AFRICA CENTRE
FOR HEALTH SYSTEMS
AND GENDER JUSTICE

POLICY BRIEF
SRHR IN AFRICA
2026

SEXUAL & REPRODUCTIVE HEALTH AND RIGHTS IN AFRICA

Whether women can act on their rights — not whether services exist — should measure SRHR progress

SRHR policy has concentrated on a familiar set of services. But access alone says little about whether women and girls have the time, resources, safety and power to exercise bodily autonomy.

STRUCTURAL DETERMINANTS | BODILY AUTONOMY | EQUITY-FIRST POLICY

EXECUTIVE SUMMARY

SRHR policy in Africa has traditionally concentrated on maternal health, contraception, HIV, adolescent pregnancy and gender-based violence. These priorities remain urgent. Yet their dominance has produced a narrow understanding of SRHR that focuses on particular services, conditions and reproductive moments while overlooking the wider realities that determine whether women and girls can exercise bodily autonomy and attain reproductive wellbeing.

Several dimensions remain insufficiently visible within policy, financing, service delivery and research: menstrual and gynaecological health beyond

menstrual products; the effect of unpaid care work and time poverty on healthcare access; the practical relationship between women's economic agency and reproductive autonomy; and the growing effect of technology-facilitated gender-based violence on access to information, advocacy and participation.

Their neglect lies in their fragmentation. Menstrual health is separated from clinical care. Unpaid care is treated as an economic issue rather than a health-access barrier. Economic empowerment and SRHR are financed through separate programmes. Digital violence is approached as a technology concern rather than a threat to bodily autonomy and rights-based participation. Addressing these gaps requires moving beyond measuring the availability or uptake of services to ask whether women have the time, resources, safety, information, social power and responsive health systems needed to act on decisions about their bodies and health.

The policy problem

Progress in SRHR cannot be measured only by the number of clinics, commodities distributed or women reached with information. Service availability does not automatically translate into meaningful access.

A woman may live near a healthcare facility yet be unable to attend because she cannot leave children or dependent relatives. She may know contraception is available but lack the financial or household power to obtain it. She may experience disabling menstrual pain but be told that suffering is normal. She may rely on digital platforms for reproductive health information while facing harassment, surveillance or the non-consensual circulation of personal information.

This shows how health systems, household economies, social norms, technology and gendered power interact to shape SRHR. **The central failure is not always the absence of attention — it is the failure to connect the different conditions that determine whether rights can be exercised in practice.**

01 Menstrual and gynaecological health beyond hygiene

Menstrual health is one of the clearest neglected dimensions of SRHR. Although menstruation has received increasing attention, many programmes still define the issue primarily through menstrual products, sanitation facilities and school attendance.

These interventions matter, but they do not represent the full spectrum of menstrual health. Painful menstruation, heavy or irregular bleeding and other changes may be associated with endometriosis, adenomyosis, fibroids, bleeding disorders or polycystic ovary syndrome. Yet women and girls are frequently socialised to consider pain and disruption normal, while providers may minimise symptoms, offer repeated short-term pain relief, or lack the training and diagnostic resources to identify underlying conditions.

The consequences extend beyond physical discomfort to mental health, fertility, sexual wellbeing, school attendance, income, employment and participation in family and community life. Diagnostic delays are common for conditions such as endometriosis, while many people with polycystic ovary syndrome remain undiagnosed (WHO, 2025a, 2026a).

Menstrual health must be repositioned as a health-systems, labour-rights and human-rights issue — not only a hygiene concern, and understood across the life course, from adolescence through perimenopause and menopause. SRHR does not begin with sexual activity or end with childbirth.

POLICY IMPLICATIONS

Governments and health systems should:

- Incorporate menstrual history, pain and abnormal-bleeding assessment into primary, adolescent, family-planning and routine reproductive-health care.
- Develop clear referral pathways for suspected endometriosis, fibroids, PCOS, anaemia and other conditions.
- Train providers to treat menstrual pain and abnormal bleeding as legitimate clinical concerns.
- Include menstrual and gynaecological conditions in national health-benefit packages and essential-service planning.
- Collect data on diagnosis, treatment delays, out-of-pocket cost and the social and economic consequences of untreated conditions.

02 Unpaid care work and time poverty

Women and girls perform a disproportionate share of childcare, domestic labour and care for people who are ill, older or living with disabilities. These responsibilities are often unpaid, socially expected and largely invisible within health-system planning. For many women the principal barrier to healthcare is not distance or cost — it is the inability to leave care responsibilities, close a small business, travel during clinic hours, or spend an uncertain amount of time waiting.

The burden is greatest for women in rural areas, informal settlements and low-income households, where limited transport, water, sanitation, childcare and social protection increase the time needed to sustain households. Yet SRHR access assessments rarely measure time poverty. Missed appointments may be recorded as poor utilisation without examining the care responsibilities that made attendance impossible, so services are designed around institutional convenience rather than women's daily realities.

Unpaid care work is not only an economic or household concern — it is a structural determinant of health access.

POLICY IMPLICATIONS

Health systems should:

- Extend service hours and offer flexible appointment systems.
- Strengthen mobile, community-based and outreach services; cut waiting times and unnecessary repeat visits.
- Integrate services so women can obtain several forms of care in one visit.
- Explore safe childcare at high-volume facilities and community health events.
- Include unpaid care and time use in SRHR access assessments; strengthen social protection, transport and community care.

03 Economic agency and reproductive autonomy

Women's financial resources and control over household decisions influence whether they can pay for transport, obtain medicines, seek confidential care or make reproductive decisions without coercion. Education, household wealth, employment, financial autonomy, partner attitudes and access to acceptable healthcare all interact to shape SRHR decision-making (UNFPA, 2019).

This relationship is not entirely neglected in research, but it remains poorly translated into programme design. Economic-empowerment initiatives often measure income, savings, credit and enterprise growth without examining healthcare access, bodily autonomy, exposure to violence or reproductive decision-making. SRHR programmes, in turn, may provide information and services without addressing the economic dependence that prevents women from acting on them.

Integrated programming must avoid treating economic empowerment as an automatic solution. Increased income does not necessarily produce autonomy and may, in some cases, create household conflict or increase exposure to violence. Programmes must ask who controls income, how decisions are made, whether women can retain and use earnings, and whether economic change is paired with social-norm and violence-prevention work.

Economic agency must complement, not replace, public investment in accessible and affordable healthcare. The objective is not to make women individually responsible for purchasing rights that governments should guarantee.

POLICY IMPLICATIONS

Funders and implementers should:

- Include SRHR access, reproductive autonomy and health expenditure in economic-empowerment monitoring frameworks.
- Incorporate financial capability, savings, social protection and market access into programmes serving women facing SRHR barriers.
- Assess whether women control the income generated through empowerment programmes.
- Build in safeguards and referral for women who face violence or backlash after gaining economic power.
- Invest in implementation research comparing integrated models of economic agency, SRHR and gender-transformative engagement.

04 Technology-facilitated gender-based violence

Digital platforms increasingly shape how women and girls obtain health information, seek services, mobilise communities and participate in public debates about abortion, contraception, sexuality, gender-based violence and comprehensive sexuality education. These opportunities carry significant risks. Technology-facilitated gender-based violence can include harassment, cyberstalking, impersonation, doxxing, sextortion, image-based abuse, hacking and coordinated disinformation. Violence may begin online and escalate offline, and the threat of abuse may cause women to withdraw, self-censor or avoid seeking sensitive information and services (UNFPA, n.d.).

For advocates, providers, journalists and grassroots women leaders, digital attacks restrict participation and weaken accountability. For service users, poor privacy and data-security practices can expose information about pregnancy, contraception, HIV status, abortion, sexual orientation or experiences of violence. The evidence base in African contexts remains limited, which calls for careful research rather than exaggerated claims.

Technology-facilitated violence is not only a digital-rights issue — it is an emerging barrier to health information, bodily autonomy, confidentiality and SRHR advocacy.

POLICY IMPLICATIONS

Governments, funders, technology companies and SRHR organisations should:

- Integrate digital safety and data protection into SRHR programming; strengthen protection of sensitive health and personal data.
- Establish survivor-centred reporting, psychosocial support and referral mechanisms.
- Train advocates, community organisations and providers in digital-security practices.
- Require digital-health platforms to build in privacy, consent and safety by design.
- Document the impact of digital violence — and ensure legal responses protect survivors without expanding surveillance or restricting legitimate expression.

Gender norms: cross-cutting, not neglected

Gender norms, partner influence, household power and reproductive decision-making remain central to this analysis — but they should not be presented as a separate neglected field. Substantial research and programming already recognise the role of gender norms in shaping contraceptive access, sexual relations and healthcare decisions, and global frameworks increasingly measure women's ability to decide about sexual relations, contraception and reproductive healthcare.

The continuing challenge is not recognition but implementation. Programmes must move beyond awareness campaigns to engage the institutions and relationships through which power is exercised — households, healthcare facilities, faith institutions, community leadership and economic systems. **Gender norms should operate as a cross-cutting lens across menstrual health, care work, economic agency and digital participation.**

A policy agenda for neglected SRHR

African governments, regional institutions, development partners and civil-society organisations should adopt six priorities.

01

Expand the meaning of SRHR

Include menstrual and gynaecological health, chronic reproductive conditions, infertility, menopause, sexual wellbeing and the structural conditions that shape bodily autonomy.

02

Design services around women's realities

Account for care responsibilities, informal employment, transport constraints, disability, safety and time poverty.

03

Integrate rather than fragment

Economic empowerment, gender justice, social protection, digital rights and SRHR should share outcomes and referral pathways while keeping specialised expertise.

04

Strengthen primary healthcare

Equip primary providers to recognise menstrual and gynaecological conditions, manage first-line care and refer in time.

05

Protect participation and privacy

Safeguard data, confidentiality, consent and the ability of women and girls to participate in digital health and advocacy without violence.

06

Finance implementation research

Move beyond describing barriers — test practical models, identify what works in context, and establish how to sustain it within public systems.

Conclusion

The neglected dimensions of SRHR are not always new issues. Many are longstanding realities dispersed across health, economic justice, care, technology and gender-equality agendas. A more comprehensive framework must ask not only whether services exist, but whether women and girls can reach them, afford them, trust them and decide about their use. It must recognise pain that has been normalised, time that has been taken for granted, economic dependence that restricts choice and digital violence that silences participation. **The next phase of SRHR policy in Africa must move from fragmented interventions towards systems that recognise women's lives in their entirety.**

References

United Nations Population Fund. (2019). *Research on factors that determine women's ability to make decisions about sexual and reproductive health and rights: Volume I.* UNFPA.

United Nations Population Fund. (n.d.). *Technology-facilitated gender-based violence: A growing threat.* UNFPA.

UN Women. (2023). *Gender, unpaid care and social protection: Policy priorities for West and Central Africa.* UN Women Regional Office for West and Central Africa.

World Health Organization. (2022, June 22). *WHO statement on menstrual health and rights.* WHO.

World Health Organization. (2025a, October 15). *Endometriosis.* WHO.

World Health Organization. (2025b). *Social and behaviour change interventions for contraception and family planning.* WHO.

World Health Organization. (2026a, January 22). *Polycystic ovary syndrome.* WHO.

World Health Organization. (2026b). *Menstrual health.* WHO.