SEXUAL & REPRODUCTIVE RIGHTS IN AFRICA (SRRA) Digest

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THE EDITORIAL

The second edition of the Sexual and Reproductive Rights in Africa (SRRA) Digest has been compiled in honour of the 10th Anniversary of the SRRA Programme that is housed within the Centre for Human Rights, University of Pretoria. As such, the editorial team has decided to include profiles of alumni from the programme, some of whom have gone on to forge careers in human rights and even specifically in sexual and reproductive health and rights (SRHR). This is a testament to the relevance of the programme, and serves as motivation for its continuance.

On a more sombre note, however, the current state of the world, and very significantly the African region provides a stark reminder that it is not time to be comfortable or complacent as the rise of poly-crises in the form of conflicts and climate shocks infiltrate and loom. Not only have they taken seizure of parts of the region, but they continue to create increased volatility, instability, as well

as vulnerability even concerning SRHR. Furthermore, the penetration of anti-rights mobilisation continues to take a dangerous turn, threatening to deter women's rights, agency and autonomy within the African region and the rest of the Global South, as well as jeopardising the realisation of the rights of LGBTQ+ persons.

The need to arm scholars, activists and advocates with the knowledge and tools to influence policy, and law has never been more urgent. In addition, they must assist in upholding the tenets of human rights mechanisms such as the Protocol to the African Charter on the Rights of Women in Africa (Maputo Protocol), or popularise the aspirations of the International Conference on Population and Development Programme of Action (ICPD POA), both of which, amongst other instruments, accord reverence to the realisation of SRHR.

As we prepare to welcome the 10th cohort of the programme in the year 2025, we are therefore reminded that part of the intention of the SRRA Programme is not simply to achieve academic excellence, and churn out graduates. The purpose of the programme is also to have an impact and to contribute to creating societal shifts. We are proud to state that the development of the SRRA Digest was not only inspired by the SRRA Programme, but is also a testament to the Centre for Human Rights' commitment to the advancement of SRHR discourse and practice on the African continent.

Co-editors:

Maryanne Nkechi Obiagbaoso and Yumba Bernadette Kakhobwe

Feature Articles

Case analysis
Case:

County Government of Bungoma & 2 Others v. Josephine Oundo Ongwen (a.k.a. Josephine Majani) & 2 Others (Kenya Civil Appeal No. 61 of 2018)

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Introduction

The first socio-economic right that the Constitution of Kenya 2010 guarantees is the right to the highest attainable standard of health, which includes the right to healthcare services, including reproductive healthcare. This right is available to every person, and the use of the term "every person" is not accidental, as other rights refer to 'every citizen', such as political rights under Article 38 of the Constitution. The essence of the right to reproductive healthcare is thus recognised, and the state must ensure its enforcement. To foster the implementation of reproductive healthcare, on 1 June 2013, the government passed a directive that public health facilities were obligated to offer free maternity healthcare services. This directive recognised the high maternal mortality rate in Kenya which was at 488 deaths per 100,000 live births due to birth complications that are not treated because of lack of access to skilled healthcare personnel. Further, the directive was in line with the Millennium Development Goals (MDGs) with targets including eradication of poverty.

In the analysis below, the right to maternal healthcare is discussed in the context of patient care and child-birth. The setting is a public hospital, where these services are to be offered freely, considering the rights of every person visiting the hospitals, particularly mothers-to-be. The overall treatment of patients, from physical welfare to emotional aspects of healthcare service provision is highlighted in the case which affirmed the right to quality reproductive healthcare as mandated by the Constitution of Kenya 2010.

Case history

The matter is an Appeal from the judgement of the High Court of Bungoma, Kenya dated 22 March 2018. The main issues before the trial court were as follows:

a. Whether the petition before the court was competent;

b. Whether the petitioner's rights to health, information and dignity had been violated;

c. Whether the national and county governments failed to allocate sufficient resources to the provision of healthcare services which resulted in a violation of the petitioner's rights.

The High Court ruled in favour of Josephine and affirmed that her rights were violated and as a result she was awarded damages worth Kshs. 2,500,000.

Dissatisfied, the County Government of Bungoma (1st Appellant), the Bungoma County Cabinet Secretary for Health (2nd Appellant) and Bungoma County Referral Hospital (3rd Appellant) lodged the Appeal subject of this analysis before three Court of Appeal Judges; Kiage, Tuiyott and Joel Ngugi JJ.A.

a. The Appeal challenged the High Court decision on three major grounds;

b. That the evidence on record was insufficient for the court to find that Josephine's rights had been violated;

c. That the findings of the constitutional and human rights violations were unsound given the progressive nature of the right to health; and

d. That the damages awarded to Josephine were excessive based on the circumstances of the case.

Facts

The Respondent in the Appeal was (Josephine Oundo Ongwen, also known as Josephine Majani), a woman from a marginalised socio-economic setting. Josephine Majani was admitted to the Bungoma District Hospital (the third Appellant) on 8 August 2013 because she needed maternal

healthcare services. At the time of her admission to Bungoma District Hospital, which is located in the western region of Kenya, a rural area characterised by lower income levels, where she was experiencing delayed labour, as she was past her 'due date'.

While at the hospital, Josephine was seen by Dr Wekesa who advised that since she was past her 'due date' she should undergo a medical procedure known as 'inducement.' However, due to a shortage of space in the hospital, she was forced to share a bed with another patient. The nurses further informed her that she would have to walk from the labour ward to the delivery ward. The inducement drug was administered to Josephine, and she eventually gave birth on the hospital corridor floor on her way to the delivery room.

Josephine had to then purchase cotton wool that would be used for perineal care after birth and the inducement drug for it to be administered to her despite the Presidential Directive for free maternity care. When she was induced, the nurses did not check and monitor her progress and when she sought help, the nurses ignored her pleas. When a nurse finally attended to her, Josephine was told that she was not due for delivery without conducting a physical examination.

Due to the intensity of the labour pains, she was forced to walk to the delivery room. As she attempted to go back to the labour ward, she passed out. She regained consciousness and heard shouts, and insults followed by physical assault from the nurses who were displeased that she had given birth on the floor. The nurses at the hospital physically and verbally abused Josephine when they found her on the corridor floor. These actions by the nurses amounted to the neglect of Josephine.

She was ordered to carry her placenta and walk to the delivery room to have it expelled. She did not have a clear recollection of what happened until she viewed the feature

on Kenya Television Network (KTN) and recognised herself. The Centre for Reproductive Rights then instituted a suit at the High Court seeking a declaration of her rights, damages for the violation of her rights and orders compelling the respondents to monitor the quality of healthcare provided in the healthcare facilities to promote maternal healthcare.

The appellants denied violating Josephine's rights, alleging that during the period of her admission at the hospital, she did not raise any complaint and that the allegations were far-fetched. They argued that the evidence aired by KTN was not properly entered as part of the evidence.

At the High Court, the trial judge held that the physical and verbal abuse of Josephine the Petitioner by the hospital violated her right to dignity, right to be free from torture, cruel and inhuman and degrading treatment.

The High Court further held that the neglect of Josephine was a failure on the part of the County and National Government to ensure healthcare services are of quality standard and available. The High Court further held that the mistreatment of Josephine was a violation of her right to dignity, and the right to be free from torture, and cruel, inhuman and degrading treatment.

In terms of remedies available for the violation of Josephine's rights as highlighted above, the High Court directed the County Government of Bungoma, and the Bungoma Referral Hospital to offer an apology to Josephine. Furthermore, an award of Kshs. 2,500,000 was granted as compensation.

Issues on appeal

At the Court of Appeal, the Court framed the following issues for determination:

a. Whether there was sufficient evidence to warrant the court's findings that Josephine's rights had been violated;

b. Whether the findings of constitutional and human rights violations were sound considering that the right to health was progressive

c. Whether the damages awarded were excessive in the circumstance.

Analysis and determination

The County Government of Bungoma and the Bungoma Referral Hospital argued that the video clip from KTN was wrongfully admitted into evidence and it should be ignored. They further argued that the petitioner's case at the trial court was contradictory and insufficient to warrant the findings of the High Court.

The Court of Appeal held that Josephine had demonstrated on a balance of probability that she was admitted to the hospital where she had to purchase her drugs and cotton wool despite the government policy and Presidential Directive of free maternity service. Josephine gave birth on the floor of the hospital corridor without assistance. Furthermore, she was physically and verbally abused by the two nurses and was forced to carry her placenta to the delivery room. Additionally, she was not informed of any procedure for filing complaints or grievances.

On the issue of the right to health being a progressive right, the Court of Appeal stated that every woman is entitled to respectful maternal care during childbirth as part of the right to health under Article 43 of the Constitution of Kenya 2010. The Court further emphasised that the right to respectful maternal healthcare includes;

a. Right to be free from physical violence and verbal abuse during labour and childbirth;

b. Right to be free from discrimination during labour and childbirth;

c. Right to dignified and respectful care which entails

the right to be granted acceptable levels of privacy and confidentiality during labour and childbirth.

On progressive realisation of the right to health, the Court stated that the Appellants could argue on issues of availability of drugs, hospital beds and even medical personnel. However, the Court further clarified that a human rights-based approach to maternity care commanded by a purposive reading of Article 43 of the Constitution of Kenya 2010 does not only include the clinical components, but also ensures positive and affirming care experiences for women during childbirth.

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The Court of Appeal emphasised that every woman has a right to dignified and respectful care throughout pregnancy and childbirth. The Court further reprimanded the Appellants for failure to establish a human rights-based approach to clinical protocols for women during childbirth. It therefore concluded that the Appellants denied Josephine the right to enjoy the highest attainable standard of physical and mental health, including her sexual and reproductive health.

On damages, the Court of Appeal stated that the Appellants did not give any reasons why they found the damages excessive. The Court emphasised that the award of Kshs.2,500,000 to Josephine for all the indignity she suffered at the hands of the Appellants is insufficient to cover the emotional trauma she suffered. Kiage JA and Tuiyott JA agreed with the judgement of Joel Ngugi JA. Kiage JA emphasised that no mother should go through that traumatic experience and that the government must

ensure a functional system of health including maternal healthcare.

Consequently, the Appeal was dismissed and the decision of the High Court was upheld in its entirety.

Significance

This case highlighted the extent of violations of the rights of women within the healthcare system in Kenya, particularly during labour and childbirth at the hands of medical personnel who are expected to take care of expectant women. The following issues arise from this decision;

a. Time taken in appeal

The matter was filed at the High Court in 2014 and the judgement issued in March 2018. The Appeal was lodged in 2018 and a final decision was made in February 2024. This amounts to a total of ten years in litigation to assert the right to reproductive healthcare in Kenya. It can be observed with concern that the amount of time spent in Court in such cases is too long, and sadly, this is the situation for most people. 'Justice delayed is justice denied' and unfortunately for Josephine this is a lived reality.

b. Obstetric violence

The case depicts a true picture for women seeking public health services in facilities claiming to offer maternal healthcare in Kenya. The mistreatment and abuse of women and their rights is rife and clear as highlighted in the case. Women seeking maternal healthcare are a matter of concern but are mistreated during labour and childbirth.

The Court of Appeal reiterated that women have a right to be treated respectfully and in a dignified manner during labour and childbirth. It emphasised that women have a right to acceptable levels of privacy. Josephine was not accorded

these rights when she gave birth on the floor.

Josephine was further verbally and physically assaulted which was a violation of her right to dignity and the right to be free from torture, cruel, inhuman and degrading treatment. The Court of Appeal's decision signifies a step in the right direction on the standard permissible under the Constitution of Kenya 2010, regarding reproductive healthcare. This is because it recognised that the violence meted out during labour and childbirth constitute acts of violence against women hence a violation of their human rights.

c. Progressive realisation of the right to health

The Court of Appeal further pronounced itself on the issue of progressive realisation of the right to health. Based on the decision it is evident that the progressive realisation of the right to health does not permit the mistreatment of women during labour and childbirth, it only applies to the issues of allocation of resources. The court also urged the health facility to encourage a human rights-based approach to the clinical protocols. This will ensure that women are treated respectfully and with dignity during pregnancy, labour and childbirth.

Additionally, the court's decision highlighted the failure to implement the recommendation for the allocation of 15% of the national budget to the healthcare sector as per Resolution 135. As a result of the strained budgets, there was an inadequacy of beds and nurses at the hospital to cater for the patients.

Notably, although the court recognises that no amount of money that can sufficiently compensate Josephine for the harm and damage she suffered, the award sets a precedent when it comes to the quantification and award of damages in cases where the SRHR of women have been violated.

Conclusion

This case is a restatement of the failure to adopt a human rights-based approach to maternal healthcare service provision in Kenya. The decision is a positive step towards affirming the rights of women to maternal healthcare that respects their right to dignity, privacy and freedom from torture, cruel, inhuman and degrading treatment. The decision recognised obstetric violence as a human rights concern that amounts to a violation of women's rights.

The decision emphasised the role played by the national and county governments in the promotion and protection of the right to health, specifically maternal healthcare of women in Kenya. It unearthed the horrific and traumatic experiences that women face during labour and childbirth.

However, it is worth pointing out that there is a dearth of precedence in this area of women's rights, especially in the quantification of damages for violations in these circumstances. For instance, the appellate court relied on the case of *Federation of Women Lawyers (Fida- Kenya) & 3 others v Attorney General & 2 others; [2019] eKLR* in making a comparison of an award of damages. Although both cases involve the SRHR of women, the circumstances and the harm suffered are not similar.

Furthermore, matters relating to the reproductive rights of women often drag into court, hence taking a long time to resolve. Therefore, key stakeholders must have the necessary policy discussions with the Judiciary to understand how to go about these cases. One of the possible solutions would

be to have specific procedures on how to deal with these issues, this will facilitate an expedited process and ensure access to justice to the victims.

Article 2

A judicial perspective of the age of consent in Kenya

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Introduction

The Court of Appeal in Kenya in the case of *Wambui v Republic (Criminal Appeal 102 of 2016)* raised the alarm on the enforcement of the penal sections of the Sexual Offences Act of 2006 with regards to the age of consent for minors who engage in consensual sexual relations. This decision sparked a raging debate within the country on whether to lower the age of consent. The provisions of the Children's Act of 2001 and the Sexual Offences Act fix the limit of consent to engage in consensual sexual relations at 18 years. The Sexual Offences Act therefore criminalises all sexual relations or contact with or between children under the age of 18 years. The Kenyan courts have repeatedly made decisions on this matter with two clear discourses taking centre stage. The discourse of protectionism views children below the statutory age of majority as incapable of making informed decisions and are therefore in need of protection from the State and a legal guardian. This discourse is reflected in some of the decisions of the court that perfunctorily impose the penal provisions of the act to the letter even in the face of clear injustice. Other courts like the Constitutional Court and the Court of Appeal in different matters have been reluctant to mindlessly enforce the penal provisions of the act and have chosen to pass judgments that reflect the discourse of self-determination that recognises the twin principle of evolving capacity and best interest of a child in matters where the age of consent appertain.

Cases on the age of consent

In *CKW v Attorney General & another [(2014) eKLR (Constitutional Court of Kenya)]* the petitioner instituted a suit seeking a declaration that sections 8(1) and 11(1) of the Sexual Offences Act of Kenya which created the offence of defilement were invalid to the extent that they criminalised consensual sex between adolescents which was inconsistent with the

rights of a child as provided under the Kenyan Constitution. A male minor who was 16 years old at the time of the commission of the alleged crime had been charged with the offence of defilement in the Criminal Court for engaging in sexual relations with his girlfriend of the same age. The Constitutional Court in its decision affirmed that where a person commits the sexual act of penetration with a child the offence of defilement is committed whether or not consent was given. The court held that sections 8(1) and 11(1) did not violate his rights in any way as the law was meant to protect adolescents from harmful sexual conduct either from adults or other adolescents. The court further stated that the law had the goal of protecting children from premature sexual conduct as children are vulnerable and they need protection.

The Sexual Offences Act was enacted to introduce a comprehensive law that would address the rising cases of sexual assault, and rape, and protect all persons from unlawful sexual acts especially vulnerable groups like children. There is no doubt that children of all ages need to be protected due to their developing mental capacity, unique vulnerability and dependence. However, mindless enforcement of the penal sections of the Sexual Offences Act without rationality and proportionality and without addressing the issues regarding maturity, morality, and autonomy causes prejudice and injustice and takes away from the noble intentions of the legislation

“There is no doubt that children of all ages need to be protected due to their developing mental capacity, unique vulnerability and dependence. However, mindless enforcement of the penal sections of the Sexual Offences Act without rationality and proportionality and without addressing the issues regarding maturity, morality, and

autonomy causes prejudice and injustice and takes away from the noble intentions of the legislation.”

In *POO (A Minor) v Director of Public Prosecutions & Another* a minor was also charged with the offence of defilement for engaging in consensual sexual relations with a girl his age who later became pregnant. The court evaded to answer whether a child can consent to consensual sexual relations but rather dealt with the issue of inequality in treatment between boys and girls in defilement cases. The court, however, advocated for the need for counselling and guidance rather than penal sanctions for minors who engaged in consensual sexual relations.

In the case of *Wambui v Republic* the accused male had been charged with defilement for engaging in consensual sexual relations with his 17-year-old girlfriend. The Court of Appeal quashed the conviction and set aside the 15-year prison sentence. The court in its reasoning relied on the decision in *Gillick v West Norfolk and Wisbech Area Health Authority [[1985] 3 All ER 402],* to hold that adolescents may not have attained the age of maturity, but they may well have reached the age of discretion and can make intelligent and informed decisions about their lives and their bodies. The court further acknowledged that the process of growing up is a continual process and therefore a law that places fixed limits is artificial and not sensitive to human development and social change.

The Constitutional Court of South Africa in the case of *Teddy Bear Clinic for Abused Children and Another v Minister of Justice and Constitutional Development* also acknowledged that adolescents engaging in consensual sexual relations were developmentally normative behaviour which is derived from constitutionally protected rights of dignity and privacy.

The Constitution of Kenya expressly provides that on issues relating to children their best interest is of paramount importance. The principle of best interest is a twin principle to the evolving capacities of a child, which go hand in

hand. The Children's Act expounds on these principles by obligating the State to put measures in place that ensure that all judicial proceedings guarantee adolescents an opportunity to be heard and their views taken into consideration by their level of maturity and understanding.

Therefore, in the interpretation of the provisions of the Sexual Offences Act, these twin principles come into play in realising what is the best way to deal with children who are engaging in consensual non-exploitative sexual intercourse. Prosecution and imprisonment of a child engaging in consensual sexual relations only creates an unfriendly environment for children to seek advice and guidance about their sexuality which is a vital component in their development. Preferring charges against minors also exposes children to stigmatisation, degradation, a sense of shame, anger and disillusionment.

The African Committee of Experts on the Rights and Welfare of the Child in their General Comment 7 on Sexual Exploitation recognised that no international treaty including the African Charter on the Rights and Welfare of the Child sets the age of sexual consent. This onus is left to the States to establish an age that recognises the need for the protection of children but also is conscious that adolescents often start engaging in sexual activity before they turn 18 years old.

They also acknowledged that many national laws did not distinguish sexual relations between adolescent peers and between an adult and a child. Consequently, it has led to the prosecution and imprisonment of children for consensual sexual activities. The Committee acknowledged that there is an age at which a child may be termed as mature even though they are below the age of 18. Therefore, to acknowledge the evolving capacities of children, the Committee urged States to recognise that children who have reached the age of maturity have the right to engage in consensual non-exploitative sexual activities without penal sanctions.

The Committee advocated for the decriminalisation of peer-to-peer consensual sexual conduct provided that the adolescents were close in age and above the age of maturity. This can be achieved when States construct a justice system that does not criminalise adolescents as sexual offenders as it deters them from accessing education and sexual and reproductive health services integral for their development.

Conclusion

One of the core reasons for the enactment of the Children's Act was to give effect to the constitutional rights of the child with the interest of the child being of paramount importance. This principle does not only apply to the private social welfare associations about a child but also to legislative bodies and judicial persons exercising any powers conferred under any law. It is on this premise that a sober and pragmatic approach should be taken in reviewing the provisions of the Sexual Offences Act to be in line with the twin principles of best interest and the evolving capacity of a child. The law and its administration thereof should be cognisant of the different developmental stages of a child and hold them accountable based on their age and degree of maturity. This will take away the rigidity, prejudice and miscarriage of justice that fixed limits imposed on the application of the legal age of sexual consent.

Article 3

Maternal healthcare and human rights violations in Zimbabwe

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Introduction

The right to basic health is guaranteed in section 76 of the Zimbabwean Constitution. According to section 76, healthcare must be accessible, available, acceptable and of good quality for the right to health to be realised. However maternal healthcare services remain inaccessible to the vast majority of Zimbabwean women, resulting in the violation of this right and a spike in maternal mortalities and childbirth-related injuries. For instance, the inadequate health infrastructure, underfunded, under-resourced government hospitals and high costs of private hospitals serve as a barrier to women accessing maternal healthcare. This puts women in Zimbabwe at risk of maternal mortality and life-changing childbirth-related injuries.

Problem statement

According to WHO, maternal mortality refers to a female death from any cause related to or aggravated by pregnancy, delivery of the child or within 42 days of terminating the pregnancy, irrespective of the duration and the site of the pregnancy. Zimbabwe remains a state with one of the highest maternal mortality rates in the world. UNICEF estimates that the maternal mortality ratio in Zimbabwe is 363 per 100, 000 live births and 1.23 percent of the GDP is lost annually and this owed to maternal complications. Globally, the maternal mortality ratio is 223 maternal deaths per 100, 000 live births.

As far as childbirth-related injuries are concerned, various reports indicate that women have been subjected to life-changing injuries such as obstetric fistula. Obstetric fistula can be defined as one of the most tragic childbirth injuries that are characterised by a hole forming between the birth

canal and bladder and/or rectum that is caused by prolonged labour without access to timely, quality medical treatment. The injury results in the ongoing and uncontrollable secretion of urine or faeces. This injury does not only have physical implications but it also has psychological effects as it results in the stigmatisation of an individual, leaving them emotionally scarred. Other factors contributing to maternal mortality and childbirth-related injuries are postpartum haemorrhage, eclampsia, obstructed labour and sepsis. Various socio-economic factors such as poverty, high medical care costs, inaccessibility to medical facilities and poor treatment by medical practitioners are also contributing factors.

It can be said that the intersection of class and race may be the result of the violation of the right to health and reproductive rights, as predominantly black, impoverished women are most affected. Marginalised women cannot afford the high-quality maternal healthcare services offered by private hospitals. As a result, they resort to relying on public healthcare services at poorly funded hospitals that lack necessary resources such as water and electricity, to ensure the wellbeing of their patients. Furthermore, large public hospitals that occasionally have the necessary resources are inaccessible as they are situated far from rural areas. This serves as a barrier to accessing maternal healthcare services.

Legislative framework

The international instruments that enshrine the right to health that will be discussed in this article are the Universal Declaration of Human Rights (hereinafter 'UDHR'), the International Covenant on Economic, Social and Cultural Rights (ICESCR)and the Convention on the Elimination of All Forms of Discrimination against Women (hereinafter 'CEDAW'). According to Article 25 of the UDHR, the right

to health is part of the right to an adequate standard of living. The right of women to access healthcare is entrenched in Article 12 of CEDAW. Article 12 provides that women should have equal access to healthcare facilities. Article 25 of the UDHR and Article 12 of CEDAW emphasise the importance of accessing healthcare without discrimination and the poor allocation of resources serving as a barrier when enjoying the right to health.

At a regional level, Article 14 of the Maputo Protocol sets out a woman's right to health, including sexual and reproductive health. The African Charter on Human and Peoples' Rights also guarantees the right to health in Article 16. Article 16 states that every individual shall have the right to enjoy the best attainable state of mental and physical health. Based on these regional provisions, it is paramount that States ensure that the right to health is promoted and protected by taking measures to improve accessibility to healthcare services.

Zimbabwe has ratified the afore-mentioned international and regional instruments thus committing itself to ensuring that the right to health is promoted and protected. Section 76(1) of the Zimbabwean Constitution enshrines the right to healthcare services. The right to health includes the entitlement to timely and appropriate healthcare. The right to health is inherent and applies to all individuals based on equality and non-discrimination. The right to health is closely interconnected with other human rights such as the right to dignity and the right to life. In General Comment 14, the UN Committee on Economics, Social and Cultural Rights stipulates that States must promote and protect the right to health by ensuring that healthcare services are available and accessible. Furthermore, the healthcare facilities should be medically appropriate and of good quality through the provision of necessary medicines, equipment and skilled healthcare professionals. If states satisfy their obligations as set out in General Comment 14, there will be a decline in maternal mortality rates and the right to health will be protected.

The case of *Alyne da Silva Pimentel v Brazil* illustrates the importance of States fulfilling their obligations as set out in General Comment 14. In *Alyne da Silva Pimentel v Brazil* it was held that States are obliged to address and reduce maternal mortality by recognising and strengthening reproductive rights. The case highlighted how a lack of resources in healthcare facilities and discrimination against women contributes to maternal mortality. Furthermore, the case emphasised the importance of a State ensuring that healthcare facilities have the necessary equipment and skilled healthcare professionals to curb maternal mortality.

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Although the Alyne case has influenced some African countries to improve their provision of maternal healthcare services, the matter has had little to no impact in Zimbabwe. A lack of resources in healthcare facilities as well as discrimination against women based on age, race and class remain barriers to accessing maternal healthcare services.

In comparison to Zimbabwe, Seychelles has satisfied its obligations as set out in General Comment 14. The country has the lowest maternal mortality in Africa with a maternal mortality rate of 3 deaths per 100, 000 live births (Integrated African Health Observatory 2023). Seychelles has been able to achieve this remarkably low maternal mortality rate by

committing itself to ensuring the wellbeing of mothers and infants. Seychelles has invested in recognising and protecting the right to health by implementing Universal Health coverage, making healthcare services free (WHO 2019). Free healthcare is inscribed in Article 29 of Seychelles' Constitution. According to Article 29, everyone has the right to the highest attainable standard of physical and mental health. To protect this right, the State has ensured that citizens have access to free healthcare facilities and services within 20 minutes of their habitual residence. Thus, healthcare services, including maternal healthcare services, are easily accessible in Seychelles. The accessibility of maternal healthcare in Seychelles has enabled the country to have a low maternal mortality rate.

Recommendations and conclusion

To address the issues contributing to the high maternal mortality rate in Zimbabwe, the State must follow a similar approach to Seychelles by prioritising making healthcare accessible when allocating its resources. The State must ensure that healthcare facilities are in close proximity to the habitual residences of citizens. Basic resources such as water, electricity, medication and equipment must be made available to these healthcare facilities. Furthermore, healthcare workers must be trained sufficiently so that they can treat patients efficiently and effectively. Previously, healthcare workers were sensitised to the new Maternal and Perinatal Death Surveillance and Response, WHO guidelines. The training provided to healthcare workers was centred around equipping them with knowledge on how to improve service provision through the investigation of deaths and

researching the recommended and different approaches to preventing maternal mortality. However, the training was not structured and the maternal mortality rate remained high. Thus, a more structured approach must be adopted. Finally, healthcare services must be made affordable so that class does not remain a barrier to accessing healthcare.

One can deduce that the right to healthcare as set out in section 76 of the Constitution and general reproductive rights are poorly recognised and enforced in Zimbabwe. This can be attributed to the state's socio-economic context. However, through the proper allocation of resources and training of healthcare practitioners, the right to healthcare can be safeguarded in Zimbabwe.

Opinion Piece

What are we going to do about the anti-rights movement in the African region?

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Introduction

The threat to SRHR has arguably never been more palpable for those working in the human rights community. However, for those outside of this sphere, seemingly unaffected by the current debates and anticipation of possible fundamental shifts, the danger to their SRHR may worryingly seem faraway and elusive.

Since the advent of the decision taken in *Dobbs v Jackson Women's Health Organisation* in 2022, which saw the reversal of the constitutional recognition of the right to abortion, a right once guarded based on the findings and conclusion of *Roe v Wade (1973)*, what has resulted is an atmosphere of chaos across the United States (US). With the constitutional protection of the right to abortion denied, there have been increased cases of conscientious objection, and uncertainty surrounding the point at which, or if at all to provide life-saving treatments to pregnant women in distress. Healthcare workers' refusal to provide treatment and obscure policies, demonstrate a fearfulness of falling within the ambit of abortion provision, plaguing healthcare institutions across the country.

The stranglehold on abortion care, as well as oppressive surveillance are causing anxiety over being branded a criminal in the case of both healthcare workers and those seeking healthcare assistance. This is leading to increased health risks, and from what has been reported, the result has even been death. The implications of these developments are that added to the expected angsts associated with pregnancy, being pregnant with certain complications that may either impede the health of a woman, or diminish the chances of living a healthy long life in the case of a child, continue to shockingly make pregnant women in the US targets for potential criminalisation rather than care.

> **being pregnant with certain complications that may either impede the health of a woman, or diminish the chances of living a healthy long life in the case of a child, continue to shockingly make pregnant women in the US targets for potential criminalisation rather than care.**

The intention of this opinion piece is not only to emphasise the discomfort hovering over all of us in relation to the uncertainty concerning what significant aspects of SRHR will be affected, but also a call for vigilance. Furthermore, it is a suggestion that just as the anti-rights movement advances and marks sites for infiltration, we too, in the SRHR space, with some level of foresight of things to possibly come, must be ready with a counter-response.

What about the African region?

While the African region is racked by its own deficiencies with regarding the protection and provision of SRHR, outside of a direct link to the outcomes of the reversal of *Roe v Wade*, it cannot confidently be claimed that it is or will remain untouched by the repercussions of this decision. Abortion care in the African context has historically been problematic and inconsistent, even in jurisdictions in which it is legal (at least on paper). However, access to abortion services, is not necessarily the primary concern, as it is one amongst many other SRHR provisions that could be negatively altered.

The greatest power that has been generated because of the overturn of *Roe v Wade* is not simply related to how it has reshaped access to abortion services. The challenge ahead for SRHR policy makers, academics, advocates, activists and allies, is how this dramatic verdict has emboldened

the anti-rights movement to more aggressively organise across diverse SRHR issues. There are certainly some who have always openly and unapologetically expressed their sentiments, such as Sharon Slater, the president of Family Watch International (an anti-abortion and anti-LGBTQ+ group). She recently alleged that donor countries (mainly from the Global North) were attempting a 'sexual social recolonisation of Africa' by trying to introduce legal abortion and LGBTQ+ rights. However, many actors that remain hidden, but are influential, not to mention politically connected and well-resourced whom we also must contend with.

Although admittedly speculative, a frightening thought is that African countries seem to be taking advantage of this moment of brazenness. Earlier this year, the Protestant Council of Rwanda directed all health facilities run by its member institutions to stop performing abortions, even though Rwandan law permits abortion in certain cases.

Beyond abortion rights, also this year, a bill that sought to overturn a 2015 ban on female genital mutilation (FGM) was introduced to the Gambia's parliament. A large majority of parliamentarians seemed to support the repeal at the time, with prospects for the dismissal of the proposed bill seemingly bleak. However, in a welcome turn, the Gambia's parliament upheld the ban. In Uganda, the Constitutional Court on 3 April, 2024, upheld the 2023 Anti-Homosexuality Act, which includes the death penalty in certain cases. Therefore, it is not just abortion rights that could be compromised, it is all SRHR, especially those that seem to deviate from the conservative right.

A grave concern is also how the terms of SRHR funding could be modified, thus reconfiguring the healthcare system altogether. In addition, it is the exposure to harm of already vulnerable groups such as women, girls and LGBTQ+

persons that is being considered, conceivably peeling away at decades of progress in the SRHR space.

Harnessing the power of collectives

As we ponder over the many iterations of what could go wrong, or imagine the tactics of the anti-rights movement, what very importantly comes to mind is that the anti-rights movement is a borderless enterprise, transcending national and regional parameters, particularly in this technological age. It is essentially a transnational movement with diverse and global supporters, sympathisers and reach.

Development practice and organising in the African region is characterised by the tendency to work in silos, with intense competition amongst practitioners for ever-scare funds, including in the area of SRHR. In the midst of the looming and perhaps stealth manoeuvring of the anti-rights movement, this may well be a point of weakness on the part of the SRHR community, and an advantage in favour of the anti-rights movement. Therefore, as we contemplate appropriate responses to this threat, in this context, isolation, and thinking of only the bottom line of individual organisations may be a privilege that can no longer be afforded. The response to the anti-rights movement must include non-traditional actors and practices to increase its reach. The luxury of only speaking to mainstream organisers or specific issues may simply be insufficient.

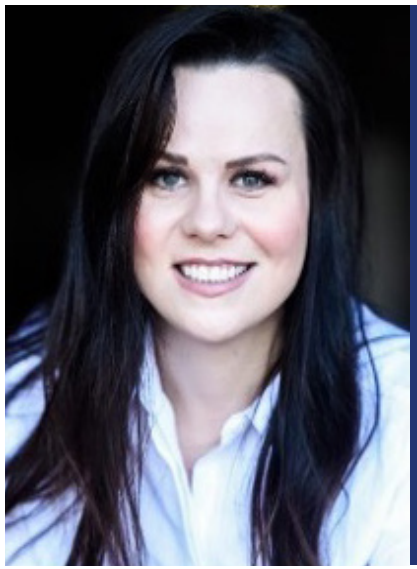
If there was ever a time for aggressive and collective action to protect the gains that have been made in SRHR, that time is now. This too may need to take on the characteristic of being national, regional, transnational and essentially borderless for any chance of impact. If there was ever an appropriate moment to admit to weaknesses and vulnerabilities in the way we approach and mobilise around SRHR, that moment has come. This must include more determined lobbying to

address ineffective policies and laws, creating interventions in which co-creation and collaboration with communities are centred, as well as intentionally and strategically popularising mechanisms that speak to SRHR. States must be held accountable for not honouring their commitments to signed human rights mechanisms that have a bearing on SRHR, and it is necessary to challenge those who have not made a commitment at all. The power of the collective and decisive action may be the only way forward.

Conclusion

The actions of the anti-rights movement did not begin with the overturning of *Roe v Wade*, nevertheless, debatably, this decision has served as justification and a catalyst for its continuity. Very importantly, it has confirmed that the anti-rights movement has allies who are powerful and influential. For the anti-rights movement, Dobbs v Jackson Women's Health Organisation was a historical and possibly trajectory-shifting win. The question is, what is the stance to adopt to confront the new-found resoluteness of a movement that would see the world return to a time when the already marginalised, already invisible, already vulnerable have less rights, less protection and worse health than they do now? Regardless of the strategies adopted, the exclusion of collective action leaves the SRHR community exposed to an organised, tactical and global force, and therefore, it must respond accordingly.

Events



Danielle Visser is a qualified attorney with experience in general litigation, and has served as a Law Clerk at the Constitutional Court of South Africa. She is also a Doctoral Researcher in the SRRA programme at the Centre for Human Rights, University of Pretoria.

Advancing sexual and reproductive health rights in Africa: Highlights from esteemed speakers in the second quarter

In the realm of SRRA, education and advocacy play pivotal roles in shaping policies and practices that impact millions. During the second quarter of presentations aimed at educating students from the SRRA Master's programme, two distinguished speakers provided insight into the continent's pressing issues.

Dr Jewelle Methazia kicked off the series with a thought-provoking discussion on the adequacy of liberal abortion laws in ensuring access for all who need it. Central to her presentation was the notion that while legal frameworks are essential, they alone may not suffice in guaranteeing comprehensive reproductive health services. Drawing on global and regional perspectives, Dr Methazia highlighted disparities in access to safe abortion services across different socioeconomic groups and geographical locations within Africa.

> **"while legal frameworks are essential, they alone may not suffice in guaranteeing comprehensive reproductive health services."**

Her presentation underscored the importance of addressing not just legislative barriers but also cultural and economic factors that hinder access to reproductive healthcare. Dr Methazia emphasised the need for sustained efforts to protect and promote reproductive rights across diverse African contexts by advocating for a holistic approach that integrates legal reforms with community engagement and healthcare infrastructure improvements.

Following Dr Methazia, Dr Caroline Kabiru delved into research conducted by the African Population and Health Research Center (APHRC) on the needs of pregnant and parenting adolescents in Africa. Her presentation provided a comprehensive overview of the challenges faced by this vulnerable group, including stigma, limited educational opportunities, and inadequate healthcare access.

Dr Kabiru's research highlighted the complexities of adolescent reproductive health, noting that interventions must be tailored to address the unique socio-cultural dynamics prevalent across different regions. By integrating qualitative and quantitative methodologies, APHRC's research not only documented the lived experiences of adolescents but also informed evidence-based policy recommendations aimed at enhancing support systems and services.

> **"interventions must be tailored to address the unique socio-cultural dynamics prevalent across different regions."**

One of the key takeaways from Dr Kabiru's presentation was the importance of empowering adolescents with comprehensive sex education and access to youth-friendly health services. By promoting education and economic opportunities for young parents, Dr Kabiru advocated for a rights-based approach that ensures adolescents are not only protected from harm but also equipped with the tools

to make informed decisions about their reproductive health.

These monthly presentations serve as a crucial platform for deepening understanding and fostering dialogue on SRRA among future leaders and policymakers. The insights shared by Dr Methazia and Dr Kabiru underscored the interconnectedness of legal frameworks, healthcare infrastructure, and socio-cultural norms in shaping reproductive health outcomes in Africa.

Moving forward, there is a clear call to action for stakeholders across sectors to collaborate in advancing comprehensive strategies that promote gender equality, protect reproductive rights, and ensure universal access to quality healthcare services. By bridging research with advocacy, these presentations contribute to a broader movement aimed at achieving sustainable development goals related to health and well-being.

As the discussions on SRRA continue to evolve, the contributions of experts like Dr Jewelle Methazia and Dr Caroline Kabiru are instrumental in guiding evidence-based policies and interventions. Their presentations not only shed light on existing challenges but also inspire meaningful action towards creating a more inclusive and equitable society where every individual can realise their reproductive rights and live healthy, fulfilling lives.

Colloquium on the role of the regional/sub-regional human rights bodies in advancing sexual and reproductive health rights in Africa

Participants including both academic scholars and civil society in attendance at the 'Colloquium on the role of the regional/sub-regional human rights bodies in advancing sexual and reproductive health rights in Africa', 23-24 August 2024.

Participants including both academic scholars and civil society in attendance at the 'Colloquium on the role of the regional/sub-regional human rights bodies in advancing sexual and reproductive health rights in Africa', 23-24 August 2024.

From left to right: SRRA Doctoral-Fellow, Dr Sindiso Nkomo; SRRA DPhil scholar and co-editor of the SRRA Digest, Yumba B Kakhobwe; SRRA LLD scholar and co-editor of the SRRA Digest, Maryanne Nkechi Obiagbaoso; and SRRA LLD scholar, Dr Amon Aruho Kategaya at the 'Colloquium on the role of the regional/sub-regional human rights bodies in advancing sexual and reproductive health rights in Africa'.

From 23-24 August 2024, the Centre for Human Rights hosted the 'Colloquium on the role of the regional/sub-regional human rights bodies in advancing sexual and reproductive health rights in Africa.'

The colloquium was a collaboration between the Centre for Human Rights, University of Pretoria; Dullah Omar Institute (DOI), University of the Western Cape; Initiative for Strategic Litigation in Africa and KELIN. The forum touched on diverse SRHR issues in the African region, such as female genital mutilation (FGM), HIV/AIDS and the SRHR of young people. It sought to share, popularise and enhance knowledge on the practical use of existing African regional and sub-regional human rights bodies, given the often inconsistent or non-existent application of SRHR provisions at the national level.

Representing the SRRA programme, Post-Doctoral Fellow, Dr Sindiso Nkomo presented on 'Laws and policies relating to the SRHR of young people in Seychelles', Dr Amon Aruho Kategaya shared his perspectives on 'Laws and policies relating to the SRHR of young people: Perspectives from Uganda', and Maryanne Nkechi Obiagbaoso spoke on 'Adolescent sexuality education as a human right'.

Colloquium on the sexual and reproductive health and rights of vulnerable groups in Africa

Participants in the 'Colloquium on sexual and reproductive health and rights of vulnerable groups in Africa', University of Pretoria, 26-27 September 2024.

The United Nations Sustainable Development Goals (SDGs) represent a collective global commitment to eradicating poverty and reducing inequalities, underpinned by the 'Leave no one behind' principle. This guiding framework

calls for an inclusive approach, ensuring that all people, especially the most marginalised, have equitable access to resources, rights, including SRHR, and opportunities. However, refugees, asylum seekers, and migrant workers face numerous barriers that extend beyond the mere lack of resources. Discriminatory laws, exclusionary policies, and harmful social practices continue to marginalise these vulnerable groups, further deepening inequalities.

In Africa, the 'Leave no one behind' principle is especially crucial for ensuring SRHR. Goal 3 of the SDGs emphasises universal health coverage, a vital aspect of which includes SRHR for marginalised populations such as refugees, asylum seekers, and migrant workers. Yet, these groups face significant challenges accessing essential SRHR services, often exacerbated by factors like ethnicity, immigration status, religion, disability, sexual orientation, and gender identity. These intersecting identities increase their vulnerability to discrimination, perpetuating deep-rooted inequalities.

"In Africa, the 'Leave no one behind' principle is especially crucial for ensuring SRHR. Goal 3 of the SDGs emphasises universal health coverage, a vital aspect of which includes SRHR for marginalised populations such as refugees, asylum seekers, and migrant workers. Yet, these groups face significant challenges accessing essential SRHR services"

To address these pressing issues, the Centre for Human Rights, at the University of Pretoria, hosted a two-day 'Colloquium on the sexual and reproductive health and rights of vulnerable groups (migrants, refugees, asylum seekers and internally displaced persons) in Africa' on 26-27 September 2024. The colloquium brought together experts,

advocates, and researchers from across the continent to explore ways to ensure that refugees, asylum seekers, and migrant workers are not left behind in SRHR advocacy.

The event featured 14 thought-provoking presentations, each shedding light on the multifaceted SRHR challenges faced by vulnerable groups across Africa. The colloquium explored diverse and critical issues surrounding SRHR for vulnerable groups in Africa, with presentations focusing on challenges faced by refugees, asylum seekers, and migrant workers. Key topics included the role of courts and legal frameworks in Cameroon and Nigeria in protecting SRHR, the specific needs of queer asylum seekers in Kenya, and the impact of restrictive immigration policies on migrant dependents in the UK. Presenters also discussed the intersection of sexual violence, mental health, and SRHR in conflict zones like the Democratic Republic of Congo, as well as access to maternal health services for adolescent girls in Nigeria's IDP camps. Technology's role in improving SRHR access and the importance of strategic litigation in liberalising abortion laws in Kenya and Malawi were also highlighted, emphasising the need for intersectional, rights-based approaches to ensure equitable SRHR access for all.

The colloquium underscored the importance of integrating human rights approaches to ensure the protection and fulfilment of SRHR for Africa's most vulnerable populations. In the words of one speaker, 'Addressing SRHR for refugees, asylum seekers, and migrant workers is not just a health issue—it is a matter of justice.' In addition, an interesting feature of this Colloquium is that it brought together established and emerging scholars in the field of SRHR. About half of the papers presented were from past and present students of the LLM Programme in SRRA. This is very important in that it aligns with one of the aims of the

Participants in the ‘Colloquium on sexual and reproductive health and rights of vulnerable groups in Africa’, University of Pretoria, 26–27 September 2024.

programme - to produce the next generation of scholars in the field of SRRA. More importantly, the Colloquium featured a presentation from a final-year law student from the Kabarak University in Kenya.

The colloquium ended with a strong call for collaboration between governments, civil society, and international organisations to address these gaps, ensuring that no one is left behind in the quest for SRHR in Africa.

Interview

The picture depicts the San people who are an indigenous group found in Botswana, Zimbabwe, Namibia and South Africa.

Exploring the sexual and reproductive health and rights of indigenous women in the African context, **featuring Dr Sindiso Nkomo**

Dr Sindiso Nkomo is a Post-Doctoral Fellow at the Centre for Human Rights, University of Pretoria under the SRRA Programme. Her areas of expertise include SRHR, women's rights, rights of special interest groups and international protection of human rights law.

The focus of your PhD was on SRHR in relation to indigenous women. What makes someone an 'indigenous' person?

Answer: There is no agreed definition of who an indigenous person is. The definition is more contested in Africa because of the belief among African Governments that all black people or people without any relations with their colonisers are indigenous peoples of those countries. Due to the difficulty in coming up with an agreed definition of who an indigenous person is, the UN and African human rights systems have developed different criteria/ features that one must satisfy to be regarded as an indigenous person.

The UN system has developed a modern understanding of the term indigenous peoples based on the following:

- Self- identification as indigenous peoples at the individual level and accepted by the community as their member.
- Historical continuity with pre-colonial and/or pre-settler societies.
- Strong link to territories and surrounding natural resources.
- Distinct social, economic or political systems.

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According to the African Commission's Working Group of Experts on Indigenous Populations/Communities indigenous peoples are "societies facing extreme forms of marginalisation and discrimination." The Working Group reiterates that indigenous peoples have the following characteristics:

- Their culture and way of life differ considerably from the dominant society to the extent that their culture is under threat of extinction;
- The survival of their particular way of life depends on access to lands and natural resources;
- They suffer from discrimination as they are regarded as less developed and less advanced than other more dominant sectors of society;
- They often live in inaccessible regions and are often geographically isolated; and
- They are subject to domination and exploitation within national political and economic structures.

Deducing from the above criteria, most people who would be regarded as indigenous in Africa include the San, Khoisan, Doma, Ogiek, Endorois, Benet, Batwa, Ik, Himba, Masaai, Samburu, Turkana and others.

What drew you to this topic?

Answer: In 2020 while working for the Zimbabwe Human Rights Commission, I received a complaint from a person belonging to one of the indigenous communities in Zimbabwe about how women in their community were giving birth at home without skilled personnel, hence leading to higher infant and maternal mortality. I took an interest in this subject and decided to do further research in this area to understand why indigenous women were giving birth at home and whether they were also enjoying legal protection to further the realisation of their SRHR.

Did your study look at indigenous women in specific jurisdictions/communities?

Answer: The main focus of my study was on San women in two districts of Zimbabwe, that is Tsholotsho and Plumtree Districts. However, I also drew good practices from the experiences of the indigenous peoples of Botswana and Canada.

Based on your findings, what are the main challenges that indigenous women face when it comes to SRHR?

Answer: High maternal mortality rates and lower rates of voluntary contraceptive usage among indigenous women. In Africa, for example, indigenous women such as the San women have a high probability of giving birth without skilled personnel. Many indigenous communities also live in secluded and remote rural communities, where they are easily forgotten, and access to general health is highly compromised. In addition, indigenous women have limited or close to no access to basic maternal services such as antenatal, intrapartum, and postnatal care. They are excluded from enjoying reproductive health services because they lack healthcare services that are "available, accessible, acceptable and of good quality".

The intersecting and multiple forms of discrimination indigenous women face proves that they are not a homogenous group. The various grounds (such as age, gender, location, sexual orientation, ethnic origin, and status) on which indigenous women face discrimination negatively impact the experiences of individual women and their patterns of experiences.

To what extent do you find that the discourse on SRHR includes/considers indigenous women?

Answer: From my research, I found that the discourse on SRHR tends to treat indigenous women like any other ordinary woman. For example, the human rights treaties

that provide protection for the different rights that are linked to SRHR do not have specific provisions that relate to indigenous people. Further, the CEDAW which is a woman-specific treaty treats women as a homogenous group and does not have specific provisions that address the rights linked to the SRHR of vulnerable women such as indigenous women. The indigenous people-specific instruments, that is, the ILO Convention 169 and United Nations Declaration on the Rights of Indigenous People (UNDRIP) also do not entrench the SRHR of indigenous people but rather provide the steps to realise the right to health of indigenous people. The ILO Convention addresses aspects of SRHR of indigenous peoples linking it to labour rights such as the right to maternity leave.

What are some of the implications of your findings?

Answer: My research findings can influence legislative and policy change at international, regional and national levels. The research findings also suggested areas for further study.

Do you think your findings are particular to the jurisdictions/communities that you focused on, or are they common across the African region? Please give examples if possible.

Answer: I think the findings of my research are common across the African region because most indigenous women's limited enjoyment of their SRHR is influenced by discrimination due to their identity and non-recognition of their indigenous identity by their governments. Further, most indigenous peoples are located in areas that are far from social services which makes it difficult for them to make use of sexual and reproductive health services. Indigenous women also have limited knowledge about their SRHR which makes it difficult for them to hold their governments accountable for the violation of those rights.

Were there any unexpected or surprising discoveries during your research?

Answer: I discovered that the non-recognition of most groups that self-identify as indigenous is an African problem. I also noted that unlike Zimbabwe, other African countries have attempted to appoint leaders for indigenous people in parliamentary positions although the positions are usually reserved for one indigenous person. For example, Botswana and Namibia have in the past appointed Ministers who represent the needs of indigenous peoples. I also discovered that other countries have progressive laws and policies that emancipate indigenous peoples. For instance, in Canada, provinces are allowed to come up with their laws and regulations, therefore, provinces where indigenous peoples are found have the power to make laws and policies that suit the needs of indigenous peoples.

What recommendations would you make for better protection of the SRHR of indigenous women?

Answer: The UN and African human rights systems need to develop stronger norms and standards that will ensure the promotion and protection of the SRHR of indigenous peoples. Also, international and regional human rights instruments should to a larger extent strive to incorporate indigenous women's SRHR to ensure that they enjoy maximum protection.

- There is a need to develop a specific and comprehensive human rights instrument in Africa to address all the human rights that apply to indigenous populations. This instrument should address the health rights needs of indigenous peoples, including their SRHR.
- There is a need to raise awareness of the peculiar challenges that indigenous women face in the realisation of their reproductive health and rights at the regional

level so that these challenges are addressed in human rights frameworks. More importantly, states are to exhibit political will to address the SRHR needs of indigenous peoples at the national level. In this regard, budget allocation and policy framework should target the SRHR needs of indigenous peoples.

- The relevant human rights bodies should ensure that during the reporting process, states are asked questions on the measures taken to realise the rights to health, including the SRHR of indigenous peoples especially in Africa.

“There is a need to raise awareness of the peculiar challenges that indigenous women face in the realisation of their reproductive health and rights at the regional level so that these challenges are addressed in human rights frameworks.”

Finally, what other interesting SRHR topics are you currently working on as a postdoctoral fellow?

Answer: I am currently writing on the following areas:

- The role of the African Commission vis-à-vis SRHR and digital technologies
- Ensuring inclusive and equal access to SRHR by adolescent girls with disabilities in Africa
- Protection of the SRHR of indigenous women in human rights law
- Improving access to maternal health services for adolescent girls in IDP Camps in Nigeria
- Religion, health and the law.
- Role of the South African Human Rights Commission in furthering the realisation of the SRHR of indigenous peoples in South Africa

- Using the Constitution as a tool for change and accountability in addressing maternal mortality and morbidity in Kenya.

Alumni feature
in honour of the 10th annviversary of the SRRA programme

Keikantse Phele, SRRA programme, Class of 2015, was part of the first cohort of the SRRA programme, and therefore a special addition to the profile of scholars who are featured in this SRRA programme's 10th anniversary edition. Her experiences and body of work provide a strong testament to the validity and relevance of the programme.

Keikantse holds a Bachelor of Laws from the University of Botswana and a Master of Laws in SRRA from the Centre for Human Rights, University of Pretoria. She has 14 years of professional experience. With a background in law, human rights law, diversity, inclusion and equity, and social impact, Keikantse is also a seasoned researcher on socio-economic

matters and part-time academic. She is a Co-Founder and Co-Curator of the Gaborone Book Festival, as well as an ESG and Sustainability enthusiast. She currently works for Accountability International as a Senior Programme Manager, an international hybrid organisation.

"It was great being part of the SRRA programme, a programme that I completely enjoyed. With the leadership of Professors Ngwena and Frans Viljoen. It was a great scholarly opportunity and experience. The LLM is or was a fantastic addition to my professional and personal life.

On the professional side, I have had opportunities such as international consultancy assignments on SRHR, gender-based violence, and disability rights. In 2018, I was selected as a Mandela Washington Fellow, and I believe that my LLM thesis formed a strong component of my application. This is after I had applied a couple of times! One of my dreams has always been to work directly with an organisation that focuses on gender-based violence, and in 2019 I worked with a local women's shelter in Botswana. This, I believe, was because my LLM stood out. In my current role, I work on challenging the criminalisation of various human rights and bodily autonomy, a body of work that has many intersections that I have learnt as part of the programme.

On a personal note, I made good friends and networks from the programme. Additionally, I still have access to some lecturers who led me to opportunities.

The SRRA programme provided a diversity of learning and made me aware of the vastness of SRHR in Sub-Saharan Africa. It was a springboard for me to learn more and be curious about SRHR in Africa, and globally."

Maryanne Nkechi Obiagbaoso, SRRA programme Class of 2018, is now a Doctoral Researcher in the SRRA programme at the Centre for Human Rights, University of Pretoria, where she functions as a Tutor for the Masters in SRRA Programme and co-editor of the SRRA Digest. Maryanne is also the Founder & Executive Director of the Initiative for Women and Girls Right Advancement (IWOGRA) in Nigeria.

"I graduated from the prestigious University of Pretoria in 2019 through a scholarship opportunity at the Centre for Human Rights. This experience provided me the opportunity to practice and engage on issues of women and girls' sexual

and reproductive rights. I gained in-depth knowledge of various forms of SRHR, international human rights laws relevant to SRRA, how to apply human rights principles in realising SRHR and developed my capacity to interact with different actors like the public, media, civil society organisations and government agencies."

Sofia Rajab, SRRA programme Class of 2019, is a fierce and dynamic feminist and human rights advocate and litigator. She specialises in litigation, advocacy, research as well as legal and policy reform on SRHR, SGBV and the rights of sexual minorities and works at the domestic, regional and global levels.

"The SRRA programme played a phenomenal role in sharpening and strengthening my knowledge of regional and international law on SRHR, moulding me into a stronger analytical mind and stronger player in the advancement of SRHR in the Kenyan and African Context. The programme honed in on my existing experience and advocacy skills into an exceptional combination of experience, intellect,

skills, instinct, and intuition that propelled my career in the human rights field to the benefit of women and girls not only in Kenya, but in the world. The SRRA programme cemented my role as a general in the women's rights revolution and a new wave of African Feminism."

George Asumadu, SRRA programme Class of 2019, is a child services social worker at Torbay Council in England, United Kingdom. He works with children and families on various vulnerabilities, of which sexual and reproductive matters are a core part of his job description.

"I am currently working as a children's social care worker, supporting children and families on issues of financial deprivation, quality education, and emotional, physical and mental health difficulties. As part of this holistic support provision, I deal with numerous complexities around sexuality and sexual identity particularly with teenagers. My knowledge and experience from the SRRA programme have helped support the children and families, as well as professionals I work with."

Benta Moige, SRRA programme Class of 2020, is an advocate of the High Court of Kenya, working as a country researcher at Amnesty International Kenya.

"The SRRA programme shaped my human rights activism and work around reproductive rights in Kenya. Through the programme, I learned that activism could take many forms and that personal opinions should not inform public opinions, which are meant to be just. I am grateful for the solid foundation I received from the SSRA programme. I recommend this programme to human rights enthusiasts looking to find their footing in the human rights space."

Dr Puleng Relebohile Letsie, SRRA programme Class of 2020, is a public health, human rights, and gender activist and specialist with more than 24 years of experience in HIV, public health, Gender and development communication. She is also a Technical Review Panel member for the Global Fund to Fight AIDS, Tuberculosis and Malaria, and a member of the World Health Organisation (WHO) SocialNet (a team of 23 social scientists trained to integrate social science-based interventions into health

emergency work).

"My all-time frustration was always feeling helpless when people's rights were violated and would always ask other colleagues 'But what does the law say?'. This programme has now empowered me to know exactly what the law says and therefore I can offer the required technical assistance and support, and ably guide those whose rights have been violated. I am now able to engage in policy and other advocacy issues at national, regional and global levels – my confidence to engage in human rights issues was substantially boosted, and I am forever grateful to the programme."

Geremy Schmidt, SRRA programme Class of 2022, is a Candidate Legal Practitioner at Engling, Stritter and Partners — one of Namibia's leading law firms. After graduating from the University of Namibia, he worked as a consultant for 3 years. During this time, he completed the LLM in SRRA at the Centre for Human Rights, University of Pretoria.

"The SRRA programme fundamentally changed the way I view human rights issues in Namibia and abroad. It equipped me with the necessary skills to adopt a multifaceted and multidisciplinary approach to solving legal issues. It enhanced the way I conduct legal research and allowed me to develop my knowledge and expertise on various SRHR issues in Namibia and beyond. I will always be grateful to the Centre for Human Rights for constructing this programme and allowing me to experience it."

Angella Sheilla Nairuba Kyagera, SRRA programme Class of 2022, is currently an advocate of the High Court of Uganda, and all subordinate courts thereto. She specialises in human and health rights law, with expertise in strategic litigation, research, project management, and implementation. Over the past 7 years, she has worked in both the private and not-for-profit sectors, advancing SRHR through legal advocacy and litigation.

"The SRRA programme equipped me with a solid understanding of SRHR from domestic, regional, and global

perspectives. It has also enhanced my research, advocacy, and practical skills, which I have applied in my work. This has enabled me to contribute meaningfully to the promotion and protection of SRHR in Uganda and beyond, influencing social transformation and policy development in this critical area."

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DIGEST SUBMISSION GUIDELINES

The Digest will have four feature sections as follows:

Feature articles: This section will provide abridged information about specific SRHR topics or recent court decisions. It will provide explanations behind these happenings while examining potential SRHR implications. The topics and/or case summaries will report facts and provide context and analysis.

Events: This section will provide summaries of important events, activities or meetings on SRHR.

Recent developments: This section will provide updates on recent developments in SRHR either at the international or regional level. It will project the works of human rights bodies and identify any developments.

Interview pieces: This section will contain interviews conducted with either alumni of the SRRA programme or individuals who are doing great work on SRHR. The interviews will gather insights, opinions and stories that

project their work on SRHR. I think we can take this to the end of the Digest and include the guidelines for future contributions.

Digest submissions should:

- Contribute to contemporary debates or key developments relating to SRHR on the continent, however, comparative analyses with other contexts are also welcome;
- Besides critiquing and identifying challenges, forecast the future with reflection on opportunities at local, national, regional and international levels by multiple actors;
- They must serve to promote and advocate for SRHR in a critically engaging manner and not simply state, describe or summarise legal principles, case decisions or recent developments;
- The contribution should not have already been published in another publication;
- The Digest aims to be accessible and understood by a wide audience, including those outside of academia, as such submissions must be written in English, and avoid technical and complex language and legal jargon where possible;
- To facilitate our anonymous review process, please provide your full name and present position, institutional affiliation and acknowledgements;
- If the article has already been published elsewhere, provide full details, including whether it has been shortened, updated or substantially changed for the SRRA Digest;
- For reasons of space, the editors reserve the right to edit and shorten contributions that are too long or to refer them back to authors for shortening;

References and footnotes:

- No footnotes are required. Rather try to work explanations into the text.
- Use the abbreviated Harvard style of referencing, for example: "Child abuse is rising (Author 1999:10)" or "According to Author (1999:10), child abuse is rising".
- Keep references to the absolute minimum – preferably only for publications from which direct quotes have been taken, or for backing up potentially contentious statements.
- Provide a list of the key references at the end of the contribution.
- Feature articles should be no longer than 1500 words
- Case reviews feature articles should be no longer than 1500 words
- Current policy debate and development should be no longer than 1000 words
- Contributions for the events and updates section should be no longer than 1000 words.

All submissions should be sent by email to **maryanne.obiagbaoso@up.ac.za** and **yumba.kakhobwe@up.ac.za**