Study report on Analysis of the African Union Convention on Ending Violence Against Women and Girls (AU-CEVAWG) from

Sexual and Reproductive Health and Rights Perspectives

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List of Acronyms

Acronym	Full Meaning
AU	African Union
CEVAWG	Convention on Ending Violence Against Women and Girls
ACHPR	African Charter on Human and Peoples' Rights
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
ICCPR	International Covenant on Civil and Political Rights
ICPD	International Conference on Population and Development
SDGs	Sustainable Development Goals
WHO	World Health Organization
UNFPA	United Nations Population Fund
CSO	Civil Society Organization
SRHR	Sexual and Reproductive Health and Rights
CSE	Comprehensive Sexuality Education
GBV	Gender-Based Violence
FGM	Female Genital Mutilation
HIV	Human Immunodeficiency Virus
SDG 3	Good Health and Well-Being
SDG 5	Gender Equality

Foreword

It is with deep honor and commitment that I introduce this study on the African Union Convention on Ending Violence Against Women and Girls (AU-CEVAWG) and its intersection with sexual and reproductive health and rights (SRHR). This work comes at a pivotal moment for Africa, as our continent continues to strengthen legal and policy frameworks that safeguard the dignity, health, and equality of women and girls.

The study provides a comprehensive comparative analysis of AU-CEVAWG against global and regional instruments such as CEDAW, ICCPR, ICPD, the Beijing Platform for Action, the Abuja Declaration, the Maputo Protocol, and the Sustainable Development Goals. In doing so, it highlights areas of strong alignment, particularly in violence prevention, survivor-centered services, and accountability, while also exposing critical gaps in the Convention's treatment of SRHR. These gaps include the absence of explicit commitments to family planning, safe abortion, maternal health, and comprehensive sexuality education.

Why do these findings matter? Because violence against women and girls is not only a violation of human rights but also a direct barrier to achieving reproductive justice. Survivors often require immediate access to contraception, HIV prevention, safe abortion, and maternal health care. Without clear obligations in the AU-CEVAWG, states risk interpreting the Convention narrowly, focusing on legal protection while neglecting the health and empowerment needs of survivors. This study therefore underscores the urgent need for advocacy and petitioning to strengthen AU-CEVAWG's integration with SRHR frameworks.

As SRHR Alliance Uganda, we believe that advancing reproductive rights is inseparable from ending violence against women and girls. Our commitment is to work with governments, civil society organizations, and communities to ensure that the AU-CEVAWG is not only ratified and implemented but also harmonized with broader SRHR commitments. This will require political will, adequate financing, and strong accountability mechanisms.

I commend the authors of this study for their rigorous analysis and clear recommendations. It is my hope that this work will serve as both a policy guide and an advocacy tool, inspiring action at national, regional, and continental levels. Together, we can close the gaps, strengthen protections, and ensure that every woman and girl in Africa enjoys the full promise of dignity, health, and equality.

Ms. Olgah Daphynne Namukuza,
Country Director, SRHR Alliance Uganda

Executive Summary

This report presents a comprehensive analysis of the African Union Convention on Ending Violence Against Women and Girls (AU-CEVAWG) from a sexual and reproductive health and rights (SRHR) perspective. Adopted in February 2025, AU-CEVAWG is Africa's first legally binding continental instrument dedicated solely to eliminating violence against women and girls. The study examines how the Convention integrates SRHR within its provisions and assesses its alignment with regional and international frameworks such as the Maputo Protocol, CEDAW, ICCPR, the ICPD Programme of Action, the Beijing Platform for Action, and the Sustainable Development Goals (SDGs).

a. Background

Violence against women and girls (VAWG) remains a pervasive challenge across Africa, deeply rooted in cultural, social, and economic realities. It manifests through sexual violence, child marriages, female genital mutilation (FGM), intimate partner violence, and emerging threats such as online abuse. These violations have profound consequences on SRHR, including unintended pregnancies, maternal mortality, HIV/STI transmission, and psychological trauma. The adoption of the AU-CEVAWG was a landmark step, signaling Africa's recognition that violence against women is not only a human rights violation but also a public health crisis undermining development goals. However, while the AU-CEVAWG provides strong commitments on prevention, protection, and justice, it does not fully articulate the critical SRHR linkages necessary to ensure holistic survivor support.

b. Purpose of the Study

The purpose of this study is to evaluate the AU-CEVAWG through the lens of adolescent girls' and women's SRHR. Specifically, it seeks to map how the Convention's provisions address or intersect with SRHR priorities, identify strengths and gaps, and highlight opportunities for integration with frameworks such as ICPD+30, the Maputo Protocol, and SDGs 3 and 5. The study also aims to develop practical recommendations for governments, civil society organizations, and development partners to strengthen domestication, monitoring, and programming, while producing advocacy tools that amplify adolescent girls' SRHR priorities.

c. Methodology

The study employed a qualitative design that combined several approaches. A comprehensive literature review was conducted, covering AU-CEVAWG, related AU instruments, and global SRHR frameworks. Key informant interviews were held with civil society representatives, and development partners to capture practical challenges and opportunities. Comparative analysis was undertaken to assess the AU-CEVAWG against existing frameworks, highlighting areas of convergence and gaps. Finally, validation workshops with stakeholders ensured that findings reflected diverse perspectives and strengthened credibility for advocacy.

d. Key Findings

The analysis revealed that the AU-CEVAWG aligns with global frameworks on violence prevention, survivor protection, and accountability. Articles such as Article 5 (Prevention Measures), Article 7 (Protection of Vulnerable Groups), Article 9 (Prosecution and Justice), Article 11 (Protection and Support Services), Article 12 (Resource Allocation), and Article 14 (Monitoring and Accountability) provide strong commitments that can advance SRHR outcomes.

However, significant gaps remain. The Convention does not explicitly guarantee access to family planning and contraception, safe abortion, maternal health services, or comprehensive sexuality education (CSE). It also lacks provisions addressing structural reproductive harms such as coerced sterilization and obstetric violence. These omissions weaken AU-CEVAWG's ability to deliver holistic protection and empowerment for survivors, as violence often directly obstructs access to reproductive

health services. Implementation challenges such as limited funding, weak health system integration, and cultural barriers further constrain effectiveness.

e. Recommendations

For governments, the study recommends integrating SRHR explicitly into the AU-CEVAWG domestication, allocating adequate resources, and embedding survivor-centered health services into national GBV strategies. Civil society organizations are urged to use the AU-CEVAWG as an advocacy tool, monitor implementation, and amplify the voices of adolescents and marginalized groups. Development partners should provide technical assistance, financing, and capacity-building to support SRHR integration, while aligning donor programming with AU-CEVAWG priorities and facilitating cross-regional learning.

f. Conclusion

AU-CEVAWG represents a landmark achievement in Africa's fight against violence against women and girls. Yet, its transformative potential will only be realized if SRHR is fully integrated into its framework. Bridging the identified gaps is essential to ensure that survivors not only escape violence but also regain autonomy over their health and lives. This study provides a roadmap for governments, civil society, and development partners to strengthen AU-CEVAWG, ensuring it delivers holistic protection, health, and empowerment for women and girls across Africa.

1. Introduction

Violence against women and girls in Africa is deeply rooted in social, cultural, and economic realities, perpetuating a persistent and multifaceted challenge. Incidents such as sexual violence, forced marriages, female genital mutilation (FGM), and child marriages cause not only immediate harm but also profound and enduring effects on the sexual and reproductive health and rights (SRHR) of survivors. These violations can result in unwanted pregnancies, increased vulnerability to sexually transmitted infections, and lasting psychological trauma, all of which erode the agency of women and girls to make informed choices about their health and bodies. Particularly for adolescent girls and women, access to SRHR services, such as contraception, safe abortion care, maternal healthcare, counseling, and comprehensive sexuality education, becomes critically jeopardized in environments where VAWG is prevalent. Stigma, social exclusion, and fear of reprisal often hinder survivors from seeking these essential services, thereby reinforcing cycles of marginalization and limiting access to education and economic opportunities.

The African Union's adoption of the Convention on Ending Violence Against Women and Girls (AU-CEVAWG) in 2025 marks a transformative step in regional efforts to confront VAWG. As a legally binding instrument, the Convention calls on member states to implement holistic laws, policies, and programs aimed at eliminating violence and upholding the rights of women and girls. However, despite its firm legal provisions, the Convention's framework does not yet fully integrate the critical link between VAWG and effective access to SRHR services for adolescent girls and women. Issues such as ensuring universal, stigma-free access to reproductive healthcare, embedding SRHR services within VAWG response mechanisms, and safeguarding the bodily autonomy of all women and girls require more explicit articulation and action within the Convention's mandate.

Bridging these gaps is essential to ensure that legal and policy reforms yield tangible improvements in both the protection from violence and the fulfillment of SRHR. Therefore, this analysis will further explore how the AU-CEVAWG aligns with global and regional SRHR commitments, highlight opportunities to strengthen the Convention's provisions on SRHR access for adolescent girls and women, and propose concrete strategies for integrating comprehensive SRHR services as a core component of efforts to end VAWG across Africa.

2. Background and Contexts

The African Union Convention on Ending Violence Against Women and Girls (AU-CEVAWG) was adopted in February 2025 during the 38th AU Assembly.

The African Union Convention on Ending Violence Against Women and Girls (AU-CEVAWG) was formally adopted on 18th February 2025 during the 38th Ordinary Session of the AU Assembly in Addis Ababa, Ethiopia.

The timing of its adoption was deliberate: it coincided with growing evidence that gender-based violence was escalating across Africa, particularly in post-conflict settings and urban areas. By February 2025, UN and AU reports had already highlighted that Africa accounted for 22,600 femicides in 2025, the highest regional burden globally, with a rate of 3 per 100,000 female population. These figures underscored the urgency of a binding framework that could compel member states to act beyond policy declarations.

It is the first legally binding continental instrument dedicated solely to eliminating violence against women and girls. Unlike earlier frameworks such as the Maputo Protocol (2003), which broadly addressed women's rights, AU-CEVAWG specifically targets gender-based violence in all its forms, domestic abuse, sexual violence in conflict, harmful practices like female genital mutilation (FGM) and child marriages, workplace harassment, and emerging threats such as online abuse. Its adoption reflects Africa's recognition that violence against women is not only a human rights violation but also a public health crisis that undermines development goals, including Agenda 2063 and the SDGs.

2.1 SGBV and SRHR linkage

Sexual and gender-based violence and sexual and reproductive health and rights (SRHR) are inseparably linked in Africa: violence denies women autonomy, increases maternal mortality risks, drives adolescent pregnancies, and fuels HIV/STI transmission. Recent data shows alarming prevalence rates, underscoring why AU-CEVAWG must be leveraged to integrate SRHR into GBV prevention.

a. SGBV as a Barrier to Autonomy

Sexual and gender-based violence fundamentally undermines women's and girls' ability to exercise their SRHR. Survivors of rape, intimate partner violence, and coercion often lose control over decisions about contraception, pregnancy, and safe motherhood. This denial of autonomy is not abstract, it is reflected in lived realities across Africa.

In Uganda's refugee-hosting regions, 4,179 cases of gender-based violence were recorded in 2025, representing a 34% increase compared to 2024 (UNHCR, 2025). Many survivors reported being denied access to emergency contraception or post-rape care, leaving them vulnerable to unintended pregnancies and unsafe abortions. This illustrates how violence directly obstructs SRHR services and perpetuates cycles of poor health outcomes. In South Africa, research shows that women experiencing intimate partner violence are 50% more likely to acquire HIV (WHO, 2025). This heightened risk stems from forced, unprotected sex and the inability to negotiate condom use. The link between violence and HIV demonstrates how autonomy over sexual health is stripped away by coercion and abuse, undermining prevention efforts. In Malawi, 42% of girls are married before the age of 18 (UNICEF, 2025). These girls are often forced into early pregnancies, which carry higher risks of maternal mortality and complications such as obstetric fistula. Child marriage exemplifies how structural violence denies girls the right to delay pregnancy, pursue education, and make informed reproductive choices.

b. SGBV implication on Maternal Health and Adolescent Girls

Violence against women and girls has a direct and devastating impact on maternal health and the wellbeing of adolescent girls. Women subjected to abuse are less likely to seek antenatal care, skilled birth attendance, or emergency obstetric services, increasing the likelihood of maternal mortality. Adolescent girls, in particular, face compounded risks when exposed to child marriages and sexual violence, which drive early pregnancies and poor reproductive health outcomes.

In 2025, six Southern African Development Community (SADC) countries reported reductions in maternal deaths due to improved access to reproductive health services and expanded comprehensive sexuality education (CSE). However, violence remains a hidden driver of poor outcomes. Women experiencing intimate partner violence often delay or avoid antenatal visits, leading to preventable complications. Uganda continues to struggle with high adolescent pregnancy rates, with 25% of girls aged 15–19 either pregnant or already mothers (UNFPA, 2025). Many of these pregnancies are linked to sexual violence or coercion, particularly in refugee-hosting regions where GBV cases rose sharply in 2025. Early pregnancies increase risks of maternal death and perpetuate cycles of poverty and poor SRHR outcomes.

Adolescent girls in sub-Saharan Africa account for 63% of new HIV infections (UNAIDS, 2025). Violence, including coercive sex and child marriages, heighten vulnerability by limiting girls' ability to negotiate condom use or access HIV prevention services. In South Africa, studies show that girls experiencing intimate partner violence are significantly more likely to contract HIV, linking violence directly to poor SRHR outcomes.

c. SGBV risk on HIV and STI Transmission

Sexual and gender-based violence is a major driver of HIV and sexually transmitted infections (STIs) in Africa. Forced, unprotected sex increases vulnerability, while stigma and fear discourage survivors from accessing post-exposure prophylaxis (PEP), HIV testing, or STI treatment. This creates a vicious cycle where violence fuels infection rates, and poor SRHR systems leave survivors without adequate care.

Adolescent girls and young women account for 63% of new HIV infections in sub-Saharan Africa (UNAIDS, 2025). Many of these infections are linked to coercive sexual encounters, child marriage, and intimate partner violence. Girls subjected to violence often lack the power to negotiate condom use, making them disproportionately vulnerable to HIV and other STIs. Studies in South Africa show that women experiencing intimate partner violence are 50% more likely to acquire HIV (WHO, 2025). This heightened risk is due to forced, unprotected sex and reduced access to prevention services. Programs addressing HIV in South Africa now integrate GBV screening and survivor-centered care, recognizing that violence is a structural driver of infection.

In Nigeria, surveys show that adolescent girls exposed to sexual violence report higher rates of untreated STIs compared to peers (UNFPA, 2025). Limited access to youth-friendly health services and stigma around sexual violence prevent girls from seeking treatment, perpetuating cycles of infection and reproductive ill-health.

d. Policy and Advocacy Linkages

The adoption of the AU-CEVAWG on 18 February 2025 provides a binding framework to integrate SRHR into GBV prevention and response. For example, in Kenya, civil society organizations are already using AU-CEVAWG to push for survivor-centered health services, including safe abortion care and HIV prevention, within national GBV strategies. In Zambia, advocacy groups are leveraging the convention to demand stronger enforcement against child marriages while expanding access to contraception for adolescent girls. These practical applications show how AU-CEVAWG can bridge the gap between violence prevention and SRHR advancement.

e. Violence as a Barrier to Accessing SRHR

SGBV acts as a profound barrier to accessing SRHR services across Africa. Survivors of violence often face stigma, fear of retaliation, and discrimination when attempting to seek care. Many survivors reported being denied access to emergency contraception or post-rape care, leaving them vulnerable to unintended pregnancies and unsafe abortions. Similarly, in South Africa, many individuals hesitate to seek HIV testing or treatment due to fear of further abuse or social stigma. These examples show how violence strips women and girls off autonomy and prevents them from accessing lifesaving SRHR services. Key populations such as sex workers and other marginalised individuals also face compounded barriers: violence and discrimination often prevent them from accessing condoms, HIV prevention tools, or youth-friendly SRHR services.

2.2 Justifications for the Analysis

The AU-CEVAWG, adopted in February 2025, represents a landmark step as Africa's first standalone, legally binding instrument that is entirely focused on preventing and eliminating all forms of VAWG.

While the Convention mandates protection and support services (including medical care), it does not fully articulate linkages to SRHR essentials such as access to emergency contraception, safe abortion where permitted, comprehensive sexuality education, or prevention and management of reproductive harms from violence (e.g., obstetric violence, coerced sterilisation, or FGM/C impacts on reproductive health). This analysis is therefore necessary due to:

- The need to maximize the Convention's potential through stronger SRHR integration, aligning it with ICPD+30, Maputo Protocol commitments, and SDGs 3 and 5.
- Persistent high rates of sexual and gender-based violence across Africa, which directly affect or relate to SRHR (e.g., barriers to post-violence reproductive care and reproductive justice for survivors).
- Opportunities for civil society, including SRHR Alliance Uganda, to influence domestication, ratification, and monitoring processes, especially as the Convention requires 15 ratifications to enter into force and faces calls for stakeholder review to address implementation gaps (e.g., in Article 14).

- ❖ The strategic role of evidence-based advocacy in bridging VAWG and SRHR silos, ensuring holistic responses that empower women and girls, particularly adolescents, marginalized groups, and those in vulnerable contexts.

Through this targeted adolescent girls and young women's SRHR-focused review, ANSA through SRHR Alliance Uganda aims to contribute actionable insights and recommendations that will inform.

2.3 Objectives of the Analysis

2.3.1 Overall Objective

To produce a high-quality, actionable analysis of AU-CEVAWG through the lens of adolescent girls and young women's SRHR, strengthening its implementation and alignment with international and regional SRHR standards.

2.3.2 Specific Objectives

Specifically, the analysis will:

1) Map and assess how the Convention's provisions address or intersect with key elements of adolescent girls and young women's SRHR, including bodily autonomy, sexual violence response, reproductive health services, harmful practices, and rights in conflict/humanitarian settings.

2) Identify strengths and gaps, and highlight opportunities for integration with the Maputo Protocol, ICPD+30 commitments, and SDG 5 and 3 targets.

3) Develop practical recommendations for Member States, the African Commission on Human and Peoples' Rights (ACHPR), civil society, and development partners on domestication, monitoring, and programming.

4) Produce advocacy tools such as a policy brief and a PowerPoint presentation to amplify adolescent girls and young women's SRHR priorities within AU-CEVAWG implementation.

3. Approach and Methodology

3.1 Study Design

This study adopts a qualitative design, focusing on the analysis of the AU-CEVAWG through the lens of adolescent girls and young women's SRHR. A qualitative approach is the most appropriate because it allows for in-depth exploration of the Convention's provisions, contextual interpretation of gaps, and incorporation of perspectives from key stakeholders. The design emphasizes descriptive and analytical methods rather than statistical measurement, ensuring that the findings capture both textual nuances and lived experiences.

3.2 Data Collection Methods

- **Literature Review:** A comprehensive desk review will be conducted, covering the AU-CEVAWG text, travaux préparatoires, related AU instruments (particularly the Maputo Protocol), and global SRHR frameworks such as ICPD+30. Secondary sources, including UN reports, AU communiqués, and civil society publications, will be analyzed to establish the current state of knowledge and identify gaps in SRHR integration.
- **Key Informant Interviews:** Up to eight semi-structured interviews will be conducted with representatives from civil society organizations, AU institutions, government agencies, and development partners. These interviews will provide insights into practical challenges, opportunities for domestication, and perspectives on how AU-CEVAWG can better address SRHR priorities for adolescent girls and young women.

- **Comparative Analysis:** A comparative review will be undertaken to assess AU-CEVAWG against existing frameworks such as the Maputo Protocol, ICPD+30 commitments, and SDGs 3 and 5. This analysis will highlight areas of convergence, duplication, and gaps, offering a structured basis for recommendations.
- **Validation:** Findings will be validated through stakeholder consultations, including feedback sessions with civil society networks such as SRHR Alliance Uganda. Validation ensures that the analysis reflects diverse perspectives and strengthens credibility for advocacy.

3.3 Analytical Approach

The study will employ a clause-by-clause textual analysis of the AU-CEVAWG to identify explicit, implicit, and missing SRHR linkages. Data from literature review and interviews will be triangulated to ensure consistency and depth. Comparative matrices will be used to map AU-CEVAWG provisions against SRHR standards, while validation workshops will refine recommendations for policy briefs and advocacy tools.

3.4 Ethical considerations

This study necessitated strict observation of ethical and socio-cultural considerations. All the necessary steps were taken by the team to ensure the confidentiality of the responses and anonymity of the respondents were upheld. Participation in the study was voluntary i.e., no respondent was "coerced" to participate in this study in any form including the exchange of material gifts/inducements for participation. Verbal consent was sought from all respondents individually who participated in individual interviews. All the sources of information for the literature review and analysis were also recognized and referenced.

4. Key Findings of Study

This section presents the main insights derived from the comparative analysis of the AU-CEVAWG in the context of SRHR. The findings highlight areas where the Convention aligns with existing regional and global frameworks on gender equality and reproductive rights, while also exposing significant gaps that limit its effectiveness.

They underscore both the strengths of AU-CEVAWG as a landmark instrument for addressing violence against women and girls, and the critical omissions that weaken its integration with SRHR commitments. These findings provide the evidence base for advocacy, policy dialogue, and petitions aimed at strengthening AU-CEVAWG to ensure it delivers holistic protection, health, and empowerment for women and girls across Africa.

4.1 Highlights of the SRHR related AU-CEVAWG Articles

This subsection provides a concise overview of the AU-CEVAWG articles that directly touch on sexual and reproductive health and rights (SRHR). It highlights the provisions that strengthen survivor protection, access to health services, and accountability, while pointing to their relevance in advancing SRHR outcomes. The focus here is on drawing out the most critical articles that shape how the AU-CEVAWG contributes to safeguarding women's and girls' reproductive health within the broader framework of violence prevention and response. Key articles are highlighted below:

- **Article 5 – Prevention Measures:** This article obligates member states to adopt proactive laws, policies, and educational programs aimed at preventing violence against women and girls. It emphasizes the elimination of harmful practices such as child marriages and female genital mutilation, while also mandating awareness campaigns to challenge discriminatory norms. By embedding prevention into national strategies, Article 5 seeks to address the root causes of

violence and ensure that communities are equipped to protect women and girls before harm occurs.

- **Article 7 – Protection of Vulnerable Groups:** Article 7 recognizes that certain groups, including adolescents, women in conflict zones, refugees, persons with disabilities, and marginalized populations, face heightened risks of violence. It requires states to adopt targeted measures that guarantee equal access to justice, health, and protection services for these groups. This provision is particularly important in humanitarian settings, where adolescent girls and displaced women often face sexual exploitation and lack access to reproductive health care.
- **Article 9 – Prosecution and Justice:** This article mandates effective investigation, prosecution, and punishment of perpetrators of violence. It emphasizes survivor protection during judicial processes, including confidentiality, non-discrimination, and access to legal aid. By strengthening accountability mechanisms, Article 9 seeks to break the cycle of impunity that often surrounds gender-based violence cases in Africa.
- **Article 11 – Protection and Support Services:** Article 11 requires member states to establish survivor-centered services such as shelters, medical care, psychosocial support, and legal aid. It stresses the importance of integrated services that address both immediate safety and long-term recovery, including reproductive health care. This article is critical for ensuring that survivors not only escape violence but also regain autonomy over their health and wellbeing.
- **Article 12 – Resource Allocation:** Recognizing that commitments require resources, Article 12 obligates states to allocate adequate financial and human resources for implementation. It encourages partnerships with civil society and development partners to strengthen service delivery. Without such resource commitments, the Convention's provisions risk remaining aspirational rather than actionable.
- **Article 14 – Monitoring and Accountability:** Article 14 establishes mechanisms for monitoring implementation, including reporting obligations to the African Commission on Human and Peoples' Rights. It calls for systematic data collection, evaluation, and civil society participation to ensure transparency and accountability. This article is vital for tracking progress, identifying gaps, and ensuring that commitments translate into measurable change.

4.2 Comparative Analysis of the AU-CEVAWG and SRHR Thematic areas.

This subsection provides a focused examination of how the AU-CEVAWG articles intersect with key SRHR thematic areas such as family planning, safe abortion, maternal health, HIV/STI prevention, and comprehensive sexuality education. It highlights points of convergence where the Convention supports SRHR outcomes, while also identifying gaps that weaken its effectiveness in addressing the full spectrum of reproductive rights. The analysis sets the stage for understanding both the strengths and limitations of AU-CEVAWG in advancing SRHR, and informs advocacy strategies aimed at bridging these gaps.

a) Sexual Violence

Sexual violence represents a critical violation of both human rights and reproductive health. It encompasses acts such as rape, sexual assault, sexual exploitation, and abuse, each with far-reaching consequences for survivors. These consequences include physical injuries, exposure to sexually transmitted infections (STIs), unintended pregnancies, and deep psychological trauma. Addressing sexual violence is essential not only for upholding justice but also for advancing SRHR, as survivors often require access to comprehensive medical care, counseling, and legal support.

What the Convention Covers:	Gaps Identified:

The AU-CEVAWG provides a robust legal framework that explicitly criminalizes various forms of sexual violence, including rape and sexual exploitation. Member states are required to enact laws that prosecute perpetrators and protect survivors. The Convention also mandates the establishment of comprehensive support systems, such as psychosocial care, medical assistance, and legal recourse. These provisions are intended to ensure that survivors have access to justice and receive holistic recovery services. Additionally, the Convention calls for preventive measures, such as awareness campaigns and training for law enforcement and healthcare providers, to strengthen the response to sexual violence. The AU-CEVAWG provides a strong legal framework against sexual violence, criminalizing rape, sexual exploitation, and abuse. It obligates states to criminalize these acts, provide legal recourse for survivors, and establish protective measures, including support services such as psychosocial care. Beyond criminalization, the Convention emphasizes survivor-centered approaches, including confidentiality, dignity, and respect in the delivery of services. It encourages collaboration between government agencies, civil society, and healthcare providers to ensure effective implementation and monitoring. The Convention also recognizes the importance of addressing stigma and discrimination faced by survivors, which can hinder their access to care and justice.	Despite the strengths of the AU-CEVAWG, several gaps persist. The Convention may lack explicit guidance on ensuring access to emergency contraception and post-exposure prophylaxis for survivors. There is also limited emphasis on integrating sexual violence response within broader SRHR services, such as reproductive health clinics. In some cases, implementation challenges arise due to insufficient funding, lack of trained personnel, or cultural barriers that discourage reporting. Furthermore, the Convention does not always address the needs of marginalized populations, such as adolescents, persons with disabilities, or other marginalised individuals, who may face increased risks of sexual violence and additional obstacles in accessing support. The Convention could further strengthen its provisions by promoting multisectoral strategies and ensuring that services are survivor-centered and accessible to all, regardless of age, gender, or background.

b) Forced Marriage:

Forced marriage is recognized as a violation of fundamental human rights and a harmful practice that undermines reproductive autonomy and bodily integrity.

What the Convention Covers:	**Gaps Identified:**
The AU-CEVAWG explicitly criminalizes forced marriage and obligates member states to enact and enforce laws prohibiting such practices. The Convention requires states to establish legal mechanisms for prosecuting offenders and protecting individuals who are at risk of being forced into marriage, particularly minors and vulnerable groups. In addition, the Convention mandates the creation of survivor support systems, such as access to shelters, psychosocial counseling, and legal aid. Preventive measures, including community awareness campaigns and training for law enforcement and social workers, are also encouraged to help identify and	Despite the Convention's strong stance against forced marriage, several gaps persist in practice. For example, the Convention may not provide explicit guidance on addressing the root causes of forced marriage, such as poverty, lack of education, and gender inequality. Implementation challenges may arise due to insufficient resources, limited capacity among law enforcement, or cultural norms that support early or arranged marriages. There is often a lack of specialized support for marginalized populations, including

respond to cases of forced marriage. By addressing forced marriage within its legal framework, the Convention seeks to ensure that individuals have the right to freely choose their partners and to protect those who are subjected to coercion or threats.	adolescents, persons with disabilities, and other marginalised individuals, who may face unique barriers to escaping forced marriage. Additionally, the integration of forced marriage prevention and response into broader SRHR services is not always emphasized, which can hinder holistic support for survivors. Enhanced monitoring, reporting, and data collection on forced marriage cases are also needed to better inform policy and practice.

c) Access to SRHR Services.

The access to SRHR services when needed is critical to prevention and protection of women from sexual related violence that may have long term harm to their health.

What the Convention Covers:	**Gaps Identified:**
The AU-CEVAWG recognizes the importance of access to Sexual and Reproductive Health and Rights (SRHR) services as a crucial component in supporting survivors of sexual violence and ensuring broader reproductive autonomy. The Convention obligates member states to provide a range of SRHR services, which include medical care, psychosocial support, and legal assistance. For example, the Convention calls for the provision of counseling and access to reproductive health clinics where survivors can receive treatment for injuries, screening for STIs, and support for trauma. Additionally, it encourages states to facilitate access to family planning services, comprehensive sexuality education, and maternal health care. An illustrative case is a survivor of sexual violence who receives emergency medical care, STI testing, and ongoing counseling at a specialized clinic, ensuring both immediate and long-term health needs are met. The Convention also promotes collaboration between health providers, social workers, and legal authorities to create a holistic response system that addresses both physical and psychological well-being.	Despite these commitments, several gaps remain. The Convention does not explicitly mandate access to emergency contraception or post-exposure prophylaxis (PEP) for survivors of sexual violence, which are critical in preventing unwanted pregnancies and HIV infection, respectively. For instance, a survivor seeking emergency contraception after an assault might face barriers due to lack of clear legal provisions or insufficient supply in health facilities. Furthermore, the integration of SRHR services with sexual violence response is often weak; reproductive health clinics may not be equipped to handle cases of violence or provide specialized support. Another challenge is the lack of trained personnel and funding, which can result in inadequate services, particularly in rural or underserved areas. Marginalized groups, such as adolescents, persons with disabilities, or other marginalised individuals, may face discrimination or stigma when accessing SRHR services, limiting their ability to receive appropriate care. For example, a young other marginalised survivor may encounter judgment or refusal of services at a clinic, highlighting the need for inclusive and sensitive approaches.

d) Harmful Practices

What the Convention Covers:	Gaps Identified:
The AU-CEVAWG addresses harmful practices as violations of fundamental human rights that threaten the health, dignity, and autonomy of individuals, especially women and girls. Harmful practices encompass a range of actions, including but not limited to, FGM, child and early marriage, forced marriage, and other customs or traditions that perpetuate gender-based violence or discrimination. The Convention obligates member states to criminalize these practices and implement laws that prohibit them. It also calls for protective measures for those at risk, including minors and vulnerable populations, and mandates the establishment of support systems such as shelters, psychosocial counseling, and legal aid for survivors. Furthermore, the Convention encourages preventive strategies, such as community education campaigns and specialized training for law enforcement and social workers, to help identify and address cases of harmful practices. By embedding these requirements within its framework, the Convention aims to eliminate harmful practices and uphold the rights of all individuals to bodily integrity and reproductive autonomy.	Despite the Convention's robust legal stance against harmful practices, practical gaps persist. One major challenge is the lack of explicit guidance on how to address the underlying causes, such as poverty, limited access to education, and entrenched gender inequality. Implementation can be hindered by insufficient resources, inadequate capacity among law enforcement, or cultural norms that reinforce harmful traditions. There is often a shortage of specialized support for marginalized groups, including adolescents, people with disabilities, and other marginalised individuals, who may encounter unique barriers when seeking protection or escaping harmful practices. Additionally, the integration of harmful practice prevention with broader SRHR services is not always emphasized, which can impede comprehensive support for survivors. Improved monitoring, reporting, and data collection on harmful practice cases are needed to inform policy and guide interventions more effectively.

e) Reproductive Autonomy

What the Convention Covers:	Gaps Identified:
The AU-CEVAWG recognizes reproductive autonomy as a critical aspect of women's rights and bodily integrity. The Convention addresses the issue of coercion in reproductive decision-making, acknowledging that forced pregnancy, denial of contraception, and barriers to accessing reproductive health services constitute violations of autonomy. Member states are obligated to protect individuals from practices that undermine their ability to make informed choices about their reproductive health, including the right to decide freely and responsibly on the number, spacing, and timing of children. The Convention also encourages the provision of information, counseling, and access to reproductive health care to empower individuals	Despite the Convention's recognition of coercion as a violation of reproductive autonomy, several gaps persist. There is a lack of explicit language guaranteeing women's right to make independent decisions regarding their reproductive health. The Convention does not directly mandate access to essential reproductive health services, such as contraception, safe abortion, or fertility counseling, which are necessary to realize full autonomy. Additionally, the absence of clear operational guidance on how states should integrate reproductive autonomy into broader GBV responses limits the effectiveness of the Convention. Marginalized groups, including adolescents, persons with disabilities, and other marginalised

in making decisions. However, while the Convention condemns coercion, it does not explicitly guarantee comprehensive decision-making rights for women or mandate access to the full range of reproductive health services, such as contraception, safe abortion, or fertility treatments. The Convention's provisions focus primarily on preventing coercion and violence related to reproductive health, but do not extend to guaranteeing full reproductive autonomy or explicitly outlining the rights and services required to achieve it. This leaves ambiguity regarding the scope of protections and the obligations of member states to ensure that women can exercise their reproductive rights without external interference.	individuals, may face additional barriers, such as stigma or discrimination, when seeking reproductive health services, and the Convention does not provide tailored strategies to address these challenges. Furthermore, limited training for health professionals and insufficient funding for reproductive health programs can hinder access and quality of care, particularly in rural or underserved areas.

4.3 Comparative Analysis of the AU-CEVAWG and other Pan-African frameworks.

This subsection examines how the AU-CEVAWG aligns with and diverges from other Pan-African frameworks that address gender equality, human rights, and sexual and reproductive health and rights. By comparing AU-CEVAWG with instruments such as the Maputo Protocol, the African Charter on Human and Peoples' Rights, and the Abuja Declaration, the analysis highlights areas of convergence that strengthen continental commitments, as well as gaps that weaken AU-CEVAWG's effectiveness in advancing SRHR.

4.3.1 AU-CEVAWG and Maputo Protocol.

a. Areas of Alignment

- Both the AU-CEVAWG and the Maputo Protocol share a strong commitment to ending violence against women and girls and protecting their rights.

- Legal Protection Both AU-CEVAWG and the Maputo Protocol establish strong legal obligations for states to criminalize violence against women and girls. They explicitly call for the prohibition of harmful practices such as child marriages and female genital mutilation, recognizing these as violations of women's rights and dignity. By embedding these protections into binding law, both instruments ensure that violence is not treated as a private matter but as a public crime requiring state intervention. This alignment is crucial because it sets a continental standard for legal accountability and harmonizes national laws with regional commitments.

- Support Services AU-CEVAWG (Article 11) and the Maputo Protocol (Article 14) both mandate survivor-centered support services, including shelters, medical care, psychosocial support, and legal aid. These provisions highlight the importance of holistic care that addresses both immediate safety and long-term recovery. The alignment here ensures that survivors are not left isolated after experiencing violence but are supported through integrated services that restore dignity and autonomy. Importantly, the Maputo Protocol goes further by explicitly linking these services to reproductive health care, which AU-CEVAWG can build upon.
- Protection of Vulnerable Groups. AU-CEVAWG (Article 7) and the Maputo Protocol (Article 23) recognize that certain groups, adolescents, women in conflict zones, refugees, persons with disabilities, and marginalized populations, face heightened risks of violence. Both instruments require states to adopt targeted measures to guarantee equal access to justice, health, and protection services for these groups. This alignment is significant because it acknowledges intersectionality: violence does not affect all women equally, and those in vulnerable contexts require tailored interventions.

- ❖ Monitoring and Accountability. AU-CEVAWG (Article 14) and the Maputo Protocol both establish mechanisms for monitoring and accountability. AU-CEVAWG requires states to report to the African Commission on Human and Peoples' Rights, while the Maputo Protocol obligates reporting to the African Union. Both frameworks emphasize data collection, evaluation, and civil society participation to ensure transparency. This alignment is critical because it creates a culture of accountability, where commitments are not symbolic but measurable, and progress can be tracked against agreed standards.

b. Gaps in AU-CEVAWG:

Despite these alignments, AU-CEVAWG leaves critical gaps when compared to the Maputo Protocol:

- ➢ **Emergency Contraception and Safe Abortion:** One of the most significant gaps in AU-CEVAWG is its silence on emergency contraception and safe abortion. The Maputo Protocol explicitly guarantees women's right to medical abortion in cases of sexual assault, rape, incest, and where pregnancy endangers health (Article 14(2)(c)). AU-CEVAWG, however, does not articulate this linkage, leaving survivors of sexual violence without clear protection for reproductive justice. This omission matters because survivors often require immediate access to emergency contraception and safe abortion services to prevent long-term health and social consequences. Without explicit provisions, states may interpret AU-CEVAWG narrowly, focusing only on physical protection while neglecting reproductive health needs.
- ➢ **Comprehensive Sexuality Education:** AU-CEVAWG lacks explicit provisions on comprehensive sexuality education, while the Maputo Protocol promotes education and awareness to eliminate harmful practices. CSE is a proven preventive measure that equips adolescents and young women with knowledge about bodily autonomy, consent, and reproductive health. Its absence in AU-CEVAWG weakens prevention strategies, leaving young people vulnerable to violence and reproductive harms. This gap matters because without CSE, efforts to prevent child marriage, sexual exploitation, and early pregnancies remain incomplete, undermining the Convention's preventive mandate.
- ➢ **Reproductive Harms from Violence:** AU-CEVAWG does not address specific reproductive harms such as obstetric violence, coerced sterilization, or the reproductive health impacts of FGM/C. The Maputo Protocol, by contrast, recognizes harmful practices and their consequences on women's health. This omission matters because survivors of violence often face long-term reproductive complications that require specialized care. Without recognition of these harms, AU-CEVAWG risks overlooking critical dimensions of SRHR, leaving survivors without adequate redress or medical support.
- ➢ **Integration with Global SRHR Frameworks:** Unlike the Maputo Protocol, AU-CEVAWG does not explicitly align with global SRHR frameworks such as ICPD+30 or the SDGs 3 and 5. This gap matters because it limits the Convention's ability to serve as a comprehensive instrument that advances both regional and global commitments. Without integration, AU-CEVAWG risks being implemented in isolation, missing opportunities to leverage global accountability mechanisms and funding streams that support SRHR.

Why the Gaps Matter

These gaps undermine the AU CEVAWG's capacity to deliver comprehensive protection. Survivors of violence often require integrated services, including emergency contraception, safe abortion care where legally permitted, HIV prevention, and maternal health services as part of a holistic recovery package. In the absence of explicit SRHR linkages, States may adopt a narrow interpretation of their obligations, prioritizing physical protection and access to justice while overlooking critical reproductive health needs. This omission risks perpetuating poor health outcomes, particularly among adolescent girls, women in humanitarian contexts, and key populations who already face systemic barriers in accessing SRHR services.

Key Recommendations for Advocacy and Petition to AU

Based on the above gaps, the following actions are recommended:

- **Integrate SRHR Explicitly:** Advocacy should focus on ensuring that AU-CEVAWG provisions are explicitly linked to sexual and reproductive health and rights (SRHR). This means pushing for interpretative guidance or amendments that mandate access to emergency contraception, safe abortion where permitted, HIV/STI prevention, and maternal health services as part of survivor-centered care. Without these linkages, survivors of sexual violence may be denied essential reproductive health services, undermining both their autonomy and recovery. Civil society petitions can emphasize that SRHR integration is not an optional add-on but a core requirement for the Convention to achieve its intended impact.
- **Align with the Maputo Protocol:** AU-CEVAWG should be harmonized with the Maputo Protocol, particularly Article 14, which explicitly guarantees reproductive rights for survivors of violence. Advocacy efforts can highlight that alignment will strengthen coherence across African legal frameworks, reduce duplication, and ensure that survivors benefit from comprehensive protections. Petitioning for this alignment is critical because the Maputo Protocol already sets a precedent for reproductive justice, and AU-CEVAWG risks being weaker if it does not incorporate these standards.
- **Promote Comprehensive Sexuality Education:** Civil society should petition for the inclusion of comprehensive sexuality education within AU-CEVAWG's preventive framework. CSE equips adolescents and young women with knowledge about consent, bodily autonomy, and reproductive health, making it a proven tool for preventing violence and harmful practices. Its absence in AU-CEVAWG leaves a gap in prevention strategies, particularly for adolescents who are disproportionately affected by child marriage and sexual exploitation. Advocacy should stress that CSE is essential for building resilient communities and empowering young people to protect themselves.
- **Address Reproductive Harms:** Advocacy must also push for AU-CEVAWG to recognize reproductive harms such as obstetric violence, coerced sterilization, and the long-term reproductive health impacts of FGM/C. These harms are often overlooked in legal frameworks, yet they profoundly affect survivors' health and dignity. Petitioning for their inclusion ensures that AU-CEVAWG addresses not only immediate violence but also the lasting consequences that undermine women's and girls' reproductive rights. This recognition would strengthen survivor-centered approaches and align the Convention with broader SRHR commitments.
- **Strengthen Civil Society Engagement:** Finally, civil society engagement should be institutionalized within AU-CEVAWG's monitoring and implementation processes. Civil society organizations are often the first responders to violence and play a critical role in advocacy, service delivery, and accountability. Petitions should call for formal mechanisms that allow civil society to participate in reporting, monitoring, and evaluation. This recommendation matters because without civil society involvement, implementation risks being state-centric, overlooking grassroots realities and survivor voices.

4.3.2 AU-CEVAWG and African Charter on Human and Peoples' Rights (1986)

a. Areas of Alignment

The AU-CEVAWG and the African Charter on Human and Peoples' Rights (ACHPR, 1986) share a foundational commitment to protecting the dignity, equality, and rights of women and girls. Both instruments recognize violence against women as a violation of fundamental human rights and obligate states to adopt laws and policies to prevent such abuses.

The Charter enshrines the right to health (Article 16) and non-discrimination (Article 18), which align with the AU-CEVAWG's provisions on survivor protection and support services (Article 11). Similarly, both frameworks emphasize accountability: AU-CEVAWG requires monitoring through the African Commission on Human and Peoples' Rights, while the Charter mandates state reporting to the Commission on compliance with human rights obligations. This alignment ensures that AU-CEVAWG

builds upon the Charter's broad human rights foundation, translating it into a specialized instrument focused on ending violence against women and girls.

b. Gaps in AU-CEVAWG

Despite these alignments, the AU-CEVAWG leaves critical gaps when compared to the broader protections of the African Charter. First, AU-CEVAWG does not explicitly articulate the right to sexual and reproductive health services, while the Charter recognizes the right to health as a fundamental entitlement. This omission means that survivors of violence may not be guaranteed access to emergency contraception, safe abortion where permitted, or HIV/STI prevention services. Second, AU-CEVAWG lacks explicit provisions on bodily autonomy and reproductive justice, which are implicit in the Charter's recognition of human dignity and equality. Third, AU-CEVAWG does not address structural reproductive harms such as coerced sterilization, obstetric violence, or the reproductive health impacts of harmful practices like FGM/C, which fall under the Charter's broader mandate to protect health and integrity. Finally, AU-CEVAWG is not explicitly linked to global frameworks such as ICPD+30 or SDGs 3 and 5, limiting its ability to leverage international accountability mechanisms.

Why the Gaps Matter

These gaps are significant as they constrain AU CEVAWG's capacity to provide comprehensive protection for survivors of violence. In the absence of explicit SRHR linkages, States may adopt a narrow interpretation of their obligations, prioritizing physical protection and access to justice while overlooking essential reproductive health needs. Survivors of sexual violence often require timely access to contraception, safe abortion care where legally permitted, HIV prevention, and maternal health services interventions that are critical to recovery, dignity, and bodily autonomy. The lack of explicit provisions on bodily autonomy and reproductive harms further risks entrenching systemic violations that undermine women's rights, dignity, and equality. Without clear integration of SRHR, AU CEVAWG risks falling short of the African Charter's broader commitments to safeguarding the full continuum of women's rights.

c. Key Recommendations for Advocacy and Petition

- **Align with the African Charter**. Civil society should petition for the AU-CEVAWG to harmonize with the Charter's provisions on health, dignity, and equality. This alignment would strengthen coherence across African legal frameworks and ensure that AU-CEVAWG does not fall short of the Charter's broader protections.
- **Address Bodily Autonomy and Reproductive Harms.** The AU-CEVAWG should be expanded to recognize reproductive harms such as obstetric violence, coerced sterilization, and FGM/C impacts. Advocacy can highlight that these harms directly undermine the Charter's guarantees of health and integrity, making their inclusion essential.

4.3.3 AU-CEVAWG and Abuja Declaration

a. Areas of Alignment

The AU-CEVAWG and the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (2001) share a common commitment to protecting health and dignity, particularly for women and girls. Both instruments emphasize the importance of healthcare access as a fundamental right.

The Abuja Declaration called for African governments to allocate at least 15% of national budgets to health, prioritizing HIV/AIDS and reproductive health services. AU-CEVAWG (Article 11) similarly mandates survivor-centered support services, including medical care and psychosocial support, which align with the Abuja Declaration's focus on strengthening health systems. Both frameworks also stress multi-sectoral collaboration, recognizing that violence and poor SRHR outcomes are interconnected with poverty, inequality, and weak health infrastructure.

b. Gaps in AU-CEVAWG

- Despite these alignments, the AU-CEVAWG leaves critical gaps when compared to the Abuja Declaration's health-centered commitments. First, the AU-CEVAWG does not explicitly mandate budgetary allocations for SRHR services, while the Abuja Declaration set clear financial targets to strengthen health systems. This omission risks underfunding survivor-centered care.
- Second, the AU-CEVAWG does not explicitly address HIV/AIDS and STI prevention, despite their strong linkage to sexual violence, whereas the Abuja Declaration prioritized HIV prevention and treatment as a continental emergency.
- Third, the AU-CEVAWG lacks provisions on health system strengthening, which the Abuja Declaration emphasized as essential for delivering SRHR services. Finally, AU-CEVAWG does not integrate monitoring of health outcomes (e.g., HIV prevalence, maternal mortality), limiting its ability to track progress in SRHR alongside violence prevention.

Why the Gaps Matter

These gaps are significant as survivors of violence often require immediate access to HIV prevention, STI treatment, emergency contraception, and maternal health services. In the absence of explicit financial commitments and clear integration into health systems, AU CEVAWG risks being implemented as a predominantly legal framework without the necessary resources to ensure effective service delivery. The omission of specific provisions on HIV/AIDS and STIs is particularly concerning, given that sexual violence remains a key driver of infection among adolescent girls and young women across Africa. Without alignment to the Abuja Declaration's health financing and priority commitments, AU CEVAWG risks reinforcing under-resourced SRHR systems that are unable to adequately respond to survivors' needs.

c. Key Recommendations for Advocacy and Petition

- **Integrate Health Financing Commitments.** Advocacy should push for AU-CEVAWG to adopt clear financial obligations for SRHR services, similar to the Abuja Declaration's 15% health budget target. This ensures that survivor-centered care is adequately resourced and sustainable.
- **Explicitly Address HIV/AIDS and STIs.** Civil society should petition for the AU-CEVAWG to explicitly include HIV/AIDS and STI prevention and treatment as part of survivor support services. This would align the Convention with the Abuja Declaration's recognition of HIV as a continental emergency and strengthen SRHR outcomes.
- **Strengthen Health Systems**. The AU-CEVAWG should incorporate provisions that mandate states to invest in health infrastructure, training, and service delivery for SRHR. Advocacy can highlight that without strong health systems, survivor-centered services remain inaccessible, especially in rural and humanitarian settings.
- **Integrate Health Monitoring Indicators.** Petitions should call for the AU-CEVAWG to include monitoring of health outcomes such as HIV prevalence, maternal mortality, and access to contraception. This would align the Convention with the Abuja Declaration's emphasis on measurable progress and accountability.

4.4 Comparative Analysis of the AU-CEVAWG and other global frameworks

4.4.1 AU-CEVAWG and the ICPD (1994)

i. Areas of Alignment

The AU-CEVAWG and the International Conference on Population and Development (ICPD, 1994) share a strong commitment to advancing the rights and dignity of women and girls, particularly in relation to health and bodily autonomy. Both frameworks recognize that violence against women is a barrier to achieving gender equality and reproductive justice.

ICPD emphasized the importance of universal access to reproductive health services, including family planning, maternal health, and HIV prevention. The AU-CEVAWG (Article 11) similarly mandates survivor-centered support services such as medical care and psychosocial support, aligning with ICPD's call for comprehensive health responses. Additionally, both instruments highlight the need for multi-sectoral collaboration, acknowledging that violence and poor SRHR outcomes are interconnected with poverty, inequality, and weak health systems.

ii. Gaps in AU-CEVAWG

- Despite these alignments, AU-CEVAWG leaves critical gaps when compared to ICPD's comprehensive SRHR framework. First, the AU-CEVAWG does not explicitly guarantee access to family planning and contraception, while ICPD recognized these as fundamental rights.

- Second, the AU-CEVAWG is silent on safe abortion services, whereas ICPD affirmed the need to address unsafe abortion as a major public health concern.

- Third, the AU-CEVAWG does not include comprehensive sexuality education, which ICPD identified as essential for empowering adolescents and preventing harmful practices. Fourth, AU-CEVAWG does not explicitly address maternal health outcomes such as reducing maternal mortality, which ICPD placed at the center of reproductive health commitments. Finally, AU-CEVAWG lacks explicit integration with global development frameworks like ICPD+30 and SDGs 3 and 5, limiting its ability to leverage international accountability mechanisms.

Why the Gaps Matter?

These gaps are significant because they weaken the coherence and operational depth of the AU CEVAWG within the broader sexual and SRHR continuum. The absence of explicit guarantees on family planning and contraception undermines reproductive autonomy and limits consistent access to essential preventive services across Member States. Similarly, the exclusion of safe abortion care leaves a critical gap in the continuum of care, particularly for survivors of sexual violence, while the omission of comprehensive sexuality education reduces the framework's preventive capacity by limiting adolescents' access to knowledge needed to prevent child marriage, exploitation, and early pregnancy.

At the outcome level, the failure to explicitly address maternal health outcomes, including reductions in maternal mortality, weakens alignment with global health and development priorities. In addition, the lack of integration with key international frameworks such as ICPD+30 and Sustainable Development Goals 3 and 5 reduces opportunities for accountability, financing alignment, and coordinated implementation. Collectively, these omissions constrain AU CEVAWG's ability to deliver a fully integrated, rights-based response and limit its effectiveness in driving measurable progress on gender equality and SRHR outcomes.

iii. Key Recommendations for Advocacy and Petition

- **Integrate Family Planning and Contraception:** Advocacy should push for the AU-CEVAWG to explicitly guarantee access to family planning and contraception as part of survivor-centered care. This aligns with ICPD's recognition of reproductive choice as a fundamental right and ensures that survivors can regain autonomy over their health.
- **Include Safe Abortion Provisions**: Civil society should petition for AU-CEVAWG to address unsafe abortion by recognizing survivors' right to safe abortion were permitted by law. This would align the Convention with ICPD's public health commitments and reduce maternal mortality linked to unsafe procedures.
- **Address Maternal Health Outcomes:** Petitions should call for AU-CEVAWG to explicitly include maternal health indicators such as reducing maternal mortality and ensuring safe

delivery services. This would align the Convention with ICPD's central focus on maternal health and strengthen survivor support.

4.4.2 AU-CEVAWG and Beijing Declaration and Platform for Action (1995).

i. Areas of Alignment

The AU-CEVAWG and the Beijing Declaration and Platform for Action (1995) both recognize violence against women and girls as a fundamental barrier to gender equality and human rights. The Beijing Platform explicitly identifies violence against women as one of its twelve critical areas of concern, calling for legal reforms, survivor support services, and preventive measures.

The AU-CEVAWG (Articles 5, 7, and 11) aligns with this by mandating prevention programs, protection of vulnerable groups, and survivor-centered services such as medical care and psychosocial support. Both frameworks also emphasize multi-sectoral collaboration, acknowledging that violence and poor SRHR outcomes are interconnected with poverty, inequality, and weak health systems. Importantly, both instruments highlight the role of civil society and community engagement in monitoring and advocacy, ensuring that women's voices shape implementation.

ii. Gaps in AU-CEVAWG

Despite these alignments, the AU-CEVAWG leaves notable gaps when compared to the Beijing Platform's comprehensive SRHR commitments.

- AU-CEVAWG does not explicitly guarantee access to family planning and contraception, while the Beijing Platform calls for universal access to reproductive health services.
- AU-CEVAWG is silent on safe abortion, whereas the Beijing Platform recognizes unsafe abortion as a major public health issue and urges states to review restrictive laws.
- AU-CEVAWG does not include comprehensive sexuality education (CSE), which the Beijing Platform identified as essential for empowering adolescents and preventing harmful practices.
- AU-CEVAWG does not explicitly address maternal health outcomes, such as reducing maternal mortality, which the Beijing Platform placed at the center of reproductive health and rights. Finally, AU-CEVAWG lacks explicit integration with global frameworks like ICPD+30 and SDGs 3 and 5, limiting its ability to leverage international accountability mechanisms.

Why the Gaps Matter

These gaps matter because they weaken AU CEVAWG's ability to fully operationalize a rights-based and life-course approach to protecting women and girls. While the framework aligns broadly with gender equality objectives, its omission of explicit guarantees on access to family planning and contraception undermines the Beijing Platform's commitment to universal access to reproductive health services. This limits reproductive autonomy and constrains women's and girls' ability to make informed decisions about their health and futures. Similarly, the absence of safe abortion provisions creates a critical policy blind spot, particularly given the Beijing Platform's recognition of unsafe abortion as a major public health concern requiring regulatory review and reform.

In addition, the lack of comprehensive sexuality education significantly weakens preventive action by limiting adolescents' access to essential information needed to reduce vulnerability to child marriage, sexual exploitation, and early pregnancy. The failure to explicitly address maternal health outcomes, including the reduction of maternal mortality, further narrows the framework's impact within the reproductive health continuum. Finally, the absence of clear linkage to global accountability frameworks such as ICPD+30 and SDGs 3 and 5 reduces opportunities for policy coherence, financing alignment,

and measurable progress tracking. Collectively, these gaps constrain AU CEVAWG's effectiveness in translating commitments into comprehensive, system-wide SRHR outcomes.

4.4.3 AU-CEVAWG and the SDGs

i. Areas of Alignment

The AU-CEVAWG and the SDGs (2015–2030) share a strong commitment to advancing gender equality and health rights. AU-CEVAWG's provisions on violence prevention (Article 5), protection of vulnerable groups (Article 7), and survivor-centered services (Article 11) align directly with SDG 5 (Gender Equality), which calls for the elimination of all forms of violence against women and girls, and SDG 3 (Good Health and Well-Being), which emphasizes universal access to health services.

Both frameworks highlight the importance of multi-sectoral collaboration, recognizing that violence and poor SRHR outcomes are interconnected with poverty, inequality, and weak health systems. Additionally, AU-CEVAWG's monitoring provisions (Article 14) align with the SDGs' emphasis on data collection and accountability, ensuring progress can be tracked and reported.

ii. Gaps in AU-CEVAWG

Despite these alignments, AU-CEVAWG leaves critical gaps when compared to the SDGs' comprehensive SRHR commitments.

- AU-CEVAWG does not explicitly guarantee access to family planning and contraception, while SDG 3.7 calls for universal access to sexual and reproductive health services.
- AU-CEVAWG is silent on safe abortion, whereas SDG 3 recognizes the need to reduce maternal mortality, much of which is linked to unsafe abortion.
- AU-CEVAWG does not include comprehensive sexuality education, which SDG 4.7 promotes as part of quality education and empowerment.
- AU-CEVAWG does not explicitly address maternal health outcomes, such as reducing maternal mortality to less than 70 per 100,000 live births (SDG 3.1). Finally, AU-CEVAWG lacks explicit integration with the SDGs' global accountability framework, limiting its ability to leverage international monitoring and financing mechanisms.

Why the Gaps Matter

These are significant because they weaken AU CEVAWG's alignment with the Sustainable Development Goals (SDGs) as a globally agreed framework for health, education, and gender equality outcomes. The absence of explicit guarantees on access to family planning and contraception creates a critical disconnect from SDG 3.7, which calls for universal access to sexual and reproductive health services. This limits the framework's ability to support reproductive autonomy and consistent access to essential preventive services. Similarly, the silence on safe abortion care undermines efforts to reduce maternal mortality under SDG 3, particularly in contexts where unsafe abortion remains a major, preventable cause of death and morbidity among women and girls.

These gaps also constrain AU CEVAWG's preventive and systems-strengthening potential. The exclusion of CSE weakens alignment with SDG 4.7, which emphasizes education as a driver of empowerment and sustainable development, leaving adolescents with limited tools to prevent early pregnancy, exploitation, and harmful practices. In addition, the lack of explicit maternal health targets, including

the reduction of maternal mortality to less than 70 per 100,000 live births under SDG 3.1, reduces the framework's ability to drive measurable health outcomes. Finally, the absence of clear integration with SDG monitoring and financing mechanisms limits accountability, resource mobilization, and cross-sector coordination, ultimately weakening implementation effectiveness at scale.

4.4.4 AU-CEVAWG and CEDAW (1979)

i. Areas of Alignment

The AU-CEVAWG and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW, 1979) share a foundational commitment to protecting women's rights and eliminating gender-based violence. Both instruments recognize violence against women as a violation of human rights and dignity. CEDAW obligates states to eliminate discrimination in healthcare (Article 12) and ensure access to services, including family planning.

AU-CEVAWG (Article 11) aligns with this by mandating survivor-centered services such as medical care, psychosocial support, and legal aid. Both frameworks also emphasize legal accountability, requiring states to adopt laws and policies to prevent violence and protect women's rights. Additionally, AU-CEVAWG's monitoring provisions (Article 14) align with CEDAW's reporting obligations to the UN Committee on the Elimination of Discrimination Against Women, ensuring oversight and accountability.

ii. Gaps in AU-CEVAWG

Despite these alignments, the AU-CEVAWG leaves notable gaps when compared to CEDAW's comprehensive SRHR protections.

- AU-CEVAWG does not explicitly guarantee access to family planning and contraception, while CEDAW requires states to ensure women's access to healthcare services, including family planning.
- AU-CEVAWG is silent on safe abortion, whereas CEDAW's General Recommendation No. 24 clarifies that reproductive rights include access to safe abortion where permitted by law.
- AU-CEVAWG does not include comprehensive sexuality education (CSE), which CEDAW recognizes as essential for eliminating discrimination and empowering women and girls.
- AU-CEVAWG does not explicitly address maternal health outcomes, such as reducing maternal mortality, which CEDAW highlights as a critical component of women's right to health. Finally, AU-CEVAWG lacks explicit integration with global frameworks like CEDAW's monitoring system, limiting its ability to leverage international accountability mechanisms.

Why the Gaps Matter

These gaps are significant because they create a misalignment between AU CEVAWG and the binding normative standards established under CEDAW, which form the cornerstone of women's rights protections in international law. The absence of explicit guarantees on access to family planning and contraception weakens the operationalization of women's right to health, as articulated under CEDAW, and limits consistent access to essential reproductive healthcare services. Similarly, the silence on safe abortion care departs from CEDAW General Recommendation No. 24, which affirms reproductive rights as an integral component of the right to health, including access to safe abortion where legally permitted. This gap undermines the continuity of care required for survivors of sexual violence and restricts the full realization of bodily autonomy.

These omissions are also significant because they weaken both prevention and accountability mechanisms within AU CEVAWG. The lack of comprehensive sexuality education limits alignment with

CEDAW's emphasis on education and empowerment as tools for eliminating discrimination against women and girls, thereby reducing the framework's capacity to address structural drivers of inequality. In addition, the absence of explicit maternal health outcomes, including reductions in maternal mortality, weakens alignment with CEDAW's interpretation of women's right to health as a life-saving obligation. Finally, the lack of integration with CEDAW's monitoring and reporting architecture reduces opportunities for international scrutiny, compliance tracking, and enforcement, ultimately constraining the framework's effectiveness in driving sustained, measurable progress on SRHR and gender equality.

Key Recommendations for Advocacy and Petition

- **Address Maternal Health Outcomes.** Petitions should call for the AU-CEVAWG to explicitly include maternal health indicators such as reducing maternal mortality and ensuring safe delivery services. This would align the Convention with CEDAW's emphasis on women's right to health and strengthen survivor support.

- **Align with Global Frameworks**. Finally, the AU-CEVAWG should be harmonized with CEDAW's monitoring and reporting mechanisms to ensure coherence with global commitments. Advocacy can emphasize that integration enhances accountability, attracts international support, and ensures Africa's commitments are consistent with global SRHR standards.

4.4.5 AU-CEVAWG and International Covenant on Civil and Political Rights (ICCPR)

i. Areas of Alignment

The AU-CEVAWG and the ICCPR share a foundational commitment to protecting human dignity, equality, and the right to life and security. ICCPR obligates states to protect individuals from torture, cruel, inhuman, or degrading treatment (Article 7), which aligns with AU-CEVAWG's provisions on eliminating violence against women and girls (Article 5).

Both frameworks emphasize non-discrimination: ICCPR (Article 2 and 26) requires equal protection under the law, while AU-CEVAWG (Article 7) mandates targeted measures for vulnerable groups such as adolescents, refugees, and women in conflict zones. AU-CEVAWG's monitoring provisions (Article 14) also align with ICCPR's reporting obligations to the UN Human Rights Committee, ensuring accountability. Together, these instruments reinforce the principle that violence against women is not only a social issue but a violation of civil and political rights.

ii. Gaps in AU-CEVAWG

Despite these alignments, the AU-CEVAWG leaves critical gaps when compared to ICCPR's broader human rights protections.

- AU-CEVAWG does not explicitly guarantee bodily autonomy and reproductive choice, while ICCPR's protections of privacy (Article 17) and liberty (Article 9) implicitly safeguard reproductive decision-making.

- AU-CEVAWG is silent on safe abortion and reproductive health services, whereas ICCPR jurisprudence has increasingly recognized denial of reproductive health care as a violation of the right to life (Article 6).

- AU-CEVAWG does not address structural reproductive harms such as coerced sterilization or obstetric violence, which fall under ICCPR's prohibition of cruel, inhuman, or degrading treatment (Article 7).

- AU-CEVAWG lacks explicit provisions on freedom of information and education related to SRHR, while ICCPR (Article 19) protects the right to seek and receive information, a foundation for comprehensive sexuality education.

Why the Gaps Matter

These gaps are significant because they weaken AU CEVAWG's alignment with core civil and political rights under the ICCPR, which provide a foundational human rights lens for bodily integrity and autonomy. The absence of explicit guarantees on bodily autonomy and reproductive choice limits the framework's ability to fully operationalize ICCPR protections related to privacy and liberty, which are essential for safeguarding informed reproductive decision-making. Similarly, the silence on safe abortion and broader reproductive health services creates a critical protection gap, particularly as ICCPR jurisprudence increasingly interprets denial of essential reproductive healthcare as a potential violation of the right to life.

The implications extend further into accountability and protection from abuse. By not explicitly addressing structural reproductive harms such as coerced sterilization and obstetric violence, AU CEVAWG risks falling short of ICCPR standards prohibiting cruel, inhuman, or degrading treatment. In addition, the lack of provisions on access to SRHR-related information and education weakens alignment with the ICCPR's protection of freedom of expression and the right to seek and receive information. Collectively, these gaps reduce the framework's capacity to safeguard autonomy, prevent rights violations, and ensure informed, dignified access to reproductive health services.

iii. Key Recommendations for Advocacy and Petition.

- **Integrate Bodily Autonomy and Reproductive Choice.** Advocacy should push for AU-CEVAWG to explicitly recognize bodily autonomy and reproductive choice as part of survivor protection. This aligns with ICCPR Articles 7, 9, and 17, ensuring that survivors can exercise their rights to privacy, liberty, and freedom from cruel treatment.

- **Include Safe Abortion and SRHR Services.** Civil society should petition for AU-CEVAWG to address unsafe abortion and guarantee access to reproductive health services. This would align the Convention with ICCPR's evolving interpretation of the right to life (Article 6) and strengthen reproductive justice.

- **Address Structural Reproductive Harms.** AU-CEVAWG should incorporate provisions recognizing harms such as coerced sterilization, obstetric violence, and reproductive impacts of FGM/C. Advocacy can highlight that these practices violate ICCPR's prohibition of cruel, inhuman, or degrading treatment (Article 7).

- **Promote Access to SRHR Information and Education.** Petitions should call for AU-CEVAWG to explicitly include access to SRHR information and comprehensive sexuality education. This would align the Convention with ICCPR's protection of freedom of information (Article 19) and empower adolescents to make informed choices.

- **Strengthen Monitoring and Accountability**. Finally, AU-CEVAWG should harmonize its monitoring mechanisms with ICCPR's reporting system, ensuring coherence with global human rights standards. Advocacy can emphasize that integration enhances accountability, attracts international support, and ensures Africa's commitments are consistent with international law.

4.5 Policy-Level Findings.

The AU-CEVAWG is a significant step forward in providing a continental legal framework against violence. It is legally binding and broad in its definitions. However, it lacks explicit SRHR provisions, which are crucial for addressing the full spectrum of needs faced by survivors of gender-based violence. The Convention's comprehensiveness in defining and criminalizing various forms of violence, including emerging threats such as digital violence, demonstrates its adaptability and relevance in today's context. Its requirements for state reporting and monitoring are designed to foster accountability and transparency, positioning it as a strong tool for advocacy and policy reform across the continent.

Despite these strengths, the absence of direct mandates or language around SRHR is a notable limitation. While the Convention obliges governments to criminalize harmful practices and provide support to survivors, it does not require the integration of essential SRHR services, such as access to contraception, emergency medical care, or counseling, into national legal or policy frameworks. This omission is significant because survivors often need comprehensive SRHR support to recover fully and reclaim their autonomy. As a result, the Convention's current scope may fall short of ensuring that all women and girls, particularly those from vulnerable or marginalized groups, receive the holistic care and protection they need.

Furthermore, the language regarding reproductive autonomy in the Convention is less robust than in other frameworks, such as the Maputo Protocol or the Sustainable Development Goals, which explicitly affirm women's rights to make informed choices about their reproductive health. Without clear guarantees of access to services like safe abortion and fertility treatments, the Convention does not fully protect women's decision-making rights or address the broader determinants of health and well-being.

4.6 Implementation-Level Findings

The Convention's implementation faces challenges due to a lack of operational detail. States have a general duty to provide health services, but without clear guidelines, integration of SRHR services into GBV responses is inconsistent. Thus, many health systems may not systematically integrate reproductive health support for survivors unless further directed.

In practice, this means that while member states are expected to respond to gender-based violence, there is no standardized requirement or protocol for including SRHR care as part of that response. The absence of detailed operational guidance often leads to fragmented services, where survivors may receive legal or psychosocial support but lack access to essential reproductive health interventions. This gap is particularly problematic in settings with limited resources or weak health systems, where the lack of clear direction can result in inadequate or inconsistent care.

Additionally, the Convention does not provide tailored strategies for vulnerable and marginalized groups, such as adolescents, people with disabilities, and other marginalised individuals, who may face unique barriers to accessing both protection and SRHR services, hence the risk of perpetuating existing inequalities and failing to achieve its goal of universal rights and support.

While AU-CEVAWG establishes a strong legal foundation and demonstrates a commitment to tackling violence in all its forms, its lack of explicit SRHR integration, weak language on reproductive autonomy, insufficient operational guidance, and limited attention to intersectionality leave critical gaps. Addressing these shortcomings, by aligning more closely with international best practices, developing multisectoral strategies, and setting clear, measurable targets, will be essential to ensure that all survivors receive comprehensive, inclusive care and can fully exercise their rights.

4.7 Strengths and Gaps of AU-CEVAWG

The AU-CEVAWG is a landmark legal instrument aimed at creating a unified and robust continental response to gender-based violence. Its comprehensive framework reflects both progress and areas needing improvement in the pursuit of gender equality and protection of women's rights.

4.7.1 Strengths

AU-CEVAWG stands out for several key strengths that lay the foundation for meaningful change:

- The Convention is a legally binding instrument, offering a strong continental basis for action. This binding nature compels member states to take concrete steps, aligning national laws and policies with the Convention's standards. It provides a shared legal reference point, encouraging consistency and accountability across Africa.

- It defines VAWG broadly, including physical, sexual, psychological, and economic violence. By encompassing a wide spectrum of violence, including emerging forms such as digital violence, the Convention recognizes the evolving nature of threats faced by women and girls. This broad

definition ensures that protections are not limited to traditional forms of violence, but also cover new and increasingly prevalent risks.

- It establishes state obligations, ensuring accountability through reporting and monitoring. The Convention requires member states to criminalize harmful practices, adopt preventive measures, and provide support to survivors. The inclusion of reporting and monitoring mechanisms helps track progress and identify areas needing further attention, fostering a culture of transparency and responsibility.

- It acknowledges emerging forms of violence, such as digital violence, broadening its scope. By recognizing new threats like cyberbullying, online harassment, and digital abuse, AU-CEVAWG demonstrates adaptability and foresight, ensuring its relevance in a rapidly changing technological landscape.

Collectively, these strengths position the Convention as a vital tool for advancing women's rights and establishing a unified approach to combating violence on the continent.

4.7.2 Gaps

Despite its strengths, AU-CEVAWG exhibits several notable gaps that limit its effectiveness, especially regarding SRHR and the intersectional needs of vulnerable groups:

- Lack of explicit SRHR integration: There is no direct mandate for providing SRHR services to survivors. The Convention's provisions focus on violence and harmful practices, but do not require states to integrate essential reproductive health services, such as access to contraception, emergency care, or counseling, into their response frameworks. This omission is critical, as survivors often need comprehensive SRHR support to fully recover and exercise their rights.

- Weak reproductive autonomy language: The Convention mentions coercion but does not guarantee women's decision-making rights. While the Convention condemns coercion in reproductive matters, it stops short of affirming women's rights to make independent, informed choices about their reproductive health. It lacks clear language ensuring access to services like safe abortion, contraception, and fertility treatments, rights that are explicitly protected in frameworks like the Maputo Protocol and Sustainable Development Goals.

- Limited operational guidance: The Convention does not outline how states should implement SRHR care in GBV responses. Member states are given the responsibility to act, but without detailed guidelines or mandatory protocols, implementation is inconsistent. This gap can result in fragmented services and missed opportunities to provide survivor-centered care, particularly in settings with limited resources or weak health systems.

- Inadequate focus on adolescents and intersectionality: Vulnerable groups are acknowledged but not given tailored SRHR measures. The Convention recognizes vulnerable populations, including adolescents, people with disabilities, and other marginalised individuals, but does not provide specific strategies or resources to address their unique needs. Without tailored interventions, these groups may continue to face barriers to accessing protection and reproductive health services, undermining the Convention's goal of universal rights and support.

AU-CEVAWG's legal strength and broad definitions create a foundation for progress, but its lack of explicit SRHR integration, weak reproductive autonomy protections, limited operational guidance, and insufficient focus on intersectionality leave critical gaps. Addressing these issues, by adopting best practices from the Maputo Protocol and SDGs, integrating multisectoral strategies, and setting clear targets, will be essential for ensuring that survivors receive comprehensive, inclusive care and that all women and girls can fully exercise their rights.

5. 7. Recommendations

Based on the analysis, the following actionable recommendations are offered to address the implementation gaps and strengthen the integration of SRHR within responses to gender-based violence. These recommendations are tailored for governments, CSOs, and development partners, emphasizing multisectoral collaboration and prioritizing vulnerable groups.

7.1 For Governments

- **Integrate SRHR Services into National Laws:** Governments must ensure that SRHR services, such as family planning, maternal care, and post-violence reproductive care, are embedded within national GBV response frameworks. This integration should be reflected in legislation, policy, and implementation protocols, making SRHR a non-negotiable element of survivor support. By codifying these requirements, governments can create accountability mechanisms and ensure that health systems consistently provide comprehensive services, including contraception, safe abortion, emergency medical treatment, and counseling as part of GBV response.

- **Develop Operational Guidelines:** Governments need detailed, practical guidelines to implement integrated care. These guidelines should outline step-by-step procedures for health, justice, and social service providers, ensuring SRHR services are delivered alongside GBV interventions. Operational guidance should include standardized protocols for referral, follow-up, and monitoring, and be adapted to the needs of diverse populations, including those in resource-limited settings. Training and capacity building for frontline workers are crucial to operationalize these protocols effectively.

- **Prioritize Adolescents:** States must design and implement youth-friendly SRHR programs, ensuring adolescents have access to age-appropriate services and education. This includes confidential counseling, reproductive health information, and tailored medical care that addresses the unique risks and challenges faced by young people affected by GBV. Governments should collaborate with schools, youth organizations, and health providers to create safe spaces for adolescents to seek help and access services without fear of stigma or discrimination.

- **Address Needs of Marginalized Groups:** Governments should develop targeted strategies and allocate resources for vulnerable populations such as people with disabilities, other marginalised individuals, and ethnic minorities. This includes removing legal and practical barriers to access, training health workers on inclusive care, and ensuring policies explicitly protect and support these groups.

- **Set Measurable Targets and Monitor Progress:** Governments should establish clear, measurable objectives for SRHR integration in GBV responses, track progress through data collection and reporting, and regularly evaluate outcomes to ensure continuous improvement.

7.2 For Civil Society Organizations.

- **Advocacy for SRHR Inclusion:** CSOs should advocate for explicit inclusion of SRHR services in national implementation plans, ensuring that these are not left as a secondary concern. This advocacy can include policy dialogue, lobbying, and awareness campaigns, highlighting the importance of reproductive health for survivors of violence. CSOs can also push for legal reforms and budget allocations to support SRHR integration.

- **Monitor Implementation:** Civil society must track progress, collect data, and publish findings to ensure accountability. Monitoring should include evaluating the availability and quality of SRHR services for GBV survivors, identifying gaps, and advocating for corrective action. CSOs can partner with academic institutions and local communities to conduct participatory research and share evidence-based recommendations.

- **Community Engagement:** CSOs should raise awareness at the grassroots level, educating communities on how VAWG affects SRHR and what services should be sought. Community engagement should include outreach to marginalized groups, using culturally appropriate messaging and peer educators to build trust and reduce stigma associated with seeking SRHR services.

- **Build Coalitions for Change:** CSOs should form coalitions with other stakeholders, including government agencies and development partners, to amplify their advocacy and share resources for greater impact.

7.3 For Development Partners

- **Fund Integrated Programs:** Partners should invest in programs that address both VAWG and SRHR needs, ensuring holistic survivor care. Funding should prioritize multisectoral approaches, supporting collaboration between health, justice, and social services. Resources should also be directed toward underserved regions and populations to reduce disparities.

- **Provide Technical Assistance:** Development partners should offer technical support to build capacity within health and justice systems, ensuring integrated care pathways. This includes training, mentoring, and sharing best practices for SRHR and GBV response, as well as supporting the development of operational guidelines and monitoring systems.

- **Strengthen Data Systems:** Partners should support the collection of both VAWG and SRHR data, ensuring that policy decisions are evidence-based and outcomes are tracked. This involves developing robust data systems, training staff in data management, and promoting transparency and accountability. Accurate data is essential for identifying gaps, measuring impact, and informing resource allocation.

- **Promote Innovation and Research:** Development partners should encourage innovative approaches to SRHR and GBV integration, supporting pilot projects, research, and evaluation to identify effective models and scale up best practices.

Collectively, these expanded recommendations call for a coordinated, inclusive, and evidence-based approach to integrating SRHR into GBV responses. By acting on these recommendations, stakeholders can close gaps in care, promote universal access to reproductive health services, and uphold the rights and dignity of all survivors.

6. Conclusion

In conclusion, the AU-CEVAWG is a landmark continental instrument providing a comprehensive legal framework against violence; however, its potential to improve SRHR outcomes is constrained by insufficient integration of reproductive health rights. While the Convention is legally binding and provides a foundation for accountability, its success will depend on stronger operationalization of SRHR services, especially for adolescents and vulnerable groups. Linking explicitly violence and SRHR, AU-CEVAWG can drive both policy coherence and improved health outcomes across the continent.

As we look to the future, the AU-CEVAWG stands as a significant milestone in the African human rights landscape. However, its full potential will only be realized if SRHR considerations are fully integrated into violence prevention and response. To unlock the transformative power of the AU-CEVAWG, all stakeholders, including governments, CSOs, and development partners, must prioritize the explicit inclusion of SRHR in both policy and practice. This means moving beyond treating SRHR as an afterthought and instead embedding it at the core of national implementation plans, legal reforms, and budget allocations. Their efforts should extend to monitoring the availability and quality of SRHR services for survivors of GBV, identifying gaps, and pushing for corrective action through evidence-based recommendations.

Equally important is the engagement of communities, especially at the grassroots level, to ensure that survivors, particularly those from marginalized groups, understand their rights and have access to

culturally appropriate, stigma-free services. Building coalitions with government agencies, academic institutions, and development partners can amplify advocacy efforts and promote shared learning, resource mobilization, and coordinated responses.

For development partners, supporting integrated programs that address both VAWG and SRHR needs is essential for holistic survivor care. This includes providing technical assistance to strengthen health and justice systems, developing robust data systems for tracking outcomes and informing policy, and promoting innovation and research to identify and scale effective models of integration.

Finally, the promise of the AU-CEVAWG lies in a coordinated, inclusive, and evidence-based approach that ensures universal access to quality reproductive health services and upholds the rights and dignity of all survivors. These expanded recommendations if acted upon, can close persistent gaps in care, reduce disparities, and contribute to a safer, healthier, and more equitable future across Africa.

7. Appendices

Annex 1:

1. *UNHCR, "Uganda GBV Statistics in Refugee Settlements, 2025."*
2. *WHO, "Violence Against Women and HIV Risk in Sub-Saharan Africa, 2025.*
3. *UNICEF, "Child Marriage in Malawi: Country Profile, 2025."*
4. *UNODC, "Global Study on Homicide: Gender-Related Killings of Women and Girls, 2025."*
5. *WHO, "Violence Against Women and HIV Risk in Sub-Saharan Africa, 2025."*
6. *UNFPA Uganda, Adolescent Pregnancy Report, 2025.*

7. *SADC SRHR Scorecard, 2025.*
8. *UNAIDS, Global AIDS Update 2025.*
9. *UNFPA, Adolescent Sexual and Reproductive Health in Nigeria, 2025.*
10. *African Union. The African Union Convention on Ending Violence Against Women and Girls (AU-CEVAWG). Adopted February 2025. Full text available via the African Union legal instruments portal.*
11. *African Union. Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol). Adopted July 2003, entered into force November 2005.*
12. *United Nations. Transforming Our World: The 2030 Agenda for Sustainable Development. Adopted September 2015, including the 17 Sustainable Development Goals.*
13. *United Nations. Beijing Declaration and Platform for Action. Adopted at the Fourth World Conference on Women, Beijing, 15 September 1995.*
14. *United Nations Population Fund (UNFPA). Programme of Action of the International Conference on Population and Development (ICPD). Adopted Cairo, 5–13 September 1994.*
15. *United Nations. International Covenant on Civil and Political Rights (ICCPR). Adopted 16 December 1966, entered into force 23 March 1976.*

Annex 2: Document Review Matrix

Section of Convention	Provision Summary	SRHR Relevance	Strengths	Gaps/Limitations	Alignment with Frameworks	Recommendations
Definitions of Violence	Defines violence broadly (physical, sexual, economic, psychological)	Links multiple forms of violence to SRHR risks	Broad, inclusive definition of violence	Does not explicitly tie violence definitions to SRHR outcomes	Maputo Protocol, CEDAW link violence to health risks	Explicitly integrate SRHR impacts in violence definitions
Sexual Violence	Criminalizes sexual violence (rape, assault, exploitation)	Direct impact on unintended pregnancies, STIs, mental health	Strong legal grounding for prosecution	Lacks provisions for post-violence SRHR services (e.g., emergency contraception)	Maputo Protocol guarantees access to medical services	Add a requirement for post-rape SRHR care in national laws
Harmful Practices	Criminalizes FGM, child marriage	Links to reproductive harms (e.g., early pregnancy, maternal risks)	Recognizes harmful practices as gender inequality drivers	Does not explicitly connect practices to long-term SRHR outcomes	Maputo Protocol, Beijing Platform link practices to SRHR	Strengthen the link between harmful practices and SRHR outcomes
Health Services	Access to healthcare for survivors	Critical for SRHR care (contraception, maternal health)	General call for healthcare support	Lacks specificity on SRHR services integration	WHO/ICPD emphasize integrated SRHR care	Require SRHR services as part of health support frameworks
Rights & Autonomy	Protection from	Central to reproductiv	Affirms protectio	Does not explicitly affirm	CEDAW, ICPD	Add explicit language on

	coercion and exploitation	e autonomy, decision-making	n from coercion	reproductive decision-making rights	affirm autonomous reproductive choices	reproductive autonomy rights
Accountability	State obligations, reporting mechanisms	Essential for enforcing SRHR commitments	Clear state reporting and monitoring mechanisms	No SRHR-specific indicators or monitoring tools	SDGs provide measurable SRHR targets	Develop SRHR-specific indicators for accountability frameworks

Annex 3: Comparative Framework Matrix

SRHR Component	AU-CEVAWG	Maputo Protocol	CEDAW	Gaps Identified	Implications
Reproductive Rights	Implicit; mentions gender equality, but no explicit SRHR rights	Explicitly guarantees reproductive rights, including safe abortion	Explicitly affirms women's right to decide freely on childbearing	Weak explicit recognition of reproductive rights	Without explicit SRHR rights, reproductive autonomy remains under-emphasized
Safe Abortion	Not addressed in detail	Permitted under specific circumstance	Indirectly supported but not explicit	Major omission; no explicit abortion care guarantee	Survivors may lack access to safe reproductive care in cases of violence
Contraception Access	Not specified	Explicitly supported	Supported under women's health rights framework	Limited operational clarity on access	Without clear mandates, contraception access remains inconsistent
Adolescent SRHR	Minimal focus	Recognized as a priority population	Recognized but not detailed	Weak focus on adolescents, missing tailored services	ICPD, CEDAW prioritize youth SRHR. Add adolescent-specific SRHR services and education pathways
GBV Response Services	Legal focus; no SRHR integration	Health and legal integration of care services	Emphasizes health and legal access	Weak integration of health in GBV response	SDGs and ICPD call for integrated care. Mandate integrated SRHR services in GBV support systems

Annex 4: SRHR Assessment Framework

Domain	Key Questions	Indicators	Rating	Evidence Source
Reproductive Autonomy	Does the Convention guarantee reproductive autonomy?	Presence of explicit autonomy language	Low	AU-CEVAWG text
Access to Services	Are SRHR services explicitly included?	SRHR service provisions in health support	Low	AU-CEVAWG vs. WHO guidelines
Equity & Inclusion	Are vulnerable populations addressed (e.g., adolescents)?	Inclusion of marginalized groups	Medium	AU Gender Strategy
Harmful Practices	Are harmful practices addressed and linked to SRHR?	FGM, child marriage provisions	High	AU-CEVAWG text
Accountability	Are there clear monitoring mechanisms?	State reporting frameworks	Medium	AU reporting mechanisms

Annex 5: Thematic Coding Matrix

Theme	Sub-Themes	Description	Example Evidence
SRHR Integration	Reproductive rights	Limited SRHR language in Convention	Absence of explicit SRHR provisions
Violence Types	Sexual violence	Strong legal recognition of sexual offenses	Criminalization of rape and assault
Gaps	Missing SRHR services	No post-violence SRHR care outlined	Lack of guidance on integrated reproductive care
Equity	Vulnerable groups	Partial focus on marginalized populations	Limited tailored services for adolescents
Implementation	Enforcement	Legal provisions stronger than practical guidance	Weak operationalization in health systems

Annex 6: Stakeholder Mapping Matrix

Stakeholder	Role	Interest Level	Influence Level	Engagement Strategy
AU Bodies	Policy formulation	High	High	Policy dialogues, technical input
Ministries (Health, Gender)	Implementation of national laws	High	High	Legislative integration, capacity building
Development Partners	Funding & technical support	High	High	Joint programming, financial assistance
Civil Society	Advocacy, service delivery	High	Medium	Advocacy campaigns, policy monitoring