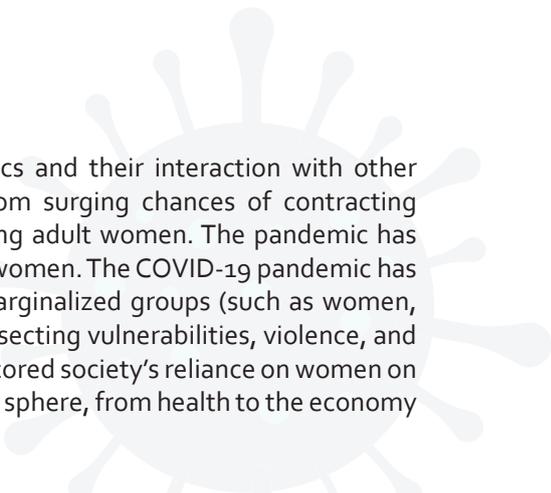
Introduction: The study was commissioned under the Advancing African Women's Human Rights to their Bodily Autonomy and Integrity through ensuring that African Governments fulfill their Obligations and Commitments on SRHR implemented by FEMNET with support from the SIDA- Bodily Autonomy and Integrity program is a 4-year project (2017-2021) in 6 countries (Tanzania, Mozambique, Liberia, Guinea, and Zambia). The Project aims to accelerate state reporting on ending and eradicating FGM, early child marriages, and harmful practices in Liberia, Mozambique, and Zambia through its implementing partners in the countries to help them in tracking their country's Commitments made by the various governments and stakeholders to improve domestication of regional and global women's rights instruments and budgetary allocation to realize SRHR policy commitments by government in their target countries.

Context of the Study: Since March 2020, the world has been under the burden of the COVID-19 pandemic. Africa is experiencing unprecedented challenges due to the Coronavirus 2019 (COVID-19) pandemic, directly and from the compounding effects of other health, economic and social factors. There are about 11.7million confirmed COVID-19 cases and 253,558 deaths on the African Continent by the beginning of June 2022. Africa has recorded fewer cases and Covid-19-related fatalities, though with more asymptomatic cases than other regions of the world. Yet, this profile hides the differential experiences and distribution of the COVID 19 effects that define the continent's pandemic landscape. The profile does not reveal how the pandemic has latched onto the gender and socio-economic disparities to unevenly spread and amplify exclusion and systemic biases along gender, social and economic lines. COVID-19 has varying impacts on women, men, girls, and boys, including: - increased intimate partner violence during lockdowns; increased stigma and discrimination of already marginalized persons like those living with HIV and disabilities, and increased infection and health risks due to unequal sharing of the burden of caretaking roles, unequal access to health information, prevention, care and financial and social protection and limited access to sexual and reproductive health and rights for women and girls.

The Study: The qualitative study explores the impact of COVID-19 on the Sexual and Reproductive Health and Rights (SRHR) of women and girls in Africa. The study documents the effects and outcomes of the COVID 19 on the experiences of women and girls in their voices and within their contexts. The project references and positions its specific tasks around the Maputo Protocol as a critical African instrument to advance women's and girls' rights. The study findings are presented as country case studies highlighting these experiences from a diverse perspective in each country as per the realities and context of the country.

Methodology: The study was conducted remotely using secondary data and literature on the internet, supplemented by strategic country key informants' interviews. It covered the six selected countries because they were sites for the project implementation. These are: the Democratic Republic of Congo, Guinea, Liberia, Mozambique, Rwanda and Tanzania. The study collected data on the state of the countries' sexual and reproductive health rights regarding the health systems' structural orientation towards providing the environment and services for the full enjoyment of SRHR. It analyses the legal and cultural normative environment for protecting women's sexual and reproductive health manifest through laws and regulations facilitating or restricting access to rights and services; and the social norms related to women's security and rights, especially concerning sexual and gender-based violence. The purposive design was appropriate because it provides an in-depth view of the individuals and the contextual effects of COVID 19 the women and girls.

Findings: The study found that the pandemic outbreak and the immediate measures taken by governments across the continent interrupted daily life and survival routines in African countries. The study established that loss of employment and livelihoods drove women into extreme vulnerability and increased the burden of care work while compounding the intersecting impacts of retrogressive socio-cultural practices on women and girls. The interruptions had immediate and lasting adverse effects on households, work, and livelihoods that follow the contours of gender and power inequalities, thus affecting women, men, girls, and boys differently. The differential experiences align with the contextual



and structural construction and positioning of gender characteristics and their interaction with other social determinants. Women faced immense suffering, ranging from surging chances of contracting HIV/AIDS to early teen pregnancies to unplanned pregnancies among adult women. The pandemic has further highlighted the persistence of inequalities between men and women. The COVID-19 pandemic has exacerbated inequalities unprecedentedly. Hitherto, systemically marginalized groups (such as women, girls, and the extremely poor) are experiencing overarching and intersecting vulnerabilities, violence, and risk exposures. The COVID-19 pandemic has also exposed and underscored society's reliance on women on the front line and at home, and the structural inequalities across every sphere, from health to the economy and security to social protection.

The COVID-19 pandemic affected African households' health and welfare and their poverty levels by impacting the productive capacity of infected and recovering workers. Given that women predominantly work in the informal sector in the sub-region, the quarantines, closures of non-essential businesses, and curfews further negatively impacted them. The pandemic led to unbudgeted health expenditures that consumed household savings and out-of-pocket often controlled by women, thus increasing poverty levels and scaling inequality. In many households, women's increased unpaid care work burden during the pandemic reduced their ability to participate in productive activities, study, and rest. The pandemic has negatively affected their mental and physical health, especially in women-headed households, and increased food insecurity, household work, survival burdens, and gender-based violence. Across the surveyed countries- Guinea, Liberia, Tanzania, Mozambique, Rwanda, and Zambia, the COVID-19 pandemic has increased the fragility of social structures, including family, with loss of jobs and related ordeals leading to breakdowns and mental distress among victims and their families. The unprecedented levels of intimate interactions within limited spaces, especially for those with large families and poor, lead to stress, tensions, and anxieties.

The impacts of the pandemic in the African continent are felt in the context of the efforts by the African Union to address gender inequality manifested by the ways women in Africa are restricted in their enjoyment of various human rights, including lack of access to land and other productive resources. The fight to combat discrimination against women through appropriate legislative, institutional, and other measures has been encapsulated in the 2003 Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (the Maputo Protocol) adopted by the African Union Member States. Overall, the study acknowledges that Africa's access and enjoyment of sexual and reproductive health rights (SRHR) has a close and insidious relationship with systemic, social, and behavioural gender inequity, poverty among women, weak economic capacity, and sexual and gender-based violence, including female genital mutilation (FGM). Thus these issues and the driving factors are best discussed in an intersecting continuum that links regional policies such as the Maputo protocol to household dynamics such as control of house resources and individual bodily autonomy. Covid-19 has disrupted health systems and is rewinding efforts to meet sexual and reproductive health needs. Globally, women and girls have reported having reduced access to services, which increases the risk of unwanted pregnancies, sexually transmitted diseases, and complications during pregnancy, delivery, and abortion. There are global predictions of up to 7 million unintended pregnancies worldwide due to Covid-19 and its measures.

The case studies underline how Africa is ill-prepared to manage future pandemics. All African countries should adopt the Maputo Protocol to enable all women, giving them the necessary capacity to manage themselves during difficult times. The Maputo protocol gives women a sense of self-awareness and realization, curbing the present incidences like unplanned pregnancies and economic hardships that the COVID-19 pandemic unleashed. Reflecting on the present pregnancy trends, one concludes that females have insufficient knowledge of their sexual reproductive health. Among teen girls and adult women who know about the sexual reproductive health demands, it is still challenging for them to access healthcare facilities. The governments need to prioritize reproductive health services access as well as equip adolescent girls and adult women with the necessary knowledge and economic empowerment to enable them to manage and overcome the future pandemics considering the present globalization world, where an emergency in one country spreads globally within a short span.

INTRODUCTION

Background to the Study

Advancing African Women's Human Rights to their Bodily Autonomy and Integrity through ensuring that African Governments fulfill their Obligations and Commitments on SRHR implemented by FEMNET with support from the SIDA- Bodily Autonomy and Integrity program is a 4-year project (2017-2021) in 6 countries (Tanzania, Mozambique, Liberia, Guinea, and Zambia). The Project, aims to accelerate state reporting on ending and eradicating FGM, early child marriages and harmful practices in Liberia, Mozambique and Zambia through its implementing partners in the countries to help them in tracking their country Commitments made by the various governments and stakeholders to improve *domestication of regional and global women's rights instruments and budgetary allocation to realize SRHR policy commitments by government in their target countries*. In particular, the Project is part of FEMNET's continued investment and leadership in promoting compliance to the African Charter on Human and Peoples' Rights (the African Charter), The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol) and the Solemn Declaration on Gender Equality in Africa by African countries¹.

The goal of the project is to *ensure that women and girls enjoy and realize their rights to bodily integrity enshrined in the related global, continental and national women right instruments* by: i) Enhancing policy advocacy capacity and knowledge of the women rights and young women-led organizations in sexual reproductive health rights (SRHR), specifically safe and legal abortion, child marriages, female genital mutilation (FGM) and their inter-linkages with women's rights and gender equality in six countries; ii) Strengthening accountability by African States on SRHR commitments enshrined in the Maputo Protocol and Plan of Action, the International Conference on Population and Development (ICPD) Programme of Action, 2030 Agenda on Sustainable Development, AU Agenda 2063 and the Beijing Platform for Action (BPfA); iii) Increasing awareness and visibility among key stakeholders in the region and enhance media capacity on SRHR issues specifically the African Commission on Human and People's Rights (ACHPR) Campaign on Decriminalization of Abortion in Africa, African Union (AU) Campaign to abolish child marriages and FGM in Africa.

Context to the Study

Since March 2020, the world has been under the burden of the COVID-19 pandemic. Africa is experiencing unprecedented challenges due to the Coronavirus 2019 (COVID-19) pandemic, both directly and from the compounding effects of other health, economic and social factors^{2,3}. There are about 11.7million confirmed COVID-19 cases and 253,558 deaths on the African Continent as of 9th June 2022⁴. Africa has recorded fewer cases and Covid-19-related fatalities, though with more asymptomatic cases than other regions of the world⁵. Yet, this profile hides the differential experiences and distribution of the COVID 19 effects that define the continent's pandemic landscape. The profile does not reveal how the pandemic has latched onto the gender and socio-economic disparities to unevenly spread and amplify exclusion and systemic biases along gender, social and economic lines. COVID-19 has varying impacts on women, men, girls, and boys,

- 1 [African Commission on Human and Peoples' Rights Pressrelease \(achpr.org\)](#)- Special Raporteur Statement. March 2021.
- 2 Dhaliwal M, Small R, Webb D, et al. 2022. Covid-19 as a long multiwave event: implications for responses to safeguard younger generations. *BMJ* :e068123. doi:10.1136/bmj-2021-068123.
- 3 Verhagen W, Bohl DK, Cilliers J, et al. 2021. Long-Term Socio-Economic Impacts of COVID-19 in African Contexts | UNDP in Africa. UNDP.
- 4 African Union COVID 19 DashBoard - [Coronavirus Disease 2019 \(COVID-19\) – Africa CDC](#) (accessed June 10th 2022)
- 5 Lewis, HC, Ware, H, Whelan, M, et al. 2022. SARS-CoV-2 infection in Africa: A systematic review and meta-analysis of standardized seroprevalence studies, from January 2020 to December 2021 [Pre-print version]. [SARS-CoV-2 infection in Africa: A systematic review and meta-analysis of standardized seroprevalence studies, from January 2020 to December 2021 | medRxiv](#) -Accessed on Feb 19th 2022.

including: - increased intimate partner violence during lockdowns; increased stigma and discrimination of already marginalized persons like those living with HIV and disabilities, and increased infection and health risks due to unequal sharing of the burden of caretaking roles, unequal access to health information, prevention, care and financial and social protection and limited access to sexual and reproductive health and rights for women and girls⁶.

Because of this, global and national strategic plans for COVID-19 preparedness and response must be grounded in comprehensive gender analysis and prioritize meaningful participation of affected groups, especially women and girls, in decision-making and implementation. In times of crisis, when resources are strained and institutional capacity is limited, women and girls face disproportionate impacts with far-reaching consequences, especially in contexts of fragility, conflict, and emergencies. The UN Women shows that hard-fought gains for women's rights are threatened due to the pandemic. Thus, post-pandemic responses must conjoin the push to address long-standing inequalities while building a resilient world in the interest of everyone, with women at the center of recovery⁷. Thus, understanding and addressing the impact of the pandemic, especially on women in low-income and middle-income countries, requires an in-depth and systemwide contextual knowledge of specific country and community level situation, informed by the question of who is affected as opposed to who is infected⁸.

Due to pandemic-related measures, especially lockdowns and stay-at-home orders, there was an explosion in unemployment and loss of livelihood. Women were facing an increasing risk of unemployment and livelihood loss. As a result, the COVID19 pandemic has adversely affected childbearing women by increasing their socio-economic vulnerability and dependency. The vulnerability has exposed them to increased sexual and gender-based violence, especially intimate partner violence, during many countries' movement restrictions. It has also raised barriers to access pre- and postnatal care and skilled care delivery through disruptions in the healthcare system and other public services. At the same time, due to the diversion of more public spending to the pandemic, maternity protections have received reduced attention amid the COVID19 response measures. Very few countries have set up deliberate measures to ensure income security for pregnant women during the final stages of pregnancy and after childbirth⁹. The COVID 19 pandemic has also underlined the fragility of women's access to sexual and reproductive health rights in Africa.

As of March 2021, forty-two (42) of the 55 Member States of the AU had ratified the Protocol on the African Charter of Human and Peoples' Rights on the Rights of Women in Africa¹⁰. However, the level of commitment demonstrated by the countries varies. Many countries have ratified, domesticated, and enacted national laws that border on issues captured in the Maputo Protocol, while a few have not. Comprehensive Protocol adoption requires the government to acknowledge women's rights, including sexual and reproductive health rights, personal freedoms and bodily autonomy, equality, and access to productive resources. It is imperative to explore how the state of commitment to operationalizing the Protocol has contributed to the impact of COVID 19 on women, especially concerning accessing sexual and reproductive health rights.

The Study

The qualitative study explores the impact of COVID-19 on the Sexual and Reproductive Health and Rights (SRHR) of women and girls in Africa. The study documents the effects and outcomes of the COVID 19 on the experiences of women and girls in their voices and within their contexts. The project references and positions its specific tasks around the Maputo Protocol as a critical African instrument to advance women

6 WHO, 2021

7 [UN Women | Explainer: How COVID-19 impacts women and girls](#) (3rd March 2022)

8 Omukuti, J, Barlow, M, Giraud, M.E, et al. 2021. Systems thinking in COVID-19 recovery is urgently needed to deliver sustainable development for women and girls. **Lancet Planet Health**, 2021; 5: e921-28

9 ILO, 2021. **World Social Protection Report 2020–22**. Geneva.

10 [Maputo Protocol Scorecard & Index: A Stepping Stone Towards Achieving Women's Rights | African Union \(au.int\)](#) Afriocan Union website accessed 23rd March 2022.

and girls' rights. The study findings are presented as country case studies highlighting these experiences from a diverse perspective in each country as per the realities and context of the country. The study explores the following thematic dimensions of COVID 19:

- i) Effects: How COVID-19 has affected the delivery of SRHR services to women and girls;
- ii) Interventions: Strategies/initiatives that government ministries have implemented and other stakeholders to ensure continued delivery of SRHR services; and
- iii) Outcomes and Effects: Adverse outcomes such as child and unintended pregnancy, violence, gender-based violence, and early and forced marriage among women and girls.

Objectives of Assignment

The study sought to establish the gendered experience of the COVID-19 pandemic and the effects of local and global responses, especially on women and girls' access to sexual and reproductive health rights in the focus countries. As such, the key objectives of the assignment are to conduct a qualitative study in the focus countries to generate country-specific case studies that capture the following:

- i) How COVID-19 has affected the delivery of SRHR services to women and girls;
- ii) The strategies/initiatives that government ministries have implemented and other stakeholders to ensure continued delivery of SRHR services;
- iii) The adverse outcomes such as early and unintended pregnancy, violence, including gender-based violence and early and forced marriage among women and girls; and
- iv) Recommendations on possible interventions to support women's and girls' empowerment through enhanced focus on SRHR and contribute to a just recovery.

Scope of the assignment

The operational scope of the study was limited to qualitatively studying and documenting the gendered impact of the COVID-19 pandemic on women and girls' sexual and reproductive health and rights (SRHR) in the six SIDA countries. Based on the findings, document and present country case studies capturing and analyzing women and girls' experiences and lived realities in the focus countries. The study delimits to the following:

Geographical coverage: It covers the six countries of the project- Tanzania, Mozambique, Liberia, Guinea, Rwanda, and Zambia.

Thematic Focus: The study examines the impact of COVID-19 on SRHR in the six countries in the context of the countries' commitment to the principles of the Maputo protocol. The scope encompasses assessing the state of compliance and activation of the countries to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. It then analyses the emerging relationship (if any) between the respective country's compliance to the Protocol and the nature of the impact of COVID-19 on the lives and rights of women and girls generally and the SRHR specifically.

Period (Time range): The Study is limited to the countries' situation in the last two years (the COVID-19 period) even though the project was conceived long before the pandemic. However, this does not preclude commentary on the state of the countries' activation of the Maputo Protocol before and during the COVID-19 pandemic.

Methodology of the Study

Due to COVID-19-related limitations and time constraints, the study was conducted remotely using secondary data and literature on the internet, supplemented by strategic country key informants' interviews. It covered the six countries purposely sampled by being the implementation of the project. These are: the Democratic Republic of Congo, Guinea, Liberia, Mozambique, Rwanda and Tanzania. The study collected data on the state of the countries' sexual and reproductive health rights regarding the health systems' structural orientation towards providing the environment and services for the full enjoyment of SRHR. It analyses the legal and cultural normative environment for protecting women's sexual and reproductive health manifest through laws and regulations facilitating or restricting access to rights and services; and the social norms related to women's security and rights, especially concerning sexual and gender-based violence. The purposive design was appropriate because it provides an in-depth view of the individuals and the contextual effects of COVID-19 on the women and girls.

Participant Selection (Sampling): The study employed purposive and convenient sampling to identify



participants and data sources. The data sources are country reports and studies, women's rights organization representatives, allies, and key informants. Other participants include government sources (reports and persons), international agencies such as UN Women, UNFPA, African Union, and others identified as relevant. It sampled six countries in Eastern, Southern Central and Western Africa- democratic republic of Congo, Guinea, Liberia, Mozambique, Rwanda and Tanzania. From these countries, the study targeted thirteen women rights organization as well as FEMNET for key informant interviews. The study also sampled local and international organizations providing services and technical support through programs that centred on the nexus between sexual reproductive health rights, gender equality, and COVID 19 mitigation. Lastly, the sampled data sources included government, media, research reports, and COVID 19 data dashpots.

Limitations of the Study: The study was designed cognizant of various limitations related to the COVID 19 working environment which, first, restricted mobility and interactions between the research team and participants; and secondly, due to the overarching ambiguity of relations between COVID 19 and women's health in many countries. Furthermore, there was limited information and data across the countries which hindered many participants from providing in-depth qualitative data. As a result, many of the country partners contacted did not respond, while others indicated they had not implemented any COVID 19-related programs to provide credible information. To remedy this limitation, the study employed triangulation procedures to enhance the accuracy, depth, and completeness of the data.

Conceptual Approach to Assessing the impact of COVID 19 on SRHR

The study conceptualized the impact as multi-dimensional and multi-level to assess the impact of the pandemic on the country's sexual and reproductive health rights situation. It established that the pandemic is conceptually linked to:

- i) The state of the health system structure - financing, human health resources, and regulatory guidelines and laws
- ii) The demand for SRHR services – abortion, family planning, and age-related restrictions
- iii) The social support system- employment, care work valuation, and social protection for women
- iv) State of sexual and gender-based violence- including child marriage and teenage pregnancy.

Based on these dimensions, a set of aligned indicators were selected to form the basis of impact assessment by establishing the descriptive status in 2019 before the pandemic and then comparing that with the present situation. For analysis, the indicators thematically clustered to capture the entire continuum of the SRHR spectrum, from individual access to services to structural barriers. It also includes a deliberate focus on SGBV as a critical dimension that brings out the intersectionality of COVID 19. The qualitative analysis used key indicators to reflect the multisectoral effects of the pandemic, the balance between primary medium and long-term effects by capturing the effects, outcomes, and impact of the pandemic, and can be aligned to global, continental, and regional targeting by different women rights organizations and allies. The study also focused on standard indicators commonly monitored, hence the availability of relevant country data and information. *Applicability of findings:* The findings of the study are intended to: i) Provide an intersectional snapshot of each country's status of the COVID-19- SRHR nexus; ii) Provide evidence for deepening or accelerating the activation of the Maputo protocol in the target countries by informing policies; and iii) Assess the intersectional effectiveness of the country approach to SRHR in the partners in the focus countries, including government investment in the promotion of women and girls' rights.

THE STUDY FINDINGS

Overall Impact of COVID 19

Available data and anecdotal evidence across the world and from the six countries surveyed show that men faced a higher mortality risk due to the virus. However, women were more likely to face a more significant social and economic burden. Before 2019, women already faced significant barriers to gender equality, especially around finances, employment, education, unpaid labor, and gender-based violence. COVID-19 only served to deepen those divides. In low-income countries, 70% of women earn their money through informal labour, such as domestic work and agriculture work that relies heavily on interaction with others. These jobs are less likely to provide paid sick leave or protect workers against job loss or unemployment. The majority of women and men surveyed by Concern told us that their ability to earn an income has declined due to COVID-related shutdowns and social distancing. However, this situation was far worse for women.

Across the six countries, most household and caring responsibilities typically fall to women. This has always impacted women: 42% of working-age women said they could not do paid work because of their unpaid care and domestic responsibilities before the pandemic. The number of men who said the same was just 6%. Increased unpaid labour at home has negatively impacted women's economic security and mental and physical health, and well-being. 43% of women surveyed by Concern reported feeling more anxious, depressed, overworked, isolated, or physically ill because of this increased workload. In Kenyan informal settlements, 26% of women surveyed said they had been physically unwell, unable to get enough rest, or felt stressed and anxious because of increased care responsibilities¹¹. The financial, social, and health stressors of a pandemic, combined with close confinement during lockdowns, meant that women and girls were at a higher risk of violence from their family members, domestic partners, or community. This was reminiscent of the experiences had during the 2014–2016 Ebola epidemic in West Africa, which recorded increased incidences of gender-based violence, and fewer resources for women and girls who were experiencing abuse (given the increased demand for healthcare workers to help to halt the spread of the virus).

Covid-19 has disrupted health systems and is rewinding efforts to meet sexual and reproductive health needs. Globally, women and girls have reported having reduced access to services, which increases the risk of unwanted pregnancies, sexually transmitted diseases, and complications during pregnancy, delivery, and abortion. There are global predictions of up to 7 million unintended pregnancies worldwide due to Covid-19 and its measures¹².

Estimates from 2021 indicated that as many as 9.5 million girls and women failed to receive essential reproductive health services in 2020. Overburdened healthcare systems diverted resources to COVID-19 response, services were reduced for non-essential treatment, and many women and girls simply feared going to a doctor's office, clinic, or hospital. According to a Concern Worldwide survey, nearly 37% of women felt that they, or others in their family, could not visit health facilities when needed (compared to just over 32% of men). The most concerning aspect is that over 68% of women said that COVID-19 was a reason for not seeking healthcare in the future. This suggests that the negative impacts of the pandemic may affect future behaviour as well as current trends¹³. Other studies show that the Global Humanitarian Response Plan for COVID-19 did not include a specific objective focused on addressing GBV during the pandemic; GBV interventions and essential services are the least funded, receiving less than 1% of global humanitarian missions funding before and during the Covid 19 pandemic¹⁴.

11 [How the impact of COVID-19 on women and girls hits especially hard | Concern Worldwide](#) (accessed March 25th 2022)

12 [5 ways women and girls have been the hardest hit by Covid-19 | Oxfam International](#) (accessed 10th March, 2022)

13 Ibid.

14 Orchid Project. 2020. Impacts of COVID-19 on female genital cutting- a policy brief. ([COVID_fe-](#)



COUNTRY CASE STUDIES



Country Case Study 1: Guinea

State of COVID 19 in Guinea

Guinea reported its first coronavirus case on 13 March 2020. The patient was a Belgian national working for the European Union Delegation in Guinea. According to the World Health Organization, from 13 March 2020 to 22 April 2022, Guinea has confirmed 36 540 coronavirus cases, from which 441 people have succumbed to the COVID-19 virus. The majority of the affected population are older men aged above 55 – about 65 percent of the positive coronavirus cases¹⁵. The government of Guinea has vaccinated about 23.3 percent of its 13.7 million people using an estimated 5 952 680 doses of the coronavirus vaccine¹⁶. The pandemic has exacerbated household poverty in a country where 43.7 percent of the population lives below the poverty line¹⁷. The majority (75 percent) live in rural areas, primarily relying on subsistence farming and low productivity jobs, including open-market vending and housework, especially for women and young people. At the macro level, the pandemic has drastically disrupted the national economic growth, rising, with the gross domestic product (GDP) estimated to grow to 18.00 billion U.S dollars by 2022.

State of the implementation of the Maputo Protocol in Guinea

Women and girls continue facing perennial challenges. In Guinea, abortion is illegal unless in a case when the mother’s life is in danger and is the primary means to keep her alive. In scenarios where abortion is performed on a woman for any other reason, the provider is subject to fourteen years in

prison under the statutory law, while the woman procuring the abortion is subject to a seven-year jail term. Additionally, there is a high prevalence of female genital mutilation (FGM) among women aged between 15 and 49 years in Guinea. Kindia and Labe are the leading and second with 98.4 percent and 98.2 percent, respectively¹⁸. Nzerekore, located in the South-east, has the lowest prevalence, standing at 84 percent. Among women aged between 15-49 years, FGM has a 94.5 percent prevalence. Holistically, FGM is Guinea women’s way of life.

Child marriage is high in Guinea, where 51 percent of girls are married before eighteen¹⁹- meaning one in two girls marry before the age of eighteen. This early marriage translates to school dropouts in the country, upsurging the literacy gap between males and females. School dropout equates to poor education and increasing trends of unemployment. Joblessness makes these women remain at home, performing domestic duties without the help of their husbands, who majority work in the private sector, including artisans. Guinea ratified the Maputo Protocol in 2003. However, the state of operationalization and impact is abysmal. Regardless of Guinea ratifying some sections of the Maputo protocol, there is no budgetary allocation for advocacy and operationalizing comprehensive sexual and reproductive health rights.

The State of Sexual and Reproductive Health

[male_genital_cutting_FGC_policy_briefing_Orchid_Project_FINAL\(1\).pdf \(reliefweb.int\)](#) cited on 23rd March 2022.

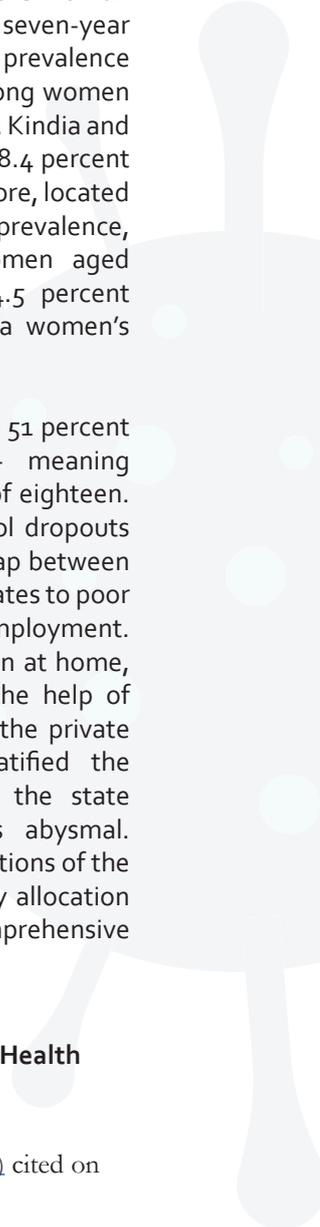
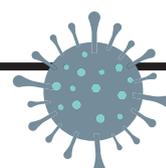
15 World Health Organization. (2022). Guinea situation. <https://covid19.who.int/region/afro/country/gn>

16 Ibid., 1.

17 The World Bank. (2020). Guinea Data. <https://data.worldbank.org/country/GN>.

18 Too Many. (2022). Guinea FGM prevalence: 94.5%. <https://www.28toomany.org/country/guinea/#:~:text=The%20prevalence%20of%20FGM%20among,the%20lowest%20prevalence%20at%2084%25>.

Efevbera, Y., & Farmer, P. (2021). ‘It is this which is normal’ A qualitative study on girl child marriage and health in conakry, Guinea. *Social Science & Medicine*, 273, 113762.



Rights in Guinea

Access to sexual and reproductive health services as a right in Guinea is significantly difficult. There are interconnected structural, social, and behavioural barriers facing women and adolescent girls accessing contraceptives. Individual fear of side effects, costs, and misinformation is part of Guinea's challenges in the advancement of SRHR²⁰. In Guinea, most women and society, in general, have a conspiracy theory that contraceptives and FP have adverse impacts, including contributing to the high trends of infertility. As such, women and adolescent girls fear embracing different methods. Also, interpersonal or family structures are critical barriers for women to access SRHR. In Guinea, customary laws dictate that men make family decisions and that women have no rights over their bodies. For instance, women cannot decide the number of children they want, and the interval between births leads to high fertility and large families. Traditionally in Guinea, it is taboo to talk about sexuality, making women, predominantly the illiterate who are the majority, be reluctant to adopt contraception and family planning. Lastly, provider attitudes and geographic proximity of the services create structural barriers for women from accessing proper SRHR. Health service providers have negative attitudes towards women seeking contraceptives in the different health centers, seeing them as immoral and engaged in prostitution. The healthcare centers are stationed far away, discouraging women and girls from seeking the health services due to the extra transport costs incurred and time spent, and the unreliability of functioning of the services upon arrival.

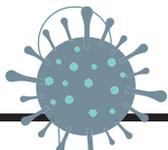
Though there are efforts to improve access to family planning, the contraceptive prevalence rates among youth and adolescents are meagre in Guinea. The government lacks coherent and resourced strategies for providing contraception and family planning products and services, including female

condoms. Consequently, one in three married women between the age of 20-49 years is pregnant, while many adolescent girls between 15-18 are pregnant or have terminated their pregnancies. During the COVID-19 period, between March 2020 to December 2021, Guinea recorded a surge in unplanned/unwanted pregnancies. According to the Guinea Internal Security Ministry, Guinea recorded a 50 percent increase in illegal pregnancy terminations, from 1743 in 2019 to 3455 in 2020²¹, underlining the potential connections between the pandemic and the state of SRHR.

In Guinea's rural areas, only 40 percent of women make at least four antenatal care visits during pregnancy compared to 71 percent in urban areas²². As a result, few women in rural areas deliver in healthcare centers and under the care of trained healthcare providers. In rural areas, most women argue that the unavailability of healthcare facilities within their environment causes a frustrating number of pregnant women who go for antenatal care services. The healthcare centers are inaccessible for rural inhabitants since they have to travel for miles, incurring high and non-refundable costs because 70 percent of this populace live in abject poverty. This is compounded by the lack of accessible, safe abortion considering the many requirements that women must avail to undergo the procedure, increasing procurement of unsafe abortion. In Guinea, access to SRHR by married women is further hindered because they cannot make reproductive health decisions independently. Women depend on their husbands' decisions regarding their birth and reproductive health. For example, Guinean married women cannot decide to use contraception without their spouses' approval.

Women are vulnerable to risks of sexually transmitted diseases, including HIV and AIDS. Though Guinea seems to have made significant progress in

- 20 Dioubaté, N., Manet, H., Bangoura, C., Sidibé, S., Kouyaté, M., Kolie, D., ... & Delamou, A. (2021). Barriers to contraceptive use among urban adolescents and youth in Conakry, Guinea. *Frontiers in Global Women's Health*, 2, 42.
- 21 Baker, T. (2020). COVID-19 Aftershocks: Access Denied Teenage Pregnancy Threatens to Block a Million Girls Across Sub-Saharan Africa from Returning to School. *World Vision International*, 2020-08.
- 22 The World Bank. (2019). Improving human capital through maternal health in Guinea: Local solutions for local problems. <https://www.worldbank.org/en/news/feature/2019/05/21/improving-human-capital-through-maternal-health-in-guinea-local-solutions-for-local-problems#:~:text=.%E2%80%9D%20she%20says-,Guinea%20has%20particularly%20worrying%20maternal%20and%20child%20health%20indicators%20in,giving%20birth%20in%20health%20facilities>.





reducing HIV/AIDS cases in the country (recorded 0.8 percent cases of HIV among women compared to 1.4 in 2000²³), available data shows a rise in gonorrhoea and syphilis incidence in the country. Furthermore, across the country, including Conakry, new waves of GBV against women have been observed during the COVID 19 pandemic. Reports by diverse human rights organizations indicate that 8 out of 10 women in Guinea experience or have ever experienced sexual harassment or physical and verbal abuse, including rape²⁴.

State Response to the COVID 19 Situation in Guinea

Like most countries globally, Guinea responded to the COVID-19 situation by shutting down public spaces, including workplaces, schools, and international borders, to curb the spread of the coronavirus. As of 23 May 2020, Guinea's government mandated negative COVID-19 certificates given within the past 72 hours for entry into the country. Using the police, the government instituted curfews and lockdowns with police-staffed checkpoints between states/towns. These lockdowns and restricted movement created tensions and often spilled into open protests, with citizens claiming that the police were using them to extort the public²⁵. Those travelling out of Conakry to the regions were required to carry a negative PCR test certificate or COVID-19 vaccination certificate. Mask wearing was mandatory and social distancing and hand washing when entering and leaving government and private establishments. Those not wearing masks are subject to a fine of 30,000 GNF. The Guinean authorities maintain police and local militia checkpoints across the whole country²⁶. Furthermore, the Ministry of Culture, Tourism, Handicrafts, and Health encouraged civilians to embrace local remedies to combat COVID-19

by steaming and taking hot lemonade water. The latter was adopted to accommodate the inadequacies of the healthcare system to handle the COVID 19 cases, especially among the rural poor, while also legitimating the traditional health practices prevalent among them.

Effects of the COVID 19 Control Measures on Women's Lives in Guinea

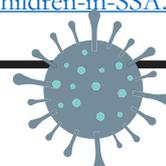
The closure of public spaces, especially schools and workplaces, negatively affected people and households. It led to the deterioration of diverse businesses, employment and livelihood systems as the majority of the people were forced to stay at home. The immediate outcome of the stay at home was increased domestic labour load on women as they customarily carry the burden of domestic chores. The restricted movement through lockdowns, closure of schools, and workplace measures directly affected women's capacity to move and act while increasing household expectations and responsibilities. The pandemic control measures negatively affected the social networks that provide psychosocial support and solidarity for women by prohibiting the different occasions, events, and practices, including weddings that provide platforms for interaction. As a result, anecdotal evidence suggests that women are more stressed, fatigued, and emotionally abused, while teenage pregnancies and unplanned pregnancies among adult women have erupted due to the restrictions. This is confirmed by actual data, which shows that by the end of 2020 alone, Guinea experienced a 4.6 percent surge in births, from 375 432 children in 2019 to 392 702 new-borns by 31 April 2021²⁷.

Furthermore, the COVID-19 measures have also been linked to the increasing HIV/AIDS, and STIs reported across the country. The maternal mortality ratio was 576 per 100 000 live births, increasing from

23 The World Bank. (2020). Prevalence of HIV, female (% ages 15-24)-Guinea. <https://data.worldbank.org/indicator/SH.HIV.1524.FE.ZS?locations=GN>.

24 Africanews. (2017). Gender based violence on the rise in Guinea [The Morning Call]. <https://www.africanews.com/2017/01/18/gender-based-violence-on-the-rise-in-guinea-the-morning-call/#:~:text=Guinea%2C%20Conakry%20is%20dealing%20with,workplace%20sexual%20harassment%20and%20rape>.

25 Anecdotal evidence and [COVID-19 pandemic in Guinea - Wikipedia](https://en.wikipedia.org/wiki/COVID-19_pandemic_in_Guinea) (accessed on 2022 Mar 21st) [Coronavirus - Guinea travel advice - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/travel-advice/coronavirus/coronavirus-guinea) (21st Mar 2022)
UNICEF. (2021). COVID-19: A catastrophe for children in sub-Saharan Africa. <https://www.unicef.org/esa/media/7626/file/COVID-19-A%20Catastrophe-for-Children-in-SSA.pdf>.





4.70 per 100 000 births²⁸. The increase in reported maternal deaths demonstrates the effects of the Guinean government's diversion of attention to combating coronavirus, forgetting other essential components, including enhancing safe deliveries. Amid all these effects, the COVID-19 measures have increased the rates of GBV due to the intensified close interactions, tensions, and eruptions among household members.

COVID 19, the Maputo Protocol and Sexual and Reproductive Health Rights in Africa

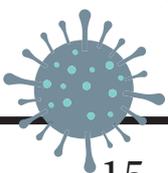
The Maputo protocol supports the idea of sexual and reproductive health and ensures that women enjoy their full rights without interference from their male counterparts or even the customary laws. The Maputo protocol advocates for total integration of the statutory laws, giving women and girls an equal opportunity to compete favourably with their male counterparts. The Guinean government's strategy to dig boreholes to ensure that women keep themselves healthy, diminishing the rates of sexual and reproductive infections. For instance, the government dug more than 1000 boreholes in different parts to increase access to water, sanitation, and hygiene (WASH)²⁹. The different actors should amplify the connections between different sectors, forms of exclusion, and deprivation against women to mediate the impact of COVID 19 on the broader health and rights of women. This is the spirit of the Maputo protocol because it conceives women's rights holistically and intersectionally.

Way Forward: Strategies, Policies, and Plans under COVID 19 in Guinea

Though there are no explicit approaches to sexual and reproductive health rights during this COVID-19 pandemic in Guinea, there are other measures that the government has taken to benefit women and girls more effectively. A critical strategy for SRHR during this COVID-19 and after the pandemic is to provide free learning materials for students and construct new classrooms to facilitate increased access to education by girls and boys. According to UNICEF, most school dropout girls note a lack of school fees and learning materials as the primary reason to quit their studies. Therefore, the government ensuring enough learning materials in different institutions will increase female literacy, thus operationalizing the Maputo protocol. The plan to avail learning materials and construct more classrooms aligns with SRHR's goal of increasing health literacy and knowledge among females in the community. Therefore, females being enlightened means that they are increasingly aware of their sexual and reproductive health rights to advocate and resist different forms of sexual violence and relevant legal protections.

28 Knoema. (2021). Guinea- Maternal mortality ratio (modeled estimate). <https://knoema.com/atlas/Guinea/topics/Health/Health-Status/Maternal-mortality-ratio>.

29 Centers for Disease Control and Prevention. (2021). Access to clean water, sanitation, and hygiene. https://www.cdc.gov/healthywater/global/wash_statistics.html.





Country Case Study 2: Liberia

State of COVID 19 in Liberia

Liberia reported the first COVID-19 case on 16 March 2020. The virus was detected in Monrovia before spreading sporadically to other locations. According to the World Health Organization, Liberia has recorded 7 432 cases of COVID-19 with 294 deaths as of 20 April 2022. Also, as of 31 March 2022, 1 208 041 vaccines had been administered³⁰. As of 21 April 2022, the country has administered 2 201 300 COVID-19 vaccine doses, accounting for 22.3 percent of Liberia's populace upon assuming that every person has taken two doses³¹. The COVID-19 trend in terms of infection has been constant since the onset of the pandemic. As of 31 July 2020, Liberia recorded 410 females, 779 males, and 102 children COVID-19 positive cases from a sample of 1 189³². The positivity trend captures individuals across the economic scale, but those in peri-urban or slums, including Slipway, Brewerville, West Point, Sonewein, and Sinkor, count for the most significant number because of the congestion experiences.

State of the implementation of the Maputo Protocol in Liberia

Liberia has ratified fundamental gender equality and women's rights protocols, including the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo-protocol). The age of marriage in Liberia remains to be eighteen years for girls. Also, despite the ratification of the CEDAW in 1984, Liberia is yet to incorporate it into the Liberian law, rendering it not justiciable in

the Liberian courts. The coalition of the Campaign remains pertinently concerned by the continued trends of violations of women's rights in the country, commencing with unequal status within the family, the persistence of discriminatory laws, limited access to employment, education, violence against women, and health services, and decision-making positions. Liberia's legal systems consist of customary and statutory laws. Discriminatory provisions in the statutory laws include married women not being allowed to appear before the traditional courts without an accompaniment from their husbands, women having no right to custody of children and parental authority, and polygamy being allowed under customary law regardless of being prohibited under the statutory law.

However, Liberians have made commendable steps to translate the Maputo protocol into operational policies and actions. According to the Wiki Gender Organization, Liberia has enacted the 2008 Gender and Sexually Based Violence Act (GSBVA)³³. GSBVA provides for establishing a specialized court to try sexual violence cases, giving women justice upon the assault. Also, the 2006 Law enactment on rape which includes spousal rape within the definition of rape, is another pivotal step that the Liberia government has made in connection with the Maputo protocol. Finally, the election of Ellen Johnson-Sirleaf as president in 2005 and making Liberia the first African country to elect a woman president is among the many Maputo protocol footprints. Thus far, regardless of having a female president between 2006-and 2018, Liberia remains among the three countries in West Africa yet to make FGM illegal³⁴.

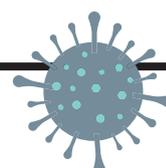
30 World Health Organization. (2022) *Improving Response as Liberia Marks Two Years since First COVID-19 Case*. <https://www.afro.who.int/countries/liberia/news/improving-response-liberia-marks-two-years-first-covid-19-case>.

31 Reuters. (2022) *Liberia*. <https://graphics.reuters.com/world-coronavirus-tracker-and-maps/countries-and-territories/liberia/>.

32 UNICEF. (2020). *UNICEF Liberia COVID-19 Situation report*. <https://www.unicef.org/media/82496/file/Liberia-COVID19-SitRep-31-July-2020.pdf>.

33 Wiki Gender Organization. (2022). *Africa for Women's Rights: Liberia*. <https://www.wikigender.org/wiki/africa-for-womens-rights-liberia/>.

The Borgen Project. (2022). *Ongoing Harm: Female Genital Mutilation in Liberia*. <https://borgenproject.org/female-genital-mutilation-in-liberia/#:~:text=Liberia%20is%20one%20of%20three,girls%20and%20women%20by%20U.N.>





The State of Sexual and Reproductive Health Rights in Liberia

Liberia has a youthful population, with about 50 percent below 25 years³⁵. Regardless of their SRHR needs, women and girls face several barriers emanating from the patriarchal nature of community, households, and government. Men are dominant in sexual matters, restricting their wives from adopting the different family planning techniques. Lack of information on diverse contraceptive methods is the first challenge. Fear and myths about the contraceptives' side effects are other obstacles preventing women from enjoying their SRHR rights. Perceived infertility, shame, and fear of condemnation for method use and spousal refusal are among the many stumbling blocks deterring women from embracing SRHR. Lastly, position in society, gender expectations, and the economic power dynamics pose a barrier to SRHR access.

In Liberia, women of the childbearing age constitute around 23 percent of the country's total population of 5.1 million people, with men being the primary decision-makers in matters to do with family planning. The population growth rate remains at 2.1 percent, with a fertility rate of 4.6 percent and a teenage pregnancy rate of 38 percent³⁶. Pregnancy and childbearing complications remain the primary cause of mortality and disability and females of productive age. Limited skilled health providers, poor geographic access due to inaccessible terrains and bad roads, and poor logistical facilities connected with GBV are standard in Liberia, contributing to low SRHR. Also, harmful traditional practices and high poverty levels significantly contribute to the unacceptable high newborn and maternal morbidity and mortality. UNFPA provides financial and technical support to the Liberian government through the Health Ministry, partnering toward reducing neonatal and

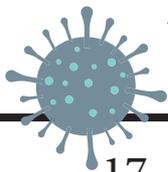
maternal mortality, which stands at 1072 per 100 000 live births, the highest maternal mortality rate worldwide³⁷.

Liberia is continuously improving women's access to contraceptives. Approximately in one million reproductive-age women, 31 percent want to space or delay their pregnancies but are not using any form of contraception, often because of inaccessibility³⁸. Over a quarter of girls aged between 15-and 19 years are already mothers, a risky process in the country considering the high maternal mortality rates. These facts dictate an urgent need for enhanced access to modern contraceptives. With a population of 5.1 million, approximately 1.5 percent of the populace aged between 15-and 49 years live with HIV/AIDS. Regardless of the percentage sounding small, it equates to 47 000 people currently living with HIV, including 3 600 children³⁹. While the percentage of HIV/AIDS is lower than in surrounding countries, it struggles with the treatment plans, education on the disease, and eradication of the stigma that could prevent further spread. More than 33 percent of Liberians living with HIV/AIDS receive antiretroviral therapy (ART), a daily medication that reduces the HIV levels in the body system⁴⁰. By 2020, 90 percent of Liberians knew their HIV status, a significant SRHR step.

State Response to the COVID 19 Situation in Liberia

The Liberian government has taken critical steps to manage COVID-19. The country has taken prudent steps to combat the virus, including implementing the mandatory mask-wearing rule, improved surveillance and testing, and rapid vaccination. The World Health Organization further highlights that the Liberian government declared lockdowns from countries recording high positivity cases, including Italy and Canada, among many others⁴¹. The government equally

-
- 35 Kpangbala, N.N., 2020. Barriers in Accessing Sexual and Reproductive Health Services among the Youth in Liberia.
 - 36 UNFPA. (2022) *Sexual & Reproductive Health*. <https://liberia.unfpa.org/en/topics/sexual-reproductive-health-14>.
 - 37 Ibid., 1.
 - 38 Clinton Health Access Initiative. (2015) *improving Contraceptive Access in Liberia*. <https://www.clintonhealthaccess.org/blog-post-liberia-contraceptives/>.
 - 39 The Borgen Project. (2021). *A Closer Look at HIV/AIDS in Liberia*. <https://borgen-project.org/hiv-aids-in-liberia/#:~:text=With%20a%20population%20of%205.1,in%20Liberia%2C%20including%203%2C600%20children>.
 - 40 Ibid., 1.
 - 41 World Health Organization. (2022) *Improving Response as Liberia Marks Two Years since First COVID-19 Case*. <https://www.afro.who.int/countries/liberia/news/improving->





encouraged people to minimize interactions and work from home, where and when possible.

Effects of the COVID 19 Control Measures on Women’s Lives in Liberia

Liberia is among the poorest countries in West Africa, with over 40.9 percent of its populace living in abject poverty, making below 1.9\$ per day. As of 13 May 2021, Liberia registered 2 125 cases of COVID-19⁴². As a result, the government’s protocols to curb the COVID-19 menace have significantly impacted Liberia’s women, girls, and children. The closure of schools meant that women had extra house chores to perform. Reduced profits among businesswomen is another retrogressive impact of the virus. Also, the societal demand for mothers to take care of their sick family members upsurged their chances of contracting the COVID-19 virus. The vulnerability of mothers reflects the dangers that children face. Closure of schools equally saw an increase in teen pregnancies and subsequent birth complications due to the government shifting its attention and primarily focusing on eradicating COVID-19 in the country. As a result of teen pregnancies, school dropout in Liberia went high from approximately 5.3 to 6.1 percent. Sexual and GBV escalated because of the ample time that couples spent together after curfews and directives to work from home.

COVID 19, the Maputo Protocol and Sexual and Reproductive Health Rights in Africa

The Liberian government and other stakeholders have ensured women’s representation in COVID-19 response planning and decision-making. Evidence across different sectors, including emergency response and economic planning, illustrates that decisions that exclude women are less effective. The Liberian government’s Ministry of Health and UNICEF embarked on a program to deliver free sanitary pads to marginalized groups, including girls from peri-urban and rural areas whose backgrounds have low economic capabilities. Also, the government of Liberia put teen and women’s interests at the forefront by delivering

free contraceptives, including condoms. The delivery of these free products aims at reducing unwanted pregnancies not only among young girls but also among married women. The government can amplify these connections by employing more healthcare professionals and bringing healthcare services closer to civilians. The Liberian government should create a budget for establishing mobile clinics to educate women and girls about the importance of family planning and embracing other contraceptives and their socio-economic gains.

Way Forward: Strategies, Policies, and Plans under COVID 19 in Liberia

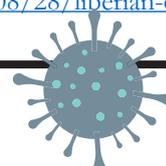
Under George Weah, the government of Liberia is constructing new healthcare facilities and expanding the existing ones as a means of countering present and future health pandemics. According to the Food and Agriculture Organization of the United Nations, rural women face more significant constraints than men in accessing productive resources, technologies, services, markets, local institutions, and financial assets, contributing to socio-economic ineffectiveness⁴³. The Liberian government’s decision to expand its healthcare sectors is a reasonable effort that rhymes with the SRHR provision. It will ensure women and girls’ reproductive health because of quick access to healthcare facilities and top-notch services. As a result, the high maternal and child morbidity and mortality rates will reduce immensely. Also, Liberia has made significant steps toward actualizing the Maputo protocol. Revised National Gender Policy of 2018, Domestic Relations Law, the Liberia Children’s Law of 2011, the Penal Law of Liberia, National Policy on Girls Education, and the Rape Law and the Domestic Violence Bill of 2019 are among the many policies that Liberia has enacted to align itself with the Maputo protocol and ensure the sovereignty of the girlchild. Hitherto, there are gaps in implementing the Maputo protocol laws and policies. For example, there are only seven safe homes in seven out of fifteen counties in the Republic of Liberia⁴⁴. Furthermore, Liberian courts

response-liberia-marks-two-years-first-covid-19-case#:~:text=In%20the%20two%20years%20since,-to%20help%20control%20the%20pandemic.

42 Social Policy Research Institute. (2021) *Liberia*. <https://spriglobal.org/portfolio/liberiacyd/>.

43 Food and Agriculture Organization of the United Nations. (2020) *Gendered Impacts of COVID-19 and Equitable Policy Responses in Agriculture, Food Security and Nutrition*. <https://reliefweb.int/sites/reliefweb.int/files/resources/CA9198EN.pdf>

Girls Advocacy Alliance. (2021). *Liberian CSOs Launch Scorecard on Government’s Performance in Domestication of Maputo Protocol*. <http://fawe.org/girlsadvocacy/2019/08/28/liberian-csos-launch-score>





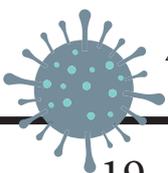
are letting the executive down in initializing safeguarding women and girls in society. Statistically, only 2 percent of all SGBV cases result in a conviction⁴⁵. Furthermore, despite the existence of the GBV unit in the ministry, there is no budgetary allocation to facilitate effective monitoring and implementation of GBV projects highlighting the peripheral positioning of its work in the country.



[card-on-governments-performance-in-domestication-of-maputo-protocol/](#).

45

Ibid., 1.





Country Case Study 3: Mozambique

State of COVID 19 in Mozambique

Mozambique reported its first COVID-19 case on 22 March 2020 in Maputo, the capital city. Professor Armindo Tiago, the Minister of Health, reported this first COVID-19 case. The patient was 75 years old male that had travelled from the United Kingdom on 20 March 2020⁴⁶. Since the onset of the pandemic, Mozambique has recorded 225 351 infections and 2 201 coronavirus-related deaths. Mozambique has administered around 27 843 440 COVID-19 vaccine doses so far⁴⁷. If each person needs two doses, about 45.8 percent of the Mozambique population has been vaccinated. During the last week of March 2022, Mozambique reported an average of 123 026 daily doses, translating to a 10% increase in vaccination within 50 days. By the end of March 2022, Mozambique has been recording zero cases of infection from its samples.

Mozambique has 32 827 883 people with a median age of 17.6 years⁴⁸. Individuals above the age of 60 seem to be the most affected category by COVID-19. The elderly make up 5 percent of the Mozambique population, and 2. 1 percent have been diagnosed with COVID-19⁴⁹. In this way, almost half of the elderly population has contracted the disease creating a huge dependency burden on households, communities, and the government of Mozambique. As a result, the country experienced the first economic contraction in almost three decades in 2020 because of the coronavirus pandemic. Between 2022-and 2024, economic

growth is expected to grow by 5.5 percent because of the natural gas production project⁵⁰. By 2021, Mozambique's GDP was \$14.30 billion and is expected to grow to \$17 billion by the 2022 fiscal year.

State of Implementation of the Maputo Protocol

Mozambique has made tremendous steps towards adopting the Maputo protocol. In 1997, Mozambique reformed the Land Law, endorsing that all Mozambicans of either gender have a right to land use. As a result of this law, 25 percent of women in Mozambique own land title deeds and user rights, a significant milestone and win for women⁵¹. Also, the government of Mozambique has promoted girls' education through enhanced school access to all, resulting in an upsurge of girl enrolment rates from 3 million in 2002 to 4.1 million in 2006. Currently, 94 percent of Mozambican girls enrol in primary schools, but only 11 percent proceed to secondary education⁵².

Also, only one percent of this population attends college, qualifying the assertion that the illiteracy rates are double among women than men in Mozambique. Eighty percent of the poor population in Mozambique comprises women. The government of Mozambique has won the war against female genital mutilation (FGM), reporting zero cases in almost half a decade now. Hitherto, Mozambique experiences one of the highest child marriage rates, whereby one in every two girls gets married before attaining the age of 18 years, as stipulated in the

46 World Health Organization. (2020) *A Case of COVID-19 Confirmed in Mozambique*. <https://www.afro.who.int/news/world-health-organization-case-covid-19-confirmed-mozambique#:~:text=Maputo%20%2D%2022%2C%20March%202020%20%2D,the%20virus%20in%20United%20Kingdom>.

47 Reuters. (2022) *Mozambique*. <https://graphics.reuters.com/world-coronavirus-tracker-and-maps/countries-and-territories/mozambique/>.

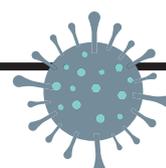
48 Worldometer. (2022) *Mozambique Population Live*. <https://www.worldometers.info/world-population/mozambique-population/>.

49 Global Citizen. (2022) *How COVID-19 is Impacting Elderly People in Mozambique Who Are Still Recovering From Cyclone Idai*. <https://www.globalcitizen.org/en/content/covid-19-elderly-people-mozambique-help-age/>.

50 The World Bank. (2020) *Mozambique Overview*. <https://www.worldbank.org/en/country/mozambique/overview#1>.

51 The Borgen Project. (2022) *Women's Rights in Mozambique: A Work in Progress*. <https://borgenproject.org/womens-rights-in-mozambique/#:~:text=In%20modern%2Dday%20Mozambique%2C%20the,a%20big%20win%20for%20women>.

52 Ibid., 1.



Constitution⁵³. There is a massive disparity between men and women in the workplace. According to The World Bank, only 6 percent of women are wage workers, against 24 percent of men⁵⁴. Private wage employment is tilted towards men, and only 33 percent is skewed towards traditionally male-dominated manufacturing, mining, and construction sectors. Also, 63 percent of women in the informal sector are underpaid, and the domestic responsibility solely depends on women since society embraces the customary laws instead of the statutory laws.

State of Sexual and Reproductive Health Rights in Mozambique

The state of sexual and reproductive health rights in Mozambique is significantly progressive, with a robust movement towards maximizing the full range of rights and services⁵⁵. However, several barriers hinder the movement. There is inadequate communication and support mechanisms between the sexual violence survivors and their nearest healthcare centers to get contraception knowledge. The lack of SRHR professionals is another challenge that women in Mozambique face upon visiting the different healthcare centers. For instance, the healthcare workers are not adequately trained, sometimes giving their clients misleading information on the most appropriate FP method for their bodies, later proving disastrous to the women's health and developing a negative attitude towards FP and contraception. There is intense stigmatization of FP and contraception among society members, making women fear adopting it. Lastly, the customary laws that outline

men as the leading reproductive health decision-makers are another challenge, giving women no freedom over their bodies. Women with disability face intersecting barriers in accessing SRHR because the government of Mozambique has no official strategies to ensure that women living with disability enjoy their SRHR rights.

In Mozambique, both government and partners have undertaken significant steps to enhance FP services and experiences over the last decade. The government has partnered with different stakeholders and trained health providers and promoted the country's Long-Acting Reversible Contraceptives (LARCs) uptake. There is high access to contraceptive services in Mozambique regardless of most women not embracing the different FP methods. Eighty-three percent of women accept that the healthcare centers are accessible, exemplifying high gratification rates for contraceptive services⁵⁶. Mozambique experiences high rates of teen pregnancy. Research indicates that 38 percent of adolescent girls have given birth to a live child, making it have the highest adolescent fertility rate in the Southern African Development Community countries⁵⁷. In October 2019, Mozambique introduced Law No. 19/2019, which makes it illegal to marry or enter into a union before attaining the age of 18, as one of the strategies to combat the increasing teen marriage trends, whereby more than 50 percent of underage girls are married. Also, since 2014, Mozambican women have had the right to legal abortion as a strategy to ensure and broaden women's access to safe abortion care⁵⁸. Regardless of abortion being legal, most women and adolescent girls consider

53 UNICEF. (2022) *Child Marriage in Mozambique*. <https://www.unicef.org/mozambique/en/child-marriage-mozambique#:~:text=English-,Mozambique%20has%20one%20of%20the%20highest%20rates%20of%20child%20marriage,and%20southern%20African%20sub%2Dregion>.

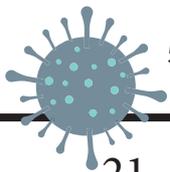
54 The World Bank. (2021) *Time for Bold Action to Advance Gender Parity in Mozambique*. <https://www.worldbank.org/en/news/opinion/2021/03/08/time-for-bold-action-to-advance-gender-parity-in-mozambique#:~:text=Only%206%20percent%20of%20women,mining%2C%20manufacturing%2C%20and%20construction>.

55 [Mozambique - progress on sexual and reproductive health despite overwhelming odds | Euro RH/FP Tracker Countdown 2030 Europe](#) (accessed Mar. 22nd 2022)

56 Galle, A., Vermandere, H., Griffin, S., de Melo, M., Machaie, L., Van Braeckel, D., & Degomme, O. (2018). Quality of care in family planning services in rural Mozambique with a focus on long acting reversible contraceptives: a cross-sectional survey. *BMC women's health*, 18(1), 1-13.

57 Jaén-Sánchez, N., González-Azpeitia, G., Saavedra-Santana, P., Saavedra-Sanjuán, E., Manguiza, A. A., Manwere, N., ... & Serra-Majem, L. (2020). Adolescent motherhood in Mozambique. Consequences for pregnant women and newborns. *Plos one*, 15(6), e0233985.

58 Ipas. (2022) *Reproductive Health*. <https://www.ipas.org/where-we-work/mozam>





other unsafe abortion methods to terminate their pregnancies, exemplifying the high maternal mortality rates in the country. Women equally face another challenge regarding the customary and statutory law dilemma. Men remain to be the sole reproductive health decision-makers in families. Women cannot decide or make FP decisions without men's approval, an incident that elucidates the inclining trajectories of families having many children and unable to provide for them entirely. Mozambique experiences a maternal mortality ratio of 520 per 100 000 live births, higher than the global average of 400 per 100 000 live births⁵⁹. STIs increase the risk of one acquiring HIV. In Mozambique, 7 percent of females between 15-49 years have STIs, two percent more than their male counterparts⁶⁰. Women are more vulnerable to HIV and STIs because they cannot make sexual reproductive decisions and polygamous marriages. Also, one in three women are victims of gender-based violence⁶¹.

State Response to the COVID 19 Situation in Mozambique

Curfews are one of Mozambique's measures in response to the COVID-19 situation. Between 9 pm to 4 am, a night curfew was raised in the Great Maputo and its surrounding environments, including Boane, Marracuene, and Matola. All religious services were banned, suspension of face-to-face classes, prohibition of private events except for weddings, and the suspension of sports activities, including professional football championships. The government encouraged different parastatals and private sector employers to allow people to work from home whenever possible to mitigate the spread of the coronavirus. Wearing masks became mandatory, and civilians were encouraged to observe social distancing apart from avoiding

crowded places whenever in public space.

Effects of the COVID 19 Control Measures on Women's Lives in Mozambique

Regardless of diminishing gender inequalities in Mozambique over the past two decades, COVID-19 threatens to erode these gains as the pandemic's economic and social consequences disproportionately impact women and girls. To prevent backsliding and continue the progress towards gender equality, Mozambique needs considerable investments in access to essential services, greater gender sensitization of pandemic response policies, and enhanced social protection systems. Around 46 percent of Mozambicans live below the poverty line, and of this populace, 63 percent are women⁶². Most women engage in the informal business, including being market vendors. COVID-19 has drastically reduced the number of customers, translating to reduced incomes and an inability to meet their daily needs, especially among single mothers. The closure of schools and workplaces has surged women's domestic and care roles in homesteads. Curfews and virtual meetings mean that couples spend most of their time at home together, leading to misunderstandings and domestic violence. As of 2018/2019, Mozambique reported 57 657 cases of domestic assault, and the number increased to 91 340 cases in 2020/2021⁶³. The rise signifies the COVID-19 impacts on domestic feuds. School closure due to COVID-19 and limited access to sexual and reproductive health services has led to the upsurge of teen pregnancy ordeals in Mozambique. Calls to the Child Helpline showed that children made 16 244 calls from January 2020, double of calls made in 2019⁶⁴. More than 6.7 percent of the total population got pregnant, increasing the chances of school dropout and early marriages.

COVID 19, the Maputo Protocol and Sexual and

bique/#:~:text=In%202014%2C%20with%20the%20goal,rape%2C%20incest%20and%20fetal%20anomaly.

59 World Health Organization. (2022) *Maternal Mortality Rates in Mozambique*. https://www.who.int/maternal-child-adolescent/events/2008/mdg5/countries/final_cp_mozambique_18_09_08.pdf.

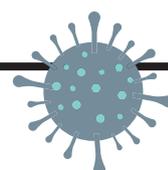
60 Boothe, M. A., Comé, C., Semá Baltazar, C., Chicuecue, N., Seleme, J., Chitsondzo Langa, D., ... & Luchters, S. (2020). High burden of self-reported sexually transmitted infections among key populations in Mozambique: the urgent need for an integrated surveillance system. *BMC infectious diseases*, 20(1), 1-11.

61 Spotlight Initiative. (2021). *Freeing Women and Girls from Violence in Mozambique*. <https://www.un.org/africarenewal/news/freeing-women-and-girls-violence-mozambique#:~:text=In%20pre%2Dpandemic%20Mozambique%2C%20one,burden%20on%20women%20and%20girls>.

62 UNICEF. (2022) *Mozambique responds to Gender-Based Violence in the Context of COVID-19*. <https://www.unicef.org/mozambique/en/stories/mozambique-responds-gender-based-violence-context-covid-19>.

Ibid., 1.

Ibid., 1.





Reproductive Health Rights in Africa

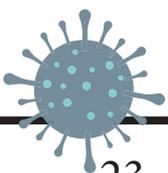
The government of Mozambique and other partners, including the Plan International Mozambique, are distributing contraceptives to mitigate the shadow pandemic. Mozambique government works towards ensuring that adolescent girls get contraception services. Also, COVID-19 has led to high unemployment rates. The private sector, where most women in Mozambique work, has been the most affected. Women losing their jobs translates to gender disparity, continuing to be subordinated in their respective families, dependent on men to provide for their different needs. Women find it hectic to afford and ensure a safe and planned reproduction life. COVID-19 has caused high school dropouts, insinuating that the level of contraception knowledge is likely to decrease in the future, making these women have inadequate knowledge about their reproductive health, including safe abortion. Research indicates that illiterate women in Mozambique have a low understanding of FP methods⁶⁵. However, these connections can be amplified by coordinating public campaigns and educating society on the prudence of embracing contraception practices to suppress unplanned pregnancies in the community.

Way Forward: Strategies, Policies, and Plans under COVID 19 in Mozambique

The government of Mozambique is making critical steps in response to COVID-19 with a focus on GBV and SRH. In partnership with UNFPA, the Mozambique government has identified vulnerable provinces, consequently planning to procure and distribute personal protective equipment and essential medicines, training service providers to respond to a surge in violence and provide psychosocial support, meeting the SRHR goals. The government projects that 3 500 of all the 71 000 pregnant women giving birth within the next three months and 4700 newborns will experience diverse complications inside and outside healthcare facilities⁶⁶. Significant investment in workforce and sustainable facilities and services vividly reflects the Mozambique government's decision to realize SRHR. Also, the government aims to build 100 more hospitals by 2030, enabling women to access efficient healthcare services, consequently reducing the high maternity-related mortalities.

65 Plan International. (n.d). *COVID-19: Sexual and Reproductive Health Needs Must be Prioritized*. <https://plan-international.org/case-studies/covid-19-sexual-and-reproductive-health-needs-must-be-prioritised/>.

66 UNFPA. (2022) *COVID-19 Response*. <https://mozambique.unfpa.org/en/covid-19-response-1>.





Country Case Study 4: Rwanda

State of COVID 19 in Rwanda

Rwanda recorded its first COVID-19 case on 14 March 2020, a male Indian citizen. According to the Ministry of Health of Rwanda, the transmission occurred abroad. The patient arrived in Rwanda from Mumbai on 8 March 2020, went under mandatory quarantine and tested positive for the coronavirus after six days⁶⁷. Since the COVID-19 onset in Rwanda, the country has recorded 129 772 infections and 1 459 deaths, whereby the majority are men above 50. Rwanda has administered at least 20 141 669 COVID-19 vaccine doses so far⁶⁸. Assuming that every individual takes two doses, it shows that 79.8 percent of the country's populace is vaccinated fully. Rwanda's current population is 13 529 719, with a median age of 20 years. Rwanda has a life expectancy of 70 years for both sexes. By 2035, Rwanda aspires to be a Middle-Income Country and a High-Income Country status by 2050⁶⁹. Rwanda has achieved a robust economic recovery in 2021, according to the 18th edition of the Rwanda Economic Update (REU18). Rwanda's Gross domestic product surged by 11.1 percent in the first nine months of 2021, reflecting a broad recovery from the 2020 recession. Regardless of the GDP getting close to the pre-pandemic levels, the World Bank indicates that the unemployment rates, especially female employment deteriorated immensely⁷⁰.

State of Implementation of the Maputo Protocol

The African continent can draw lessons from Rwanda, which has set a precedent by lifting the reservation on Article 14 (2) of the Protocol, reforming the different national laws, and sensitizing healthcare providers and law enforcement officers on the change in the law. Lifting the Article 14 (2) reservation means that women are free since they have access to health and reproductive rights, including medical abortion in cases of incest, rape, sexual assault, and where pregnancy endangers the physical and mental health of the mother or the life of the mother or fetus⁷¹. Also, Rwanda has the majority of women in its government. Women hold 64 percent of the Rwandan government positions, whereas men hold 36 percent⁷². Holistically, women's rights in Rwanda seem to flourish, setting the standard too high for other African countries and globally. President Paul Kagame has rebuilt Rwanda after the genocide, creating a new Constitution that mandates the reservation of 30 percent of the parliament seats for women. Since 2003, the Rwandan government has exhibited a balance of women and men. Thirty-four percent of higher education ICT graduates are women, ranking Rwanda fifth in the World Economic Forum's Global Gender Gap Index since 2016⁷³. Women hold 86 percent of the labor force participation, and the wage gap is 88 cents for women compared to only

67 World Health Organization. (2020) First case of COVID-19 confirmed in Rwanda. [https://www.afro.who.int/news/first-case-covid-19-confirmed-rwanda#:~:text=Rwanda%2C%20Kigali%2C%2014%20March%202020,coronavirus%20\(COVID%2D19\).](https://www.afro.who.int/news/first-case-covid-19-confirmed-rwanda#:~:text=Rwanda%2C%20Kigali%2C%2014%20March%202020,coronavirus%20(COVID%2D19).)

68 Reuters. (2022) Rwanda. <https://graphics.reuters.com/world-coronavirus-tracker-and-maps/countries-and-territories/rwanda/>.

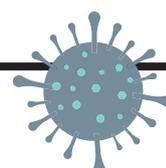
69 The World Bank. (2022) Rwanda. <https://www.worldbank.org/en/country/rwanda/overview#1>.

70 The World Bank. (2022) Rwanda economic update: Regional integration in post-COVID era. <https://www.worldbank.org/en/news/press-release/2022/02/02/rwanda-economic-update-regional-integration-in-post-covid-era#:~:text=KIGALI%2C%20February%202%2C%202022%20%E2%80%94, recovery%20from%20the%202020%20recession.>

71 Equality Now Organization. (2021) The Maputo protocol turns 18 today. But what does this mean for women and girls in Africa? https://www.equalitynow.org/news_and_insights/maputo_protocol_turns_18/.

72 Pierce, Caroline. (2020) The status of women's rights in Rwanda. <https://borgenproject.org/womens-rights-in-rwanda/#:~:text=Women%20in%20Government,a%20standard%20for%20other%20countries.>

Pierce, Caroline. (2020) The status of women's rights in Rwanda. <https://borgenproject.org/womens-rights-in-rwanda/#:~:text=Women%20in%20Government,a%20standard%20for%20other%20countries.>



74 cents for women in the United States.

Rwanda's statistics regarding the Maputo protocol implementation are notable; hitherto, one can attribute much of this effort and participation to the lack of qualified men considering that the genocide saw the death of millions of men, leaving women with limited options but to join the workforce. Concerning FGM, the term mutilation carries intense negative connotations. Instead, the Rwandan government support labia minora elongation and the use of botanicals to bring female and male pleasure, hence a positive force in their lives⁷⁴. Therefore, there is no FGM in Rwanda, aligning with the Maputo protocol. However, underage marriage trends still exist in the country. In Rwanda, 7 percent of girls are married before attaining the age of eighteen years⁷⁵. Child marriage is driven by gender inequality and the traditional belief that lasses are inferior to boys.

State of Sexual and Reproductive Health Rights in Rwanda

The Rwanda government uses a disease prevention model to promote SRH among girls and women. The disease-prevention model approach is effective in countries where people are empowered and have the necessary attitudes, knowledge, and skills to utilize SRH services⁷⁶. Hitherto, women and girls in Rwanda are significantly influenced by the existing religious beliefs on how they think and their choices. As a result, the use of this model has created a lacuna in access and utilization of the SRH services. Furthermore, the model leaves out critical players in SRH in Rwanda, parents, the community, and the school.

Poverty and social stigmatization are other barriers to SRHR among Rwandan women. According to

Asiimwe, people living in poverty hardly access SRHR services due to a lack of proper and adequate knowledge on what is available, where, and how to access such services⁷⁷. As a result, the failure to access family planning services leads to large families, which is unbearable to parents. Also, the Rwandan society believes that sexual and reproductive matters are private and should not be discussed in public. As such, women and young girls are shy about going for the services in the different healthcare centres.

Regardless of women taking more government positions than men, the sexual and reproductive health concept seems not fully integrated. More than 25 percent of girls aged between 15-and 19 years in Rwanda have their first sexual experience 15, and 15 percent of births occur among teenage mothers⁷⁸. Also, 15 percent of births in Rwanda occur to mothers below twenty years, primarily due to unplanned or unwanted pregnancies. Following the cultural and religious beliefs, many families in Rwanda take sexuality and reproductive health issues sensitively, opting to keep quiet about them. As a result, the voices of the girls and women are not listened to comprehend their desires, thus making assumptions about their SRH needs. According to Asiimwe, most young women base their SRH decisions on inaccurate media information and peer, leading to problems that adversely affect their future lives⁷⁹. A significant percentage of women in Rwanda do not understand their SRH rights, unable to seek the services. Rwanda experiences gender inequality and a lack of women empowerment issues, leading to poverty and subsequent exploitation of girls and women. Adolescent girls engage with married men alias "sugar daddies" boda-boda and bicycle operators, taxi drivers, and other attractive men⁸⁰. Poverty

74 Koster, M., & Price, L. L. (2008). Rwandan female genital modification: Elongation of the labia minora and the use of local botanical species. *Culture, health & sexuality*, 10(2), 191-204.

75 Girls Not Brides. (n.d) Rwanda Early Marriage Prevalence Rates. <https://www.girlsnotbrides.org/learning-resources/child-marriage-atlas/regions-and-countries/rwanda/#:~:text=7%25%20of%20girls%20in%20Rwanda,inferior%20to%20men%20and%20boys.>

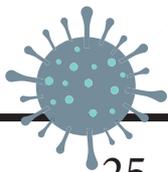
76 Asiimwe, F. (2019). Sexual and Reproductive Health Rights (SRHR) of Women in Rwanda: Challenges and Prospects. *Biomedical Journal of Scientific & Technical Research*.

77 Ibid., 1.

78 Asiimwe, F. (2019). Sexual and Reproductive Health Rights (SRHR) of Women in Rwanda: Challenges and Prospects. *Biomedical Journal of Scientific & Technical Research*.

79 Ibid., 1.

80 Scanteianu, A., Schwandt, H. M., Boulware, A., Corey, J., Herrera, A., Hudler, E., ... & Feinberg, S. (2022). "... the availability of contraceptives is everywhere.": coordinated





leads to the exchange of sex for material gain. With alcohol abuse, many adolescent girls find themselves in early marriages, rape, and prostitution, which frequently occur, making the victims suffer social stigmatization.

Since 2005, the use of contraceptives has tripled in Rwanda. Rwanda exemplifies a well-coordinate public family planning service delivery system with community health workers and nurses fulfilling diverse and complementary roles in meeting family planning client needs at the local level⁸¹. In Rwanda, the integration of family planning into other maternal and child health services is the norm. Between 2005-15, the use of contraceptives has upsurged from 17 to 53 percent. Therefore, Rwandan women understand their space and have the knowledge to access contraception services. The mortality ratio diminished significantly by 77 percent between 2000 to 2013, standing at 320 deaths per 100 000 live births. Under-5 child mortality has equally reduced by over 70 percent, a pivotal step towards meeting the 54 deaths per 1000 live birth deaths⁸². Also, despite the legal restrictions on strong stigma around abortion, Rwanda reports at least 22 unintended pregnancies that end in induced abortion. Husbands make reproductive health decisions for their wives, reflecting that women do not have any rights over their bodies. Same-sex affairs are allowed in Rwanda and have not been criminalized. Annual HIV orphans among 15-64-year-old individuals in Rwanda is 0.08 percent. Also, STIs affect the Rwandan populace. The prevalence of syphilis is 0.8 percent among HIV-negative individuals and 4.8 percent among HIV-positive women. Since 2008, GBV has been criminalized and is currently discussed in law No 68/2018 of 30/08/2018. Statistically, 35 percent of women experience physical violence, and 22 percent experience sexual violence⁸³.

State Response to the COVID 19 Situation in

and integrated public family planning service delivery in Rwanda. *Reproductive Health*, 19(1), 1-9.

81 Ibid., 1.

82 Worley, Heidi. (2015) Rwanda's Success in Improving Maternal Health. <https://www.prb.org/resources/rwandas-success-in-improving-maternal-health/#:~:text=Rwanda's%20maternal%20mortality%20ratio%20decreased,deaths%20per%201%20C000%20live%20births>.

83 Care. (n.d) Policy Brief: Update of Rwanda's gender-based violence policy. https://www.carenederland.org/content/uploads/2021/09/GBV-Policy-Revision-Briefing_-Rwanda_clean.pdf.

84 Iliza, Ange. (2021) COVID-19: Kigali under total lockdown as Rwanda battles third wave. <https://www.theeastafrican.co.ke/tea/news/east-africa/kigali-total-lockdown-3473688>.

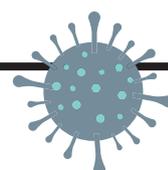
85 Maombi, Delphine. (2021) Rwanda: Trials and tribulations of teenage pregnancies. <https://allafrica>.

Rwanda

Curfew is one of Rwanda's responses to combat the spread of COVID-19. The Rwandan government enacted a curfew between midnight to 4 am. Initially, the country had made a 6 pm to 4 am curfew. However, as the coronavirus cases diminished, President Paul Kagame rethought his stand, adjusting it to midnight to expedite the recovery of the deteriorated economy. Rwanda put a lockdown in Kigali, its capital, because of high cases of coronavirus⁸⁴. Rwanda reported that 74 patients were in a critical condition in different Kigali hospitals made this lockdown decision, making President Kagame take an immediate response to rescue this sickening situation after a successful cabinet meeting. Lockdown was put in the Gicumbi, Rubavu, Rwamagana, Rutsiro, Kamonyi, Musanze, and Burera. Rwanda embraced the WHO guidelines, including making masks mandatory, sanitizing, encouraging social distancing in public, and putting water points in different stations for civilians to wash their hands. Rwanda put travel restrictions from different countries, including Italy and Canada, that recorded high coronavirus positive cases and deaths. Also, Rwanda demanded that visitors show a negative COVID-19 certificate taken within the past 72 hours. The government encouraged people to work from home to avoid the coronavirus spread chain.

Effects of the COVID 19 Control Measures on Women's Lives in Rwanda

The closure of schools and the decision for employees to offer their services virtually from home increased the role of women at home. Rwandan men still have that egocentric attitude, leaving all the domestic chores to their wives. Also, lockdown and closure of schools messed with adolescent girls' lives, causing unprecedented pregnancies, high school dropout rates, and early marriages. Between January to December 2020, approximately 19 701 girls gave birth, increasing from 15 431⁸⁵. COVID-19 has made





young girls have more free time, consequently engaging in these practices that ruin their lives and stunt Rwanda's future economic growth due to high levels of illiteracy and unemployment, leading to abject poverty. Furthermore, between March 2020 to March 2021, the maternal-related deaths increased by 6.3 percent, an upsurge associated with healthcare professionals diverting all their attention to fighting the COVID-19 menace, forgetting other patients with different needs⁸⁶. GBV is another ordeal brought by Rwanda's measures to combat COVID-19. Statistically, 28 percent of Rwandan women depict that GBV happens more than 10 percent of men⁸⁷. Rwandan women report incidences of physical and verbal abuse. Also, 49 percent of women and girls report sexual harassment incidences, increasing from 30 percent in 2019, translating to increased HIV/AIDS and STI trends.

COVID 19, the Maputo Protocol and Sexual and Reproductive Health Rights in Rwanda

Rwanda's commitment to ensuring that more than 30 percent of government slots are shared among women is an outstanding commitment to the Maputo protocol. The women in power have made a massive step in fighting for the rights of young girls and women, especially those in peri-urban and rural areas. For instance, the Rwandan women legislators have a Girls Not Brides Campaign (GNBC) that advocates for girls to finish their education before getting into marriage. The GNBC coordinates public campaigns, enlightening adolescent girls not to be lured into early marriages. During this COVID-19 period, GNBC has coordinated over 50 public awareness campaigns, a critical step that has kept the early pregnancies ordeals from escalating during the lockdown and school closure. These connections exemplify that young ladies and women comprehend their sexual and reproductive health better, comprehending their rights and boldly reporting cases of assault to relevant authorities.

Therefore, these connections can be amplified by training and imparting police officers with relevant knowledge to conduct authentic and dependable investigations that can lead to the conviction and incarceration of women harassment culprits.

Way Forward: Strategies, Policies, and Plans under COVID 19 in Rwanda

Rwanda's long-term plan to address COVID-19 is to build more classrooms and healthcare facilities and equip them with the necessary equipment. In 2021 alone, Rwanda constructed 25 214 classrooms against its ambition to have 22 505 classrooms⁸⁸. It is fascinating that Rwanda has achieved its target, meaning that girls will have an opportunity to study, creating self-awareness of SRHR. The construction of hospitals and equipping them with proper equipment means that the healthcare service will be satisfactory, reducing the country's maternal and child death rates. Also, women and teenage girls will have an opportunity to embrace the different contraception and FP methods.

Rwanda continues its Family Planning/Adolescent Sexual Reproductive Health Strategic Plan (2018-2024). The strategic plan builds on, merges, and replaces two distinct expiring strategies; the Family Planning Strategic Plan (2012-2016) and the National Adolescent Sexual Reproductive Health and Rights (ASRH&R) Strategic Plan (2011-2015)⁸⁹. the FPASRH Strategic Plan aims to ensure that Rwandan women and girls fully exercise their sexual reproductive health and have access to services of their choice, improving sexual and reproductive health and enabling an overall surge in contraceptive preference by 2024.

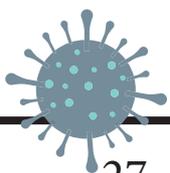
[com/stories/202106250626.html](https://www.allafrica.com/stories/202106250626.html).

86 Ibid., 1.

87 Ministry of Gender and Family Promotion. (2020). Highlights of a rapid assessment of the gendered effects of the COVID-19 pandemic on households in Rwanda. https://data.unwomen.org/sites/default/files/documents/Publications/RGA_Summary%20Report_02%20February%202021.pdf.

88 Ashimwe, Edwin. (2021) Rwanda: Construction of new classrooms at over 95%. <https://allafrica.com/stories/202110190050.html>.

89 Ministry of Health of the Republic of Rwanda. (2018) National family planning and adolescent sexual and reproductive health strategic plan. https://fp2030.org/sites/default/files/Rwanda%20FP-ASRH_Strategic%20Plan%202018%20-2014%20final.pdf.





Country Case Study 5: Tanzania

State of COVID 19 in Tanzania

The first COVID-19 case in Tanzania was reported on 16 March 2020. This first case was reported in Arusha, unrelentingly spreading to other areas within the country. According to the World Health Organization, Tanzania recorded 33 773 cases, with 800 victims succumbing to the virus on 11 March 2021⁹⁰. The COVID-19 infection rates in Tanzania remain incessant and constant. Between 1 March to 19 April 2022, the country recorded 33,861 positive cases with 803 deaths⁹¹. The number of cases reported in early 2021 and 2022 shows that the infection rates remain steady regardless of the Tanzanian government and well-wishers, including the WHO's effort to curb the spread. Also, current statistics indicate that as of 22 March 2022, 5,031,070 vaccine doses have been administered in the Republic of Tanzania⁹². WHO data indicates that between January 2020 to December 2021, 2 664 373 people were vaccinated. The government of Tanzania responded by embracing different strategies to mitigate the spread of the COVID-19 virus and ensure that its populace, especially those most vulnerable, are safe, a paradigm that has reduced the mortality rates. Among the many protocols that the government adopted include minimizing people's movements, advocating for social distancing, washing hands, sanitizing, and providing civic education for people to know their COVID-19 statuses.

The World Health Organization elucidates that the women and the elderly have been the most vulnerable victims of COVID-19. According to 2021 WHO records, women and children are at a higher risk than men of contracting the virus in Tanzania. The cultural context of women interacting with

children is the concrete reason for the high infection rates among children and the young population. The measures taken by the Tanzanian government have retrogressive impacts on the country's economy. Reduced movements and connections and approval of COVID-19-free certification in the different border points portray a slowed-down economy initially at a blossoming stage. The decline in economic productivity has made it challenging for Tanzania to run its socio-economic sectors, including education, health, and infrastructure, opting for foreign loans from countries like China to cushion the shrinking economy. The pandemic has surged poverty levels in Tanzania, especially among women, who receive unequal wages to men.

State of Implementation of the Maputo Protocol

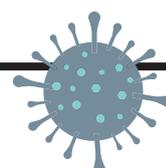
The Maputo protocol adoption rates are low in Tanzania, considering the degrading treatment that women and the female gender, in general, face within their respective communities. The World Bank opines that regardless of the many prudent opportunities existing in Tanzania, high gender-based violence rates remain extreme, hence a serious concern⁹³. It calls for the Government of Tanzania to continue strengthening the legal environment and policies to protect the country's women and girls. The Tanzania Gender Assessment 2022 and the Tanzania Gender-Based Violence Assessment 2022 agree that there are high gender gaps in human endowments, ownership and assets control, and economic opportunities. Analysis reveals that regardless of the broad structure for preventing and responding to GBV and VAC through the National Action Plan (NPA 2017- 2022) and establishing ample government coordination mechanisms,

90 World Health Organization. (2022) *United Republic of Tanzania Situation*. <https://covid19.who.int/region/afro/country/tz>.

91 World Health Organization. (2022). *Tanzania Marks Two Years since First COVID-19 Case*. <https://www.afro.who.int/countries/united-republic-of-tanzania/news/tanzania-marks-two-years-first-covid-19-case#:~:text=Dar%20es%20Salaam%2C%2016%20March,report%20of%2011%20March%202021>.

92 Faria, J. (2022) *Confirmed COVID-19 cases in Tanzania 2022*. Available at: <https://www.statista.com/statistics/1258560/confirmed-covid-19-cases-in-tanzania/>

93 The World Bank. (2022) *Tanzania Can Do More to Protect Its Women and Girls and Promote Gender Equality*. <https://www.worldbank.org/en/news/press-release/2022/04/05/tanzania-can-do-more-to-protect-its-women-and-girls-and-promote-gender-equality>.





violence against children and women remains a nationwide challenge. According to research, more than 20 percent of women aged between 15 and 49 years have experienced physical violence in the last year. To exhibit how devastating the situation is, 40 percent of women have experienced physical violence in their lifetime⁹⁴. Also, 75 percent of children have experienced physical violence before turning eighteen. Interestingly, 58 percent of women and 40 percent of men have a retrogressive attitude that a husband is justified to beat their wife under specific instances. Research attributes high GBV rates, including intimate partner violence, to two key factors; the social norms and women having low agency and decision-making powers because of low participation in employment, lower earnings, the high age gap between wives and husbands, and being in a polygamous marriage. The Law of Marriage Act is one of the laws to end GBC and VAC. The law sets the minimum age of marriage at 15 and 18 years for girls and boys, respectively⁹⁵. Hitherto, the 2019 Court of Appeal ruling gave the government an ultimatum of one year to change and make 18 years the minimum of marriage for both boys and girls, reforms that are still pending at the moment. The pending implementation makes different subjects question the government's dedication to ending GBV and VAC in society. Holistically, Tanzania is yet to adopt the United National Security Council Resolution (UNSCR).

State of Sexual and Reproductive Health Rights in Tanzania

Tanzania suffers extreme adverse sexual and reproductive health (SRH) indicators like high levels of adolescent births, maternal mortality, mother to child HIV transmission, intimate partner violence, persistence of child and teenage marriages, high school dropout rates because of pregnancy, and low contraceptive prevalence. SRH programs have

limited orientation to key populaces, and there is little evidence of SRH and HIV/AIDS integrated interventions. Regardless of Tanzania meeting its target of reducing the under-five mortality rate, infant deaths are responsible for 40 percent of under-five deaths, hence a critical area of concern⁹⁶. Disability is among the many barriers to accessing SRHR in Tanzania, especially for adolescents with disabilities who face challenges when trying to access them⁹⁷. Due to the societal and cultural-related discrimination against people with disability, the individuals end up not getting essential items like sanitary towels since they cannot visit the different dispensation centers alone. Also, inadequately skilled service providers (SPs) on sexual reproductive health rights are obstacles to accessing SRHR. The lack of skilled SPs has led to poor education, voluntary counseling and testing, and inefficient family planning among women and girls in society, using Mtwara as a case study, where girls commence having sexual intercourse at the age of 9-12 years⁹⁸. Lastly, societal structures and beliefs that husbands are the sole decision-makers hinder most Tanzanian women from adopting family planning.

In collaboration with MSI Tanzania, the government of Tanzania has implemented concrete programs to reach the most underserved peri-urban and rural women with short-term, long-term, and equally permanent contraceptive services. Also, through a partnership with DFID and USAID, Marie Stopes Tanzania has successfully reduced the high unintended pregnancies in the country. MSI has innovated the mobile service delivery to surge family planning choices and access to this vulnerable population set. Tanzania experiences a high adolescent birth rate. Research indicates that 22 percent of women aged between 20 to 24 years gave birth before attaining the age of 18 years. Three hundred sixty

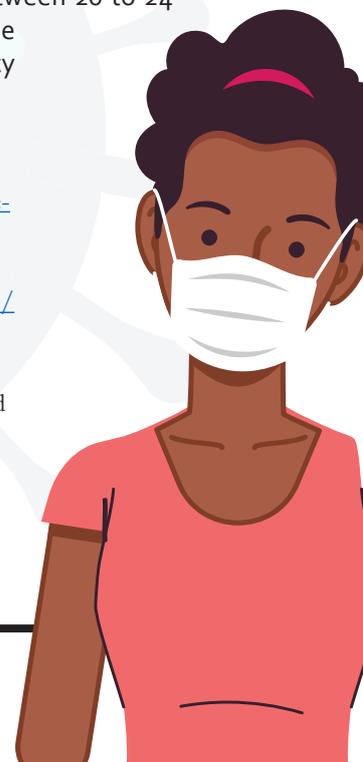
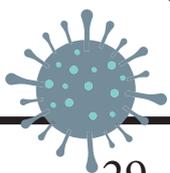
94 The World Bank. (2022) Tanzania Can Do More to Protect Its Women and Girls and Promote Gender Equality. <https://www.worldbank.org/en/news/press-release/2022/04/05/tanzania-can-do-more-to-protect-its-women-and-girls-and-promote-gender-equality>.

95 Ibid. 1.

96 Eldis.org. (2015) *Sexual and reproductive health and rights: Tanzania country fact sheet*. <https://www.eldis.org/document/A73933#:~:text=Tanzania%20suffers%20high%20adverse%20sexual,du%20to%20pregnancy%2C%20and%20low>.

97 Mesiäislehto, Virpi, Hisayo Katsui, and Richard Sambaiga. "Disparities in accessing sexual and reproductive health services at the intersection of disability and female adolescence in Tanzania." *International Journal of Environmental Research and Public Health* 18, no. 4 (2021): 1657.

98 Mbeba, R.M., Mkuye, M.S., Magembe, G.E., Yotham, W.L., obeidy Mellah, A. and Mkuwa, S.B., 2012. Barriers to sexual reproductive health services and rights among young people in Mtwara district, Tanzania: a qualitative study. *The Pan African Medical Journal*, 13(Suppl 1).





thousand girls aged between 15-and 19 give birth annually, and 57 percent of these girls have an unmet need or do not use modern contraception⁹⁹. The high birth rates in Tanzania made the former president of Tanzania, Joseph Pombe Magufuli, issue a warning that no student would attend school upon delivery. Tanzania is one of the countries with the highest child marriage prevalence rates globally. On average, two out of five girls get married before attaining the age of eighteen in Tanzania¹⁰⁰.

Women and girls in Tanzania are susceptible to HIV and other sexually transmitted infections. Syphilis, Chlamydia, and gonorrhea have a prevalence rate between 0.4 to 5.0 percent, higher among girls than boys. Statistically, 15 percent of secondary school students have adequate knowledge about STI symptoms. Half of the 15-30-year-old males and one-third of females are aware of HIV-AIDS and STI transmission¹⁰¹. Efforts to end FGM are bearing fruits in Tanzania gradually. The FGM prevalence fell to around 10 percent in 2021 from 18 percent in 1999. Communities consider FGM as a ritual that marks a rite of passage. Presently, many girls attend alternative rites of passage, and more FGM cases are being reported and handled by the Tanzanian police in collaboration with non-governmental organizations and activists. Tanzania banned FGM in 1998, adopting the National Plan of Action to end Violence against Women and Children Act (NPAEVAWC), which committed to ending violence of all forms against women and children by 2030¹⁰².

State Response to the COVID 19 Situation in Tanzania

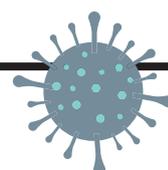
In April 2021, Tanzania announced new measures to combat the COVID-19 spread, breaking the approach of former president John Pombe Magufuli.

Travelers arriving in Tanzania must present a negative COVID-19 test certificate performed within the past 72 hours. Passengers from countries experiencing high rates of infections must undergo an additional antigenic test. Tanzanians arriving from countries experiencing high COVID-19 trends must undergo a mandatory quarantine of 14 days. It should be understood that under the leadership of John Magufuli, there were no precise statistics about the COVID-19 infection, leading to a total of 509 cases with 16 deaths since April 2020, when the disease was first discovered in the country¹⁰³. Magufuli died of heart complications, but his opponents stated that he succumbed to the COVID-19 virus. This conspiracy might be accurate due to the stern precautions that president Samia Suluhu Hassan took after Magufuli's demise.

Effects of the COVID 19 Control Measures on Women's Lives in Tanzania

The different COVID-19 measures that Tanzania adopted from WHO have negatively and positively affected women's lives in Tanzania. Most women in the country work in the informal sector. Global statistics indicate that 60 percent of the world's population earns a livelihood from the informal sector¹⁰⁴. In Tanzania, the informal sector contributes 75 percent of the total employment and 80 percent of the country's GDP¹⁰⁵. COVID-19 has made most informal economy workers vulnerable in Tanzania due to inadequate support mechanisms and social protection coverage. The COVID-19 outbreak retrogressively affected women, making them perform extra household chores, including childcare, especially after the government closing schools. Women, especially single mothers, admit that COVID-19 has negatively affected them in the

- 99 Human Rights Watch. (2021) *Tanzania: Pregnant Student Ban Harms Thousands*. <https://www.hrw.org/news/2021/10/06/tanzania-pregnant-student-ban-harms-thousands>.
- 100 UNFPA. (2014) *Child marriage fact sheet*. https://tanzania.unfpa.org/sites/default/files/pub-pdf/Child%20Marriage%20fact%20sheet%20English%202014_0.pdf.
- 101 Abdul, Ramadhani, Annette AM Gerritsen, Mary Mwangome, and Eveline Geubbels. "Prevalence of self-reported symptoms of sexually transmitted infections, knowledge and sexual behaviour among youth in semi-rural Tanzania in the period of adolescent friendly health services strategy implementation." *BMC infectious diseases* 18, no. 1 (2018): 1-10.
- 102 World Health Organization. (2021) *Rooting out Female Genital Mutilation in Tanzania*. <https://www.afro.who.int/news/rooting-out-female-genital-mutilation-tanzania/>
- 103 Africa News. (2021) *Tanzania Announces Measures in Major Shift on Pandemic*. <https://www.africanews.com/2021/05/04/covid-19-tanzania-announces-measures-in-major-shift-on-pandemic/>.
- 104 Yalla Africa. (2021) *Tanzania: Teen Pregnancies Linked to Schools Closure*. <https://allafrica.com/stories/202104280154.html>.
- 105 George, C. (2021) *The Impact of COVID-19 on Gender Aspects of the Informal Sector in Tanzania*. *Repoa Brief*. <https://media.africaportal.org/documents/Impact-of-Covid-19-PB.pdf>.





informal sector. Statistically, 40 percent of these women note that they have failed to meet the costs of taking their children back to school¹⁰⁶. The situation has pushed them into accumulating debts. Also, 45 percent of women in Tanzania who engage in petty businesses admit a decline in profits necessitated by the COVID-19 pandemic. Hitherto, the pandemic led to innovations that created more opportunities for women than men. For instance, most Tanzanian women adopted the making the mask and liquid hand wash soaps making and selling practice. Also, women ventured into making healthy foods and herbal products, including tamarind, peppers, and lemon, that boost human body immunity¹⁰⁷.

The closure of schools caused a sudden upsurge in teen pregnancies, threatening to cut short their pursuit of education for the school-going girls and turning them into petty vendors. Mrs. Kajito (not her real name) admits that she was supposed to sit for her form four national examination this year, but pregnancy obstructed her journey. Still, the pregnancy has made this a nightmare because she lacks family support and social stigma. She highlighted the closure of schools in her Pemba village when schools closed due to COVID-19 led to her pregnancy, and the man behind it has since disappeared, forcing her to take care of the child alone. Mrs. Kajito represents the teen pregnancy among many other challenges that school-going girls face during this pandemic, forcing them to drop out of school, approving the UNESCO study that many girls in different African countries got pregnant due to school closure as a result of COVID-19. According to Yalla Africa, in 15 schools (10 being secondary schools) in Tanzania and Zanzibar, 69 girls dropped out of school, 15 became pregnant, two were married, four were subjected to sexual harassment, and 23 engaged in child labor¹⁰⁸.

COVID 19, the Maputo Protocol and Sexual and Reproductive Health Rights in Tanzania

The Maputo protocol priorities and women and girls' rights connect during the COVID-19 situation as the

Tanzanian government and the UNFPA continue to avail the basic needs of married women and girls in

the country. According to the UN, the government of Tanzania, in conjunction with UNFPA, has ensured that women access family planning quickly during the COVID-19 pandemic. Different humanitarian welfare agencies have embraced public campaigns and education programs, enlightening women and families, in general, on the prudence of considering family planning. As a result, the family planning program during this COVID-19 situation is likely to lead to better reproductive health among parents and adequate care for the newborns, a positive SRHR impact. Also, under a program funded by the Plan International Australia, Tanzanian women groups have commenced making reusable pads, allowing them to flourish during this COVID-19 pandemic. Whether WASH is the first defence mechanism against COVID-19, concentration on women and girls' sexual and reproductive health is taking center stage, restoring their dignity, equality, and social inclusion. Ostensibly, these connections can be amplified by the Tanzanian government and well-wishers working towards realizing zero unmet need for family planning information and services, zero sexual and gender-based violence and harmful practices against women and girls, and zero preventable maternal deaths.

Way Forward: Strategies, Policies, and Plans under COVID 19 in Tanzania

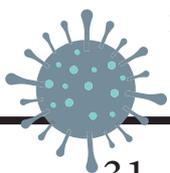
Strengthening essential health services during this COVID-19 outbreak is one of the Tanzanian government's vital strategies. Under the Essential Package of Health Services (EPHS), the government of Tanzania covers reproductive and child health. During this COVID-19 pandemic, the government is dedicated to ensuring that mothers give birth in hospitals with reduced chances of contracting the deadly virus that might endanger their lives and that of their newborns, hence fitting the SRHR. Another plan that the government of Tanzania has integrated is the adoption of more classrooms to fit students' social distancing needs. The government dedicated Tsh. 4.51 trillion in the 2019/20 fiscal year compared to Tsh. 4.64 trillion in the 2018-19 financial year¹⁰⁹. The Tanzanian government promised to

106 Ibid. 1.

107 Ibid., 10.

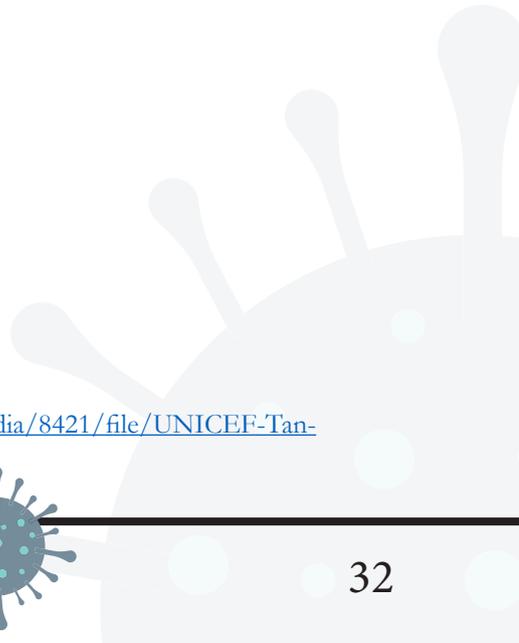
108 Yalla Africa. (2021) *Tanzania: Teen Pregnancies Linked to Schools Closure*. <https://allafrica.com/stories/202104280154.html>.

109 UNICEF. (2020) *Education Budget Brief*. <https://www.unicef.org/esa/media/8421/file/UNICEF-Tanzania-Mainland-2020-Education-Budget-Brief-revised.pdf>.

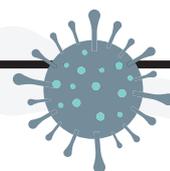




continue dedicating more finances to attain the 30-pupils-per-class goal and a ratio of 1 per 40 secondary school teacher-students by 2030¹¹⁰. This approach reflects the SRHR principles as it gives safeguards female teachers from pregnancy complications that might lead to unprecedented termination apart from giving them enough time to attend maternal health clinics and general antenatal care. Reduced contact among teachers and students will ensure female teachers' health during pregnancy and after childbirth since COVID-19 contraction can lead to miscarriage and other-related devastating complications.



UNICEF. (2020) *Education Budget Brief*. <https://www.unicef.org/esa/media/8421/file/UNICEF-Tanzania-Mainland-2020-Education-Budget-Brief-revised.pdf>.





Country Case Study 6: Zambia

State of COVID 19 in Zambia

The republic of Zambia confirmed its first COVID-19 on 18 March 2020. President Edgar Lungu confirmed Zambia's first two cases of COVID-19. The patients were a couple who had returned from France and were immediately taken to Chilanga for treatment¹¹¹. By implementing the 14-day quarantine on 13 March, the Ministry of Health discovered these two positive cases on the 18th of the same month. According to the World meter Statistics, Zambia has recorded 318 640 coronavirus cases and 3 973 deaths¹¹². More than 313 836 people have recovered from the disease, courtesy of the Zambian health workers' commendable work. 34.5 percent of the positive COVID-19 cases in Zambia are women, whereas 5.4 percent are young girls¹¹³. The Zambian Ministry of Health indicates that the SARS-Co V-2 is more prevalent among males than women. Zambia's economy fell into a deep recession because of the adverse effects of the COVID-19 pandemic. According to the African Development Bank Group, Zambia's GDP froze by 4.9 percent after growing by 4.0 and 1.9 percent in 2018 and 2019¹¹⁴. Economists highlight that the contraction results from the unprecedented deterioration in all the critical sectors of the Zambian economy, including the private sector that employs the majority of its citizens. 5.2 million doses of the COVID-19 vaccine have been given, reflecting that 2.34 million people are fully vaccinated. Statistically, 12.7 percent of the Zambian populace is fully vaccinated. Seventy percent of the Zambian population is under the

poor category¹¹⁵.

State of Implementation of the Maputo Protocol

Zambia ratified the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol) on 2 May 2006. The Republic of Zambia has 13.2 million people, 50.48 percent being women. Regardless of the Zambian government's efforts to advance gender equality, the customary law underpins it because of its rules that determine women's rights in diverse contexts. The representation of women in decision-making is still low in the country. In recent years, HIV-AIDS has become a primary health problem in Zambia, whereby women are especially vulnerable to HIV infection because of their subordinate position and lack of control of their sexuality¹¹⁶. Culture dictates that all domestic chores must be coordinated and done by women. The government of Zambia has won the war against FGM since there are zero cases of FGM reported in the country. Also, although abortion is legal in Zambia, women face various obstacles to accessing safe abortion. Inadequacy of healthcare professionals and social stigma is the main issues surrounding abortion. Few women in Zambia comprehend that they have a right to safe abortion and where to seek safe abortion services. As a result, unsafe abortion is a significant problem in Zambia. Notably, Zambia's Ministry of Health estimates that more than 30 percent of pregnancy-related deaths may be caused by unsafe abortion. Hospital-based studies indicate that post-unsafe abortion

- 111 Crisis. (2020) *Zambia: Country Confirms First Two Cases of COVID-19*. <https://crisis24.garda.com/alerts/2020/03/zambia-country-confirms-first-cases-of-covid-19-march-18-update-1>.
- 112 Worldometer. (2022) *Zambia*. <https://www.worldometers.info/coronavirus/country/zambia/>.
- 113 African Development Bank Group. (2022) *Zambia Economic Outlook*. <https://www.afdb.org/en/countries-southern-africa-zambia/zambia-economic-outlook>.
- 114 Ibid., 1.
- 115 Blystad, A., Moland, K.M., Munsaka, E., Sandøy, I. and Zulu, J., 2020. Vanilla biscuits and lobola bridewealth: parallel discourses on early pregnancy and schooling in rural Zambia. *BMC public health*, 20(1), pp.1-11.
- 116 MEWC. (2022) *Zambia*. <https://www.mewc.org/index.php/countries/east-africa/zambia#:~:text=Zambia%20ratified%20the%20Protocol%20to,the%2021st%20of%20June%201985>.





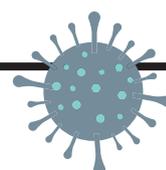
complications cause 30-50 percent of acute gynaecological admissions¹¹⁷. Zambia's Marriage Act sets 21 years as the minimum age of marriage. Hitherto, a child can decide to marry from sixteen with written consent from their legal guardian. According to UNICEF, 9 percent of women aged 25-49 years were first married by 15¹¹⁸. 29 percent of women aged 20-24 reported being married at 18 in 2021, a slight drop from 31 percent in 2014. In terms of wage gaps, there is a 28 percent gender wage gap among individuals aged 20-14 years and over 30 percent wage gap among workers aged 25-29 years¹¹⁹.

State of Sexual and Reproductive Health Rights in Zambia

The state of sexual and reproductive health rights in Zambia is rife with many challenges. Negative attitudes toward providers and society are a challenge that women face in embracing SRHR. For instance, there is a case in Zambia where a healthcare provider asked a disabled woman why she needed contraceptives since she had a disability¹²⁰. Inadequately trained providers are another challenge. Inaccessible facilities are the last barrier that Zambian women face when SRHR. The high costs of transport hinder poor women from visiting healthcare centers that are far. Above all, the Zambian government should continue with its long-term plan of building new hospitals and employing more personnel to upsurge the family planning and contraception-preference rates, assuring the country of a manageable, healthy, and productive populace.

In 1994, the International Conference on Population and Development affirmed that sexual and reproductive health and rights (SRHR) are human rights. Since this period, the government of Zambia has committed to fulfilling the SRHR of women through the different international instruments of law. However, women face various obstacles that prevent them from enjoying their SRHR rights. 10.9 percent of girls in their adolescence stage use contraceptives¹²¹. Contraceptives are associated with age, education level, and marital status. In Zambia, older adolescent girls and those with higher education levels are more likely to use contraception than younger ones and those with low education levels. Married adolescents are more likely to use contraception than unmarried. The majority of married women do not have the freedom to make sexual and reproductive health decisions. Men are the primary decision-makers as enshrined in the customary laws. In Zambia, women have a low probability of accessing contraception services, considering that 42 percent of the women population note that it takes them more than 30 minutes to get to the nearest health center¹²². One-third of Zambian women have given birth by eighteen years and more than half by twenty¹²³. In rural areas, adolescent pregnancies are high in rural than urban areas at 30 percent vs. 17 percent, respectively¹²⁴. Early pregnancies are related to school dropout and marriages. HIV has a high prevalence level among Zambian women at 14 and 28 percent in rural and urban areas among females aged 15-49 years. Also, more than one-third of all Zambian women and girls have experienced physical violence in their lives, and 17 percent of

- 117 Ipas. (2022) *Unsafe Abortion in Zambia*. <https://www.ipas.org/where-we-work/zambia/>.
- 118 UNICEF. (2021). *Case Study on Ending Child Marriage in the Republic of Zambia*. <https://www.unicef.org/esa/media/8941/file/Zambia-Case-Study-Child-Marriage-2021.pdf>.
- 119 Nsokolo, D.S., (2021). *Gender wage and labour supply differences in Zambia: evidence from the school-to-work transition survey* (Doctoral dissertation, The University of Zambia).
- 120 Yalla Africa. (2021) *Zambia: Sexual, Reproductive Health Rights for Women With Disabilities*. <https://allafrica.com/stories/202107260291.html>.
- 121 Chola, M., Hlongwana, K. and Ginindza, T.G., 2020. Patterns, trends, and factors associated with contraceptive use among adolescent girls in Zambia (1996 to 2014): a multilevel analysis. *BMC Women's Health*, 20(1), pp.1-11.
- 122 Muzyamba, C., 2021. Local characterization of the COVID-19 response: the case of a lockdown in Lusaka, Zambia. *Global Health Research and Policy*, 6(1), pp.1-8.
- 123 Blystad, A., Moland, K.M., Munsaka, E., Sandøy, I. and Zulu, J., 2020. Vanilla biscuits and lobola bridewealth: parallel discourses on early pregnancy and schooling in rural Zambia. *BMC public health*, 20(1), pp.1-11.
- 124 Blystad, A., Moland, K.M., Munsaka, E., Sandøy, I. and Zulu, J., 2020. Vanilla biscuits and lobola bridewealth: parallel discourses on early pregnancy and schooling in rural Zambia. *BMC public health*, 20(1), pp.1-11.





women have experienced sexual violence¹²⁵.

State Response to the COVID 19 Situation in Zambia

Since the emergence of COVID-19, Zambia has experienced three waves, the latest one being the most severe. The government of Zambia responded positively with the help of cooperating partners. Zambia adopted the WHO recommendations, including masking up in public, hand hygiene, avoiding crowded areas, and physical distancing. Also, the COVID-19 surveillance was strengthened, leading to the early detection of cases. However, Zambia experiences high vaccine hesitancy, causing it to fall below its adult populace target by 10 percent¹²⁶. THROUGH USAID, the U.S government has pumped more than 28 million dollars into Zambia, supporting the country's vaccination exercise¹²⁷. The USAID has aided Zambia in establishing mobile healthcare centers, easing the COVID-19 vaccination process. The government required those traveling to Zambia to show their COVID-19 negative certificates for samples collected within 72 hours before departure. 999 is Zambia's toll-free number for emergency services and reporting on COVID-19-related issues.

Effects of the COVID 19 Control Measures on Women's Lives in Zambia

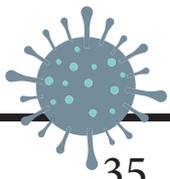
The COVID-19 measures, including the closure of

schools and reduced physical workplace attendance, mean that women's domestic duties surge. Lasses, especially from marginalized communities and with disabilities, have been affected by the secondary impacts of the COVID-19 outbreak. Girls have been exposed to child labor, early and forced marriage, violence, early pregnancies, and sexual exploitation. Women have faced severe economic shocks, taking health risks for their economic survival. According to Ngoma-Simengwa, more than 4.4 percent of the married women populace in Zambia have experience GBV, either physical or verbal¹²⁸. The government's concentration on COVID-19 has left many women with unplanned pregnancies. For instance, since the onset of the pandemic, Zambia has recorded a 50 percent decrease in access to family planning for women and a 47 percent decrease in access to SRHR services among adolescent girls¹²⁹. The ordeal has retrogressively affected Zambian women's desired family size, compromising their quality of life.

COVID 19, the Maputo Protocol and Sexual and Reproductive Health Rights in Zambia

During the COVID-19 pandemic, Zambia's attempt to implement the Global Program to End Child Marriage (GPECM) shows increased violence, teen pregnancies, and child marriage as the main obstacles to SRHR among adolescents and women¹³⁰. Women have received little to no recognition during the COVID-19 pandemic, worsening their sexual reproductive health through

- 125 Oxford Policy Management. (2021). *Combating Gender Based Violence in Zambia*. <https://www.opml.co.uk/blog/combating-gender-based-violence-in-zambia#:~:text=More%20than%20a%20third%20of,based%20violence%20in%20the%20world>.
- 126 Mudenda, S., Chileshe, M., Mukosha, M., Hikaambo, C.N.A., Banda, M., Kampamba, M., Mwila, K., Banda, D.C., Mufwambi, W. and Daka, V., 2022. Zambia's Response to the COVID-19 Pandemic: Exploring Lessons, Challenges and Implications for Future Policies and Strategies. *Pharmacology & Pharmacy*, 13(1), pp.11-33.
- 127 African Business. (2022) *Coronavirus-Zambia: U.S. Government's Initiative for Global Vaccine Access (Global Vax) to Partner with Zambia to Boost COVID-19 Vaccination*. <https://african.business/2022/03/apo-newsfeed/coronavirus-zambia-u-s-governments-initiative-for-global-vaccine-access-global-vax-to-partner-with-zambia-to-boost-covid-19-vaccination/>.
- 128 Ngoma-Simengwa, Jessie. (2020). Zambia: Quarantined with an Abuser. *Yalla Africa*. <https://allafrica.com/stories/202006020318.html>.
- 129 UNFPA. (2021) *How COVID-19 Has Increased Fertility, Adolescent Pregnancy and Maternal Deaths in East and Southern Africa Counties*. <https://zambia.unfpa.org/en/news/how-covid-19-has-increased-fertility-adolescent-pregnancy-and-maternal-deaths-east-and-southern>.
- 130 Reliefweb International. (2022) *Impact of COVID-19 on gender Equality and Women's Empowerment in East and South Africa*. <https://reliefweb.int/sites/reliefweb.int/files/resources/Impact%20of%20COVID-19%20on%20Gender%20Equality%20and%20Women%20E2%80%99s%20Empowerment%20in%20East%20and%20Southern%20Africa.pdf>.

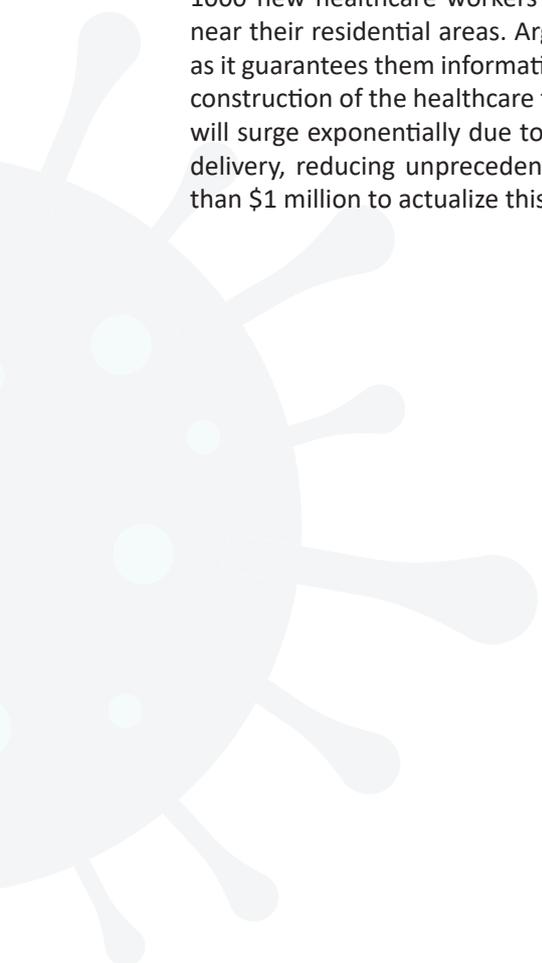




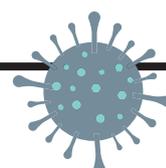
increased maternal and newborn morbidity and mortality. The loss of jobs and income among most women than men in Zambia breaches the Maputo protocol for gender equality. As a result, these women have found it hard to afford better sexual reproductive health for their young girls, including buying them sanitary towels and the WASH aspect, especially those women doing petty businesses, including hawking. The COVID-19 and Maputo Protocol can be amplified by encouraging the government and other partners to emphasize reproductive health during these challenging times. The Zambian government should invest more in providing family planning and other contraceptives to reduce the ordeals of unprecedented pregnancies. The government should pass laws to ensure equal pay between men and women in the workplace for the job done and declare customary laws that make women's subordinates null. In this way, women across Zambia will decide on the different reproductive health services.

Way Forward: Strategies, Policies, and Plans under COVID 19 in Zambia

Zambia's long-term plan to address COVID-19 is to build more healthcare centers and employ more providers. The government of Zambia aims that by 2030, it will have built 70 new healthcare centers and employ over 1000 new healthcare workers annually¹³¹. Zambians are guaranteed to get excellent healthcare services near their residential areas. Arguably, this long-term strategy affects women and girls in Zambia positively as it guarantees them information about family planning and contraception. For instance, by 2030, after the construction of the healthcare facilities, the number of women adopting family planning and contraception will surge exponentially due to adequate information. Also, women will be confident in safe abortion and delivery, reducing unprecedented maternal deaths. The Zambian government intends to dedicate more than \$1 million to actualize this plan every fiscal year.



¹³¹ United Nations Conference on Trade and Development. (2021). *COVID-19 and the Challenge of Developing Productive Capacities in Zambia*. https://unctad.org/system/files/official-document/ser-rp-2021d6_en.pdf.





CONCLUSIONS AND RECOMMENDATIONS

Almost all the African countries started recording the COVID-19 cases in March 2020. The African experience of COVID-19 has reminded countries that pandemics and outbreaks follow the contours of gender and power inequalities, thus affecting women, men, girls, and boys differently in line with the contextual and structural construction and positioning of gender characteristics and their interaction with other social determinants¹³². The experience has showed governments that pandemics are not only about losing employment but also about leaving a retrogressive impact as far as female reproductive health is concerned. Predominantly women undergo immense suffering, ranging from surging chances of contracting HIV/AIDS to early pregnancies among teens to unplanned pregnancies among adult women. The pandemic has shown that women continue to be unequal to men in this 21st century. The different challenges, especially those related to health among married women, are instigated by their husbands. For instance, the recorded increasing HIV/AIDS trends are primarily transmitted through multiple sex partnerships and unprotected sex practices especially by male partners.

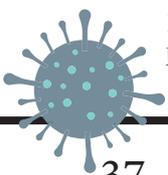
The COVID-19 pandemic has exacerbated inequalities unprecedentedly. Hitherto, systemically marginalized groups (such as women, girls, and the extremely poor) are experiencing overarching and intersecting vulnerabilities, violence, and risk exposures. The COVID-19 pandemic has also exposed and underscored society's reliance on women both on the front line and at home while simultaneously exposing structural inequalities across every sphere, from health to the economy and security to social protection¹³³. Also, the COVID-19 pandemic has exposed most African countries' failure to adopt robust gender equality safeguards and structures to enhance women's participation, autonomy, and agency. Even after the end of the peak period of the pandemic and the resumption of normal routines, including opening schools, governments are making little effort to track learners, especially girls who have dropped out, and address the rising

pregnancy among girls. The upsurge in girls dropping out of school during the current pandemic portends increased numbers of young mothers, with likely increases in maternal, neonatal, and child mortalities; poor education outcomes, and ultimately increasing gender inequality gap.

Additionally, the COVID-19 pandemic has led to family destabilization in Guinea, Liberia, Tanzania, Mozambique, Rwanda, and Zambia- a case study for the entire African continent. Loss of jobs and related ordeals have led to breakdowns and mental distress among victims and their families. The unprecedented levels of intimate interactions within limited spaces especially for those with large families and poor lead to stress, tensions, and anxieties. This has contributed to domestic violence, divorce, or increased chances of contracting STIs. Also, lockdowns and working from home factors have contributed to household inequality, giving women extra duties without a commensurate increase in pay. For instance, the presence of children after the closure of schools means that women have extra domestic responsibilities. Inclusive, the COVID-19 pandemic has directly affected African households' health and welfare and their poverty levels by impacting the productive capacity of infected and recovering workers. Given that women predominantly work in the informal sector in the sub-region, the quarantines, closures of non-essential businesses, and curfews further negatively impacted them. The pandemic led to unbudgeted health expenditures that consumed household savings and out-of-pocket often controlled by women, thus increasing poverty levels and scaling inequality. In many households, women's increased unpaid care work burden during the pandemic reduced their ability to participate in productive activities, study, and rest. The pandemic has negatively affected their mental and physical health, especially in women-headed households, and increased food insecurity, household work,

132 UNWomen, 2020.

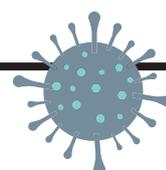
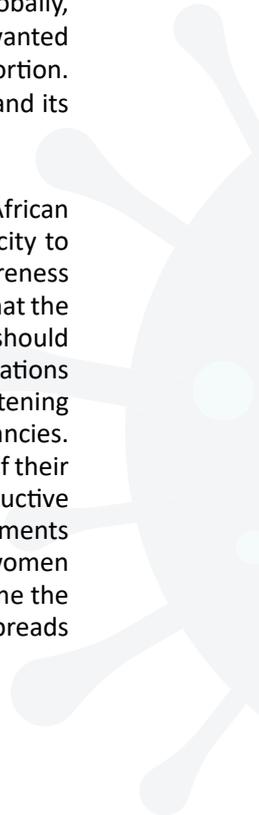
133 [UN Women | Explainer: How COVID-19 impacts women and girls](#) (accessed 20th February 2022).





survival burdens, and gender-based violence.³³⁴The impacts of the pandemic in the African continent are felt in the context of the efforts by the African Union to address gender inequality manifested by the ways women in Africa are restricted in their enjoyment of various human rights, including lack of access to land and other productive resources. The fight to combat discrimination against women through appropriate legislative, institutional, and other measures has been encapsulated in the 2003 Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (the Maputo Protocol) adopted by the African Union Member States. Overall, the study acknowledges that Africa's access and enjoyment of sexual and reproductive health rights (SRHR) has a close and insidious relationship with systemic, social, and behavioural gender inequity, poverty among women, weak economic capacity, and sexual and gender-based violence, including female genital mutilation (FGM). Thus these issues and the driving factors are best discussed in an intersecting continuum that links regional policies such as the Maputo protocol to household dynamics such as control of house resources and individual bodily autonomy. Covid-19 has disrupted health systems and is rewinding efforts to meet sexual and reproductive health needs. Globally, women and girls have reported having reduced access to services, which increases the risk of unwanted pregnancies, sexually transmitted diseases, and complications during pregnancy, delivery, and abortion. There are global predictions of up to 7 million unintended pregnancies worldwide due to Covid-19 and its measures.

Lastly, these case studies raise an alarm that Africa is ill-prepared to manage future pandemics. All African countries should adopt the Maputo Protocol to enable all women, giving them the necessary capacity to manage themselves during difficult times. The Maputo protocol gives women a sense of self-awareness and realization, curbing the present incidences like unplanned pregnancies and economic hardships that the COVID-19 pandemic has plunged most African women into. Also, non-governmental organizations should educate young girls about their rights and create the required awareness. Non-governmental organizations and other well-wishers should conduct public education campaigns in the respective countries, enlightening adolescents, and even adult women on the different ways to prevent unplanned and teen pregnancies. Reflecting on the present pregnancy trends, one concludes that females have insufficient knowledge of their sexual reproductive health. Among teen girls and adult women who know about the sexual reproductive health demands, it is still challenging for them to access healthcare facilities. As a result, governments need to prioritize reproductive health services access as well as equip adolescent girls and adult women with the necessary knowledge and economic empowerment to enable them to manage and overcome the future pandemics considering the present globalization world, where an emergency in one country spreads globally within a short span.

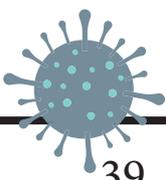




ANNEXES

Annex 1: The analysis dimensions and indicators used to capture country status

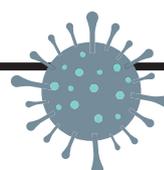
SRHR Dimension	Key Indicators
State of health systems and structures	
Health Financing	The proportion of national gross domestic product allocated as current expenditure on health services
Human health resources	The density of healthcare workers per 10,000 population
Regulatory guidelines and laws	Presence of laws and policies facilitating adolescent access to SRH services without third party authorization
	Legal minimum age of consent to marriage
Access to sexual and reproductive health services	
Integrated SRH services and rights	The proportion of the country's population accessing integrated SRH services
Access to legal abortion services	The legal status of abortion and circumstances for demand and provision of abortion services
Access to family planning and contraception services	The proportion of women of reproductive age with unmet need for family planning
Service access age-related restrictions	Presence of laws and policies facilitating adolescent access to SRH without third party authorization
State of gender inequality, sexual and gender-based violence	
Sexual coercion and violence	The proportion of girls and women reporting rape and or other forms of coerced sexual activity
Sexual and marriage consent	The proportion of girls married under the age of 18 years
Pregnancy	The incidence of teenage pregnancy
Intimate partner violence	The proportion of ever-partnered girls and women aged 15 years and over ever subjected to physical and or sexual violence by a current or former partner in the last twelve months
Sexual reproductive health outcomes	
Maternal mortality	Number of mothers dying after delivery per 100, 000 deliveries per year
Adolescent birth rates	Number of births to females aged below 18 years per 1000 females
Obstetric and gynaecological complications	The proportion of all obstetric and gynaecological admissions due to abortion





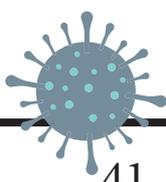
Annex 2: Partner Country Key Informant Interview /Discussion Guide

THEME	KEY QUESTIONS	RESPONSES
Theme 1: the State of COVID-19 in the Country	<p>Discussion Question: <i>What is the state of COVID 19 in the country?</i></p> <p>Key Informant probing issues</p> <ul style="list-style-type: none"> Current infection, recovery, and mortality caseload? Gender and age distribution of the caseload. Socio-economic profile of country caseload State of vaccine uptake in the country 	
Theme 2: State of implementation of the Maputo protocol	<p>Discussion Question: <i>What is the country's status in adoption, commitment, and implementation of the Maputo protocol?</i></p> <p>Key Informant probing issues</p> <ul style="list-style-type: none"> Adoption Budgetary allocation Relevant policies and laws Programs and guidelines relating to safe abortion, FGM, child marriage, women's rights, equality etc Women, education, and employment- work policies, care/ domestic work, 	
Theme 3: State of sexual and reproductive health rights	<p>Discussion question: <i>What is the SRHR situation in the country?</i></p> <p>Key Informant probing issues</p> <ul style="list-style-type: none"> Access to contraception services State of pregnancy, including teenage pregnancy Sexual rights of women and girls State of maternal health and related services Access to safe abortion and post-abortion care Reproductive health decision making and rights among married women HIV/Aids and Sexually transmitted infections Gender and sexual violence Female genital mutilation forced and child marriages 	
Theme 4: State responses to the COVID 19 situation	<p>Discussion Question: <i>What are the main measures taken by the country to manage COVID 19, especially between March 2020 and December 2021?</i></p> <p>Key Informant probing issues</p> <ul style="list-style-type: none"> Curfews and lockdowns Travel restrictions Social restrictions Changes in work routines 	





<p>Theme 5: Effect of the measures on Women’s lives and daily routines</p>	<p>Discussion Question: <i>How did the measures taken to manage the spread of Covid 19 affect women and girls’ everyday lives/routines?</i></p> <p>Key Informant probing issues</p> <ul style="list-style-type: none"> Domestic/care work Social, education and economic restrictions Unplanned and teenage pregnancy incidences Pregnancy and birth complications HIV/AIDS and STI incidence Sexual and gender-based violence Forced and child marriages Girls’ school dropout Sexual exploitation and abuse of girl children 	
<p>Theme 6: Intersections between COVID-19 and the Maputo protocol and effects on SRHR</p>	<p>Discussion Question: <i>How has the state of the country’s commitment to the Maputo protocol and general status of women’s rights exacerbated or mitigated the risks and experiences of women and girls under the COVID-19 pandemic?</i></p> <p>Key Informant probing issues</p> <ul style="list-style-type: none"> How do the Maputo protocol priorities and women and girls’ rights relate/connect during COVID-19? How explicit is the connection above (if any) to the SRHR policymakers and program implementers? How can these connections be amplified 	
<p>Theme 7: State strategies, policies and plans for SRHR under COVID-19</p>	<p>Discussion Question: <i>Are strategies, policies and/or plans prioritizing SRHR under COVID-19 interventions?</i></p> <p>Key Informant probing issues</p> <ul style="list-style-type: none"> What are the long-term plans to address COVID-19 and its effects on the general population and Women and Girls in particular? How do the above plans, strategies etc., integrate/mainstream SRHR? What resources have been allocated for the mainstreaming of SRHR in COVID-19 interventions? What plans and resources are invested in accelerating commitments and actions toward optimal compliance with the Maputo protocol? 	
<p>Theme 8: Barriers and Challenges</p>	<p>Discussion Question: <i>What challenges do women, girls and women’s rights organizations confront in accessing and enjoying their SRHR in the country?</i></p> <p>Key Informant probing issues</p> <ul style="list-style-type: none"> Structural barriers to SRHR for women and girls- legal, economic, social, cultural, geographic etc Social and behavioral barriers 	





**The African Women's
Development and
Communication Network**

12 Masaba Road, Lower Hill

P.O. Box 54562 - 00200 Nairobi, Kenya

Tel: +254 20 2712971/2 Cell: + (254)725.766932

Email: admin@femnet.co.ke

website: www.femnet.org



FEMNETSecretariat



@femnetprog



FEMNETSecretariat



FEMNET1