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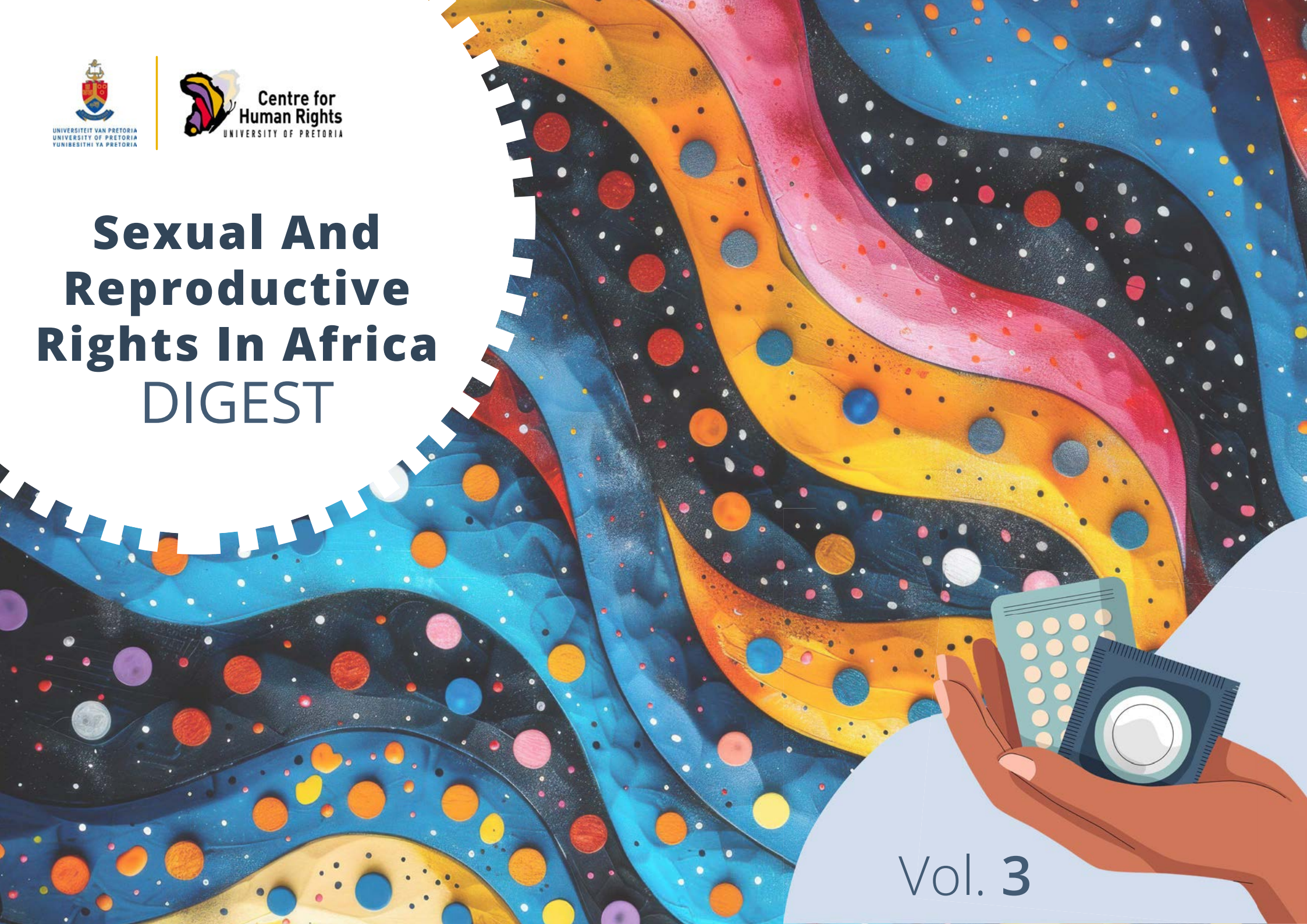
Sexual And Reproductive Rights In Africa
DIGEST



Vol. 3

TABLE OF CONTENTS

THE EDITORIAL

The third volume of the Sexual and Reproductive Rights in Africa (SRRA) Digest is richly compiled to reflect current developments in the area of sexual and reproductive health and rights (SRHR). It contains rich pieces and interviews on various emerging issues by researchers, advocates of SRHR and alumni of the SRRA programme at the Centre for Human Rights, University of Pretoria, South Africa. The third volume provides updates on regional human rights law, programmes and cases related to SRHR within the African continent that can serve as grounds for advocacy on SRHR for people of African descent.

This volume of the SRRA Digest features 6 articles on germane SRHR issues, two summaries of events, a recent development within the African Union, and an interview. As you read through the pieces, it is hoped that you find these contributions to SRHR discourse both enlightening and provocative.

Co-editors:
***Maryanne** Nkechi Obiagbaoso &*
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Feature Articles

Feature Article 1

Sexual autonomy: Barriers facing women with intellectual and developmental disabilities in Tanzania

Bijal D Lal

Introduction

Sexual autonomy, being the right to make informed choices about one's sexual experiences, is a self-evident, universal human right. Yet, for many women with intellectual and developmental disabilities (WwIDD) in Tanzania and around the world, this right is questioned. Drawing on my experiences as a special needs educator and on the lived realities of my students, this article sheds light on the systemic, cultural, and legislative barriers that hinder WwIDD from enjoying their sexual and reproductive rights. By centring the voices of WwIDD and applying the frameworks of intersectionality, disability justice, and Ubuntu, we explore the gaps in actualising these rights and what must change to ensure that everyone can experience this fundamental aspect of life with dignity.

Cultural misconceptions and dehumanisation

In Tanzania, cultural norms heavily shape how disability and sexuality are perceived. Harmful myths such as the "virgin-cure" (the belief that intercourse with a female with disabilities can cure HIV) have made WwIDD targets of sexual violence (UNICEF 2021). Language also contributes to dehumanisation. In Kiswahili, the 'ki' prefix is used for persons with disabilities (e.g., kipofu - blind), while the 'm' prefix is used for describing persons without disabilities (e.g., mtoto - child) (Waliaula 2009). This linguistic divide reinforces a binary of "us" versus "them." Coupled with global stereotypes that portray WwIDD as either asexual or easily manipulated, these beliefs strip WwIDD of agency and increase their vulnerability to exclusion and harm.

Policing of relationships and motherhood

The intimate lives of WwIDD are often closely monitored. When my student Zaitun shared her excitement about a new relationship, the response from teachers and family was to restrict her interactions, monitor her phone, and notify her mother. Such policing is driven by fears around WwIDD's decision-making abilities,

especially concerning marriage and motherhood. While men with disabilities may be encouraged to marry as a symbol of respect, WwIDD often face forced sterilisation or marriages arranged to shift caregiving burdens (Aldersey 2012; Kramers-Olen 2016).

Prevalence of violence and inaccessibility of justice

Reports show that up to 90% of WwIDD in Tanzania have experienced sexual abuse (ADD International 2017). Yet, justice systems remain inaccessible. Perpetrators are often caregivers, and police or judicial officials may distrust testimony from WwIDDs. Bribery, fear of retaliation, and social stigma further discourage reporting. Instead of addressing these failures, families often respond by tightening restrictions, masking control as care and safety.

The question of consent

A recurring theme in discourse on WwIDD is the question of whether they can provide sexual consent. This scepticism is rooted in cognitive ableism—the false belief that one's intellectual capacity defines one's right to autonomy and choice-making (Davy 2015). However, the concept of relational autonomy challenges this view, recognising that decision-making happens in social contexts and that WwIDD may require support without having their agency removed. Supportive decision-making frameworks, along with accessible sexuality education, can empower WwIDD to make informed choices about their right to experience sexual autonomy.

Gaps in language, data, and policy

Tanzania lacks a unified classification system for IDD, and many conditions, like Down syndrome, lack appropriate, commonly used Kiswahili terminology. This linguistic gap leads to misunderstanding, misdiagnosis, and exclusion from services (BBC News 2019). Disability-specific data is sparse, making it difficult to plan services or implement policy effectively. Although Tanzania has signed international treaties like the Convention on the Rights of Persons with Disabilities (CRPD) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), reporting and implementation remain a challenge (UNICEF 2021).

Theoretical approaches for change

Intersectionality helps us understand how gender and disability together increase vulnerability. The disability justice framework, particularly its principles of recognising wholeness and cross-movement solidarity, calls for WwIDD to be seen as the full persons they are, and to build alliances within feminist and disability organisations (Sins Invalid 2017). *Ubuntu*, the African philosophy of shared humanity, offers a culturally resonant model for inclusion, rejecting the dehumanisation of people with disabilities (Berghs 2017).

Recommendations

- Empower self-advocacy: Support school-based and community initiatives that provide tools for WwIDD to advocate for their needs.
- Promote inclusive sexuality education: Integrate accessible, plain-language sexual health education in Tanzanian schools, including special schools.
- Improve data collection: Strengthen national disability statistics, especially for WwIDD and their experiences with sexual violence.
- Build cross-movement coalitions: Foster collaboration between disability rights groups and feminist organisations.
- Hold governments accountable: Ensure that national policies and international treaty commitments are monitored and enforced.

Conclusion

WwIDD in Tanzania face intersecting barriers rooted in cultural stigma, systemic neglect, and legal gaps. Yet their courage, like that shown by students such as Zaitun, calls for urgent action. Real change begins with each of us: in how we teach, parent, legislate, and advocate. If we are to build truly inclusive societies, we must deliberately examine and transform the systems and interactions that deny others the right to love, dignity, and choice.

Feature Article 2

The right to reproductive healthcare: A review of the Kenya High Court case of Naila Qureshi and Another v Dr Daffique Parker and two others [2025] eKLR

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Introduction

In most instances, people walk into hospitals expecting that their ailment will be managed or treated completely. However, in other unfortunate circumstances, some people come out of the hospitals in worse conditions than they were in when they visited the hospital. The Constitution of Kenya 2010 introduced economic and social rights as part of the human rights guaranteed to every person in the Bill of Rights. Article 43(1)(a) provides that every person has the right to the highest attainable standard of health, which includes the right to healthcare services, including reproductive healthcare. However, one of the things that threatens this right is medical negligence, which, as Black's Law Dictionary explains, arises from the doctor's failure to exercise the degree of care and skill that a physician or surgeon of the same medical specification should use.

Naila Qureshi and another v Dr Daffique Parker and 2 others [2025] eKLR is a case with unfortunate circumstances. A patient consulted her doctor for medical assistance, and instead of being treated, suffered so much damage at the hands of the medical professionals. This is the plight of many women, not only in Kenya, but in the world generally. Women's reproductive health and rights continue to be violated by the people they reasonably believed would exercise care and skill while dealing with them.

Summary of the facts

Naila Qureshi was admitted to one of the most prestigious hospitals in Kenya from around 23 October 2005 to 27 October 2005. She went for a medical procedure involving her reproductive organs. She had consulted her doctor, who represented himself as a qualified consultant gynaecologist. This doctor was well aware of her medical history, having provided reproductive health services to her over the years. In this particular instance, the doctor performed a

hysterectomy. Without her knowledge, the doctor removed her uterus and ovaries through her vagina rather than through open surgery as was expected. Further, during the said surgery and without her knowledge and consent, her cervix was removed. At the time, Naila was only 31 years old and one of the consequences of the procedure was that she could no longer sexually satisfy her husband, who was the 2nd plaintiff in this case.

On or about 13 to 16 September 2006, she was admitted to the same hospital for a condition known as Pelvic Endometriosis following the advice of her doctor. She later learnt that the condition was a result of the doctor's negligence during the hysterectomy procedure. After this procedure, Naila developed a vesicovaginal fistula, a condition which caused her to suffer severe pain in her vagina and urine incontinence, which caused urine leakages. Upon consultation with her doctor and another doctor who represented himself as a Consultant Urologist, they recommended that she undergo a repair surgery, which was done on 4 October 2006. However, despite the repair procedure being done, the fistula persisted. The doctors never revealed to her that she had a fistula. Instead, they inserted a catheter and assured her that her bladder was fine when they knew all along that it was not.

As a result of the fistula, Naila had to wear diapers to contain the urine leakages. She further developed an infection in her reproductive area, which caused her to seek a second opinion. She flew to South Africa, where she was attended to by two doctors, a gynaecologist obstetrician and an urologist. The doctors advised that she had developed a fistula as a result of scarring of her bladder during the procedure to correct her pelvic endometriosis. The doctors subsequently embarked on treatment, with a view to correcting the fistula which endangered her life by leaking urine into her bloodstream.

Issues

The Court considered many issues. However, in this paper, I will focus on the main issue, which is whether the plaintiff's claim of medical negligence could be established.

Analysis and determination

In its analysis and determination, the Court, while relying on the case of Savita Garg v National Heart Institute (2004) 8 SCC 56; 2004 ALL LJ 3900, opined that a person accused of medical negligence can successfully defend the suit by showing that he acted in accordance with the general approved practice. The burden of proof herein lay on the plaintiffs to prove that the defendants were negligent and that such negligence resulted in damage.

While discussing the importance of obtaining informed consent, the Court stated that performing a surgery without obtaining the patient's express consent amounted to unauthorised invasion and interference with a person's body. According to the hospital, the consent form ought to have been signed by the nurse present during the surgery to witness that the doctor had explained the procedure to the patient. The explanation provided is meant to help patients decide their options for treatment. This was, however, not done in this case. The Court adopted special considerations affecting a particular patient as a test to determine whether the doctor obtained informed consent for the procedure that involved the removal of Naila's uterus, ovaries and cervix. It, however, found that the consent was limited to the removal of the uterus and ovaries and not the cervix. Therefore, it was found that the information given to her regarding the procedure was not adequate to enable her to make an informed decision.

Before the procedure to correct the pelvic endometriosis, Naila had never complained of having problems with urine retention. The Court therefore had to establish whether there existed a nexus between the urine leakage and the operation. In its findings, the Court concluded that the urine incontinence was a result of a complication from the endometriosis operation conducted by the consultant gynaecologist and that by the time the urologist was called in, the damage had already been done. The Court, while discussing the issue of using a multidisciplinary approach in handling patients, held that the 1st defendant, being the gynaecologist, was limited as a professional and should have avoided conducting a procedure that required the expertise of an urologist.

On the issue of liability on the part of the hospital, the Court found that the 1st defendant had indeed been

granted previous privileges to practice in the hospital. There was, however, evidence that he had a previous medical negligence case in Uganda, which led to his being disbarred from practising medicine in Uganda. The Court held that the hospital should have conducted due diligence to ensure its staff were competent and professional enough to provide patient care. The hospital was therefore liable.

The defendants were liable to compensate the plaintiff under the concept of composite negligence, where a person sustains injury without any fault or negligence on his or her part but due to the negligence of two or more persons. The plaintiffs were therefore entitled to recover the full decretal sum from any of the defendants.

Disposition of the case

The Court considered all the issues, laws, evidence and submissions by the parties. It held that the plaintiffs had proved gross medical negligence on a balance of probabilities. As a result of the defendants' negligence, Naila had lost enjoyment of conjugal rights, her employment and her earning capacity, which were also diminished, affecting her economic circumstances. She had also experienced pain and suffering, both physically and psychologically. As a result, the Court awarded Naila Kshs. 157, 207 and 524.20 in special and general damages together with costs of the suit and interests from the date the suit was filed.

Significance

i. Quality healthcare

Article 25 of the Universal Declaration of Human Rights guarantees every person the right to a standard of living adequate for their health and well-being, as well as that of their family, including the right to medical care. This right is also guaranteed under Article 43 of the Constitution of Kenya. This case, therefore, sheds light on the need for hospitals and other medical facilities to ensure their staffs treat patients with the utmost professionalism and that they exercise reasonable skill and uphold the duty of care they owe to those seeking medical assistance from them.

ii. Access to justice

As stated above, medical negligence is one of the circumstances that threaten the right to quality healthcare. In the case of Naila, the Court observed that medical negligence is a rarely litigated area in Kenya. This is largely because many individuals who suffer complications due to medical negligence are unable to afford the high cost of pursuing the matter in Court. In some instances, they may not be aware that they can seek legal redress from the Court. Proving medical negligence to the standard required in Court may also pose a challenge. This is because such evidence must be weighed to determine its probative value and it can only be challenged by the opinion of another expert. Since judges may not be experts in the field, more vigilance is required of them before they can rely on such evidence. The case of Naila, therefore, underscores that when medical professionalism is breached, it carries both ethical and legal implications which can result in liability.

iii. Bodily autonomy

This entails an individual's right to freely make decisions about their own body, life and future. Article 31 of the Constitution of Kenya 2010 provides the right to privacy. Similarly, Article 1 of the Universal Declaration of Human Rights affirms that all human beings are born free and equal in dignity and rights. This right encompasses the right to bodily autonomy, personal integrity and dignity. One of the ways that bodily autonomy is exercised is through consent, which empowers individuals to decide whether or not to undergo certain medical procedures based on full disclosure. Accordingly, this case highlights the importance of empowering women to make informed decisions that affect their lives, especially those related to their sexual and reproductive health.

iv. Sexual and reproductive health and rights

In African society, womanhood is often associated with marriage, having children and being able to care for a family. However, when a woman's SRHR are violated, particularly in a way that affects her capacity to fulfil these roles, she may face social stigma, discrimination and even isolation from society.

This case, therefore, clearly highlights how medical negligence can affect a woman's SRHR. The

consequences of such negligence are physical, emotional, social and psychological. The removal of Naila's cervix without her consent disrupted her sexual health as she could no longer enjoy sex as she used to, a factor that may cause a strain in her relationship with her husband and diminish her sense of dignity. Further, after the complications from the endometriosis operation, she started experiencing shame and psychological trauma as a result of the urine incontinence.

Conclusion

The case, therefore, sheds light on the profound impact medical negligence can have on individuals, and especially on women's SRHR. It affirms the need for professionals to be held accountable for their actions and decisions. More importantly, it affirms that these individuals, whose rights have been violated in this manner, have a legal recourse. As a result, more people facing similar circumstances may be encouraged to seek justice through the courts. In doing so, the perpetrators shall be brought to justice and held accountable. Finally, while no amount of compensation can restore what Naila lost, this case sets an important precedent for the award of damages in instances of medical negligence.

Feature Article 3

Protecting sexual and reproductive health and rights for Mozambican climate-displaced women: A legal analysis of gaps and reform pathways

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Introduction

According to the Internal Displacement Monitoring Centre's 2025 Global Report on Internal Displacement (GRID), at least 85 million people in Africa could be displaced by climate change by 2050 due to the continent's rapidly deteriorating climate. According to Perehudoff and others (2022), women and girls will bear a disproportionate burden of the consequences for their sexual and reproductive health and rights (SRHR). This is because climate impacts are forcing millions of Africans from their communities and homes. According to Desai and Mandal (2021), those displaced due to climate change are at an increased risk of gender-based violence and lack access to contraception and maternal healthcare. They are also subject to coercive survival practices, such as child marriage. However, existing regional and national legal frameworks are inadequate for addressing these vulnerabilities.

This paper examines gaps in legal protection within Africa's regional legal instruments. It focuses on the African Union Convention for the Protection and Assistance of Internally Displaced Persons in Africa (Kampala Convention), prolonged silence on SRHR. In addition, it explores the limited relevance and application of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) in situations of displacement. Furthermore, the domestic legal regimes of African states systematically overlook the reproductive health needs of those affected by climate-induced disasters.

Through a case study of Mozambique's seasonal cyclones and doctrinal legal analysis, the article illustrates the inadequacy of the current regional and legal frameworks in protecting the bodily autonomy and health of displaced women. The research article

proposes reforms to align Africa's legal architecture with the realities of climate-induced gender injustice. It asserts that without SRHR protections within the governance of climate-induced displacement, the continent's efforts to adapt to climate change will continue to marginalise the most vulnerable individuals.

Limited protections for SRHR in Africa's human rights framework

Africa's regional human rights framework is progressive in many areas. However, it still fails to provide comprehensive protection for women displaced by climate disasters with regard to their SRHR. The Kampala Convention (2009) is a landmark treaty on internal displacement for the continent. Article 1(f) obliges states to provide humanitarian assistance to displaced persons. Bona But (2015) argues that the Kampala Convention does not explicitly guarantee access to SRHR services, including contraception, safe abortion, and maternal healthcare.

Nevertheless, Article 9(2)(b) indicates that states should provide adequate humanitarian assistance, including food, water, shelter, medical care, health services, sanitation, education, and other essential social services. However, this is often narrowly interpreted and implemented, rarely addressing the specific reproductive health needs of displaced women and girls.

Furthermore, enforcement mechanisms in Africa are weak. Only 33 of the 55-member states of the African Union have ratified the Kampala Convention. Levels of compliance and monitoring are also insufficient. Although the African Union's Climate Change and Resilient Development Strategy (2022) acknowledges gender-based vulnerabilities, its provisions for SRHR are inadequate in climate change adaptation plans. Consequently, this framework misses a critical opportunity to address the link between climate-induced displacement and reproductive justice.

The Maputo Protocol (2003) is the leading regional instrument for women's rights in Africa. Article 14 enshrines robust guarantees of SRHR, including access to abortion in Article 14(1)(a)(c) and protection from harmful practices in Article 14(1)(d). However, its application to women displaced by climate change

remains ambiguous. Neither the Maputo Protocol nor the Kampala Convention explicitly address displacement or the unique SRHR challenges arising from environmental crises. Furthermore, neither document recognises climate refugees. Consequently, women who are climate refugees may find it difficult to exercise the rights set out in Article 14 of the Maputo Protocol.

Both South Africa and Kenya have incorporated the provisions of the Maputo Protocol into their domestic legal systems. However, the implementation of provisions for climate-induced population displacement remains inconsistent, particularly in humanitarian contexts where healthcare systems are already under strain. Currently, there is no explicit link between climate-induced displacement and violations of SRHR. Without clear legal obligations set out in African legal frameworks, climate-displaced women continue to be excluded from essential reproductive health services. This leaves African human rights frameworks ill-equipped to address the overlapping crises of climate change and gender inequality.

A patchwork of inadequate national legal frameworks

Amadi and others (2025) state that many African states have failed to incorporate SRHR protections into national legislation and policies addressing climate-induced displacement. This has created fragmented national legal and policy landscapes that leave women displaced by climate change vulnerable. Fischel and Madureira (2022) state that in response to seasonal cyclones, Mozambique has developed disaster management frameworks. However, while these legal and policy frameworks prioritise immediate humanitarian needs such as food and shelter, they overlook reproductive health services. Daniela (2023) states that while Mozambique's post-cyclone recovery plans include temporary gender-based violence clinics, sustained access to contraception and safe abortion care is not guaranteed. This perpetuates gaps in the provision of comprehensive SRHR. This systemic neglect reflects a broader pattern whereby domestic laws and policies treat climate-induced displacement and reproductive health as separate issues, rather than as interconnected crises requiring integrated solutions.

Although South Africa and Kenya have robust laws and policies on SRHR, these are not consistently implemented among displaced populations. South Africa's Choice on Termination of Pregnancy Act 92 of 1996 guarantees access to abortion. According to Hambrecht and Whittaker (2022), women displaced by climate change, particularly those living in informal settlements, often encounter logistical and social obstacles when trying to access healthcare. Kenya has also enacted a Climate Change Act CAP. 387A 52 of 2016, which includes a gender action plan. However, this gender action plan lacks provisions to address the SRHR needs of women displaced by climate change.

The African Union (2015) report states that loopholes in African customs and religious practices allow harmful practices, such as child marriage, to persist. These issues often become more prevalent during climate-induced displacement. Currently, there are no binding requirements to incorporate SRHR into Africa's domestic climate change adaptation strategies. Consequently, women displaced by climate change continue to be overlooked by the legal system. There is, therefore, an urgent need for legislative reform that explicitly links disaster response with reproductive justice.

Cyclones and Gender-based violence in Mozambique camps

Larios (2023) states that the devastating cyclones that hit Mozambique affected more than a million people. Cyclone Idai in 2019 exposed critical gaps in the legal protection of displaced women's SRHR. Mozambican emergency responses have focused on immediate survival needs, neglecting reproductive health services. Post-disaster assessments revealed that over 50% of women in displacement camps had experienced gender-based violence. Access to contraceptives, emergency obstetric care, and safe abortion services was also limited. These failures were largely rooted in Mozambique's disaster management laws and policies, which lack explicit mandates for SRHR.

Comino (2021) argues that although temporary gender-based violence shelters were set up at short notice due to the escalating issue, they were unable to provide displaced women with long-term protection. This occurred because some shelters were only temporary

and lacked integration with Mozambique's progressive SRHR legislation. This demonstrates that, even with stronger laws, implementation and enforcement remain lacking in Africa. The case of Mozambique highlights the urgent need to integrate legal mandates for sexual and reproductive health services into national disaster preparedness legislation. This would ensure that emergency responses address immediate humanitarian needs and reproductive health and rights, both of which are fundamental to women's dignity and autonomy in the event of climate-induced displacement.

Legal reforms needed

To address the critical gaps in safeguarding the SRHR of women displaced by climate change, African states must pursue comprehensive legal reforms at the regional and national levels. They must abandon siloed systems about climate-induced female displacement and focus on integrated solutions instead. Article 9 of the Kampala Convention should be amended or supplemented to explicitly mandate SRHR services. These services should include contraception, safe abortion and maternal healthcare, as these are all essential components of humanitarian assistance for displaced women.

Remteng and others (2022) state that African states should implement robust monitoring mechanisms to ensure compliance with programmes that recognise climate and gender justice. Chingarande and others (2020) argue that to strengthen compliance, the African Union should penalise those who do not comply. At a national level, laws and policies on climate change adaptation and disaster management must include provisions for SRHR. These provisions should require African governments to allocate funding, specifically for mobile clinics and programmes that address gender-based violence and provide reproductive health services in displacement settings.

Pope and others (2023) state that legal frameworks must address the loopholes in customary laws and religious practices that enable child marriage and other harmful practices exacerbated by climate crises. The African Union and African governments must strengthen the criminalisation of forced marriages in displacement camps to override these exemptions.

Mutambasere and others (2023) argue that these reforms should be reinforced through strategic litigation invoking the Maputo Protocol and by fostering partnerships between governments, civil society, and regional bodies. The ultimate goal is to implement protections for SRHR in the event of a climate emergency. Non-governmental organisations should maintain their efforts to submit shadow reports on government actions and leverage the African Union and United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) review processes to hold states accountable. Meanwhile, regional legal frameworks must protect women human rights defenders. Sigsworth and Kumalo (2016) state that Africa's human rights framework must systematically change to protect women affected by climate displacement and reproductive injustice.

Conclusion

Although Africa's human rights framework is progressive in some areas, it does not adequately protect the SRHR of women displaced by climate change. This leaves them vulnerable to systemic violations of their reproductive autonomy and health security. Regional instruments such as the Kampala Convention and the Maputo Protocol lack explicit, binding provisions linking climate-induced displacement to SRHR safeguards. Furthermore, domestic legal frameworks often treat disaster response and SRHR as separate issues rather than interconnected priorities. The case of Mozambique illustrates how these gaps can exacerbate gender-based violence and restrict access to essential maternal care. Urgent reforms are needed to address these shortcomings, including amending or supplementing regional treaties, integrating SRHR into climate adaptation laws, and strengthening accountability mechanisms to uphold the rights of displaced women and advance climate justice. Without such transformative changes, Africa's approach to climate-induced displacement will continue to cause gender-based harm, thereby undermining human rights and sustainable development goals.

EVENTS

Event 1

Reflecting on a powerful start to the year: Sexual and Reproductive Rights in Africa programme monthly presentations

Danielle Visser

The Sexual and Reproductive Rights in Africa (SRRA) postgraduate programme has enjoyed a dynamic and enriching start to the year, with monthly presentations that have provided students with invaluable insights into a wide range of critical issues shaping the sexual and reproductive health and rights (SRHR) landscape on the continent. From January to June 2025, students have engaged with leading experts from across Africa, spanning fields such as criminal prosecution, legal advocacy, academic research, and frontline healthcare, who generously shared their knowledge and experience. These presentations not only deepened students' understanding of SRHR issues but also encouraged critical reflection on the practical, legal, and ethical dimensions of SRHR work in Africa.

On Thursday, 27 March 2025, Dr Olayinka Adeniyi presented "The future of fertility in Africa: digital health, human rights, and assisted reproduction policies". She examined how developments in fertility treatment, including assisted reproductive technologies (ARTs), are reshaping reproductive possibilities and expectations across the continent. The session raised critical questions around accessibility, affordability, and the urgent need for clear, rights-based policy frameworks. Dr Adeniyi's presentation highlighted how fertility remains a deeply personal yet politically charged issue, intersecting with gender, class, and cultural expectations in African contexts.

The April session was held on Wednesday, 24 April 2025, with Ms Salima Namusobya presenting on *"Ensuring a human rights-based approach to the use of technology in sexual and reproductive health service delivery in Africa"*. She explored the promise and limitations of digital tools in expanding access to sexual and reproductive health services, while emphasising the risks of data privacy breaches, exclusion, and algorithmic bias. Ms Namusobya's presentation was a compelling reminder that technological innovation in SRHR must be guided by principles of equity, dignity, and autonomy.

On Thursday, 15 May 2025, Dr Patience Ndlovu led a powerful session on *"SRHR in humanitarian settings".* Drawing from fieldwork and experience in crisis contexts, Dr Ndlovu shed light on the specific vulnerabilities faced by women, girls, persons with disabilities, and LGBTQ+ individuals in emergencies such as conflict, displacement, or natural disasters. Her presentation highlighted both the logistical and legal barriers to delivering comprehensive SRHR services in unstable environments, and reinforced the need for survivor-centred, rights-based responses even amidst humanitarian crises.

Most recently, on Thursday, 26 June 2025, Maina Nyabuti addressed the topic *"Language use and access to SRHR"*. His presentation explored how language functions as both a tool of inclusion and a mechanism of exclusion. He illustrated how legal and policy language can hinder access when it is overly technical or not translated into local languages, and underscored the importance of using inclusive, affirming language, especially when working with marginalised groups. His session served as a critical reminder that language is deeply political and plays a vital role in shaping access to rights and services.

What has stood out across all the presentations is the diversity and richness of perspectives shared. The presenters, drawn from across the African continent, brought regional specificity and practical insight to each topic, allowing students to appreciate both the shared challenges and unique dynamics shaping SRHR in different countries and contexts. Whether speaking from a courtroom, a clinic, a university, or a humanitarian setting, these experts grounded their contributions in lived realities and called on students to think critically and contextually.

As the SRRA programme moves into the second half of the year, it does so with great momentum and purpose. The foundation laid by these first six months has sparked vibrant debates, inspired new avenues of research, and reinforced the programme's commitment to advancing SRHR through rigorous, interdisciplinary, and African-led inquiry. The conversations are far from over, and students are more engaged than ever in the pursuit of a just and inclusive SRHR future for the continent.

Event 2

Surrogacy rhetoric and realities played out from the eyes of the African Gender and Equality Moot Court Competition 2024: Points from the African human rights system.

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Introduction

The African Gender and Equality Moot Court Competition (AGEMCC) 2024, which was held in Kenya and organised by Equality Now, explored surrogacy as a pressing legal and ethical issue through a simulated case before the African Court on Human and Peoples' Rights (Equality Now, 2024). As a judge in the moot, I observed the tension between surrogacy rhetoric, often framed in terms of reproductive autonomy and modern family-making, and the African human rights framework, notably the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) and the African Charter on Human and People's Rights (Protocol to the African Charter, 2003; African Charter, 1981). This paper reflects on the key arguments, gaps, and insights that emerged from the moot, situating them within the broader African human rights system.

Framing surrogacy in the African context

Surrogacy, while increasingly globalised, remains legally and ethically contested in Africa (Fazail, 2023). The continent lacks a unified position or regulatory framework, resulting in fragmented and sometimes contradictory national responses (Andeso, 2024). Some states permit commercial or altruistic surrogacy under strict conditions, while others prohibit it outright, citing exploitation risks, especially to women in poverty (Adelakun, 2018).

At AGEMCC 2024, participants grappled with whether surrogacy could be justified under Article 14 of the Maputo Protocol, which guarantees women's rights to reproductive health, and how to reconcile that right with concerns about commodification, exploitation, and the best interests of the child (Maputo Protocol, 2003; Okenwa-Vincent, 2025). It also deals with the

interpretation of certain provisions within human rights instruments on the issue of surrogacy and states' responsibilities.

Surrogacy is a form of assisted reproductive technology in which a woman (the surrogate) agrees to carry and deliver a child for another individual or couple, referred to as the intended parent(s). This arrangement may be altruistic, motivated by goodwill, or commercial, where compensation is involved (Popovych et al, 2023). In the African context, surrogacy is legally and ethically contested, with divergent national positions and limited regional guidance.

Key legal issues raised in the moot

1. Reproductive Autonomy v Exploitation

Proponents' argument: Surrogacy is an extension of a woman's reproductive autonomy, enshrined in Article 14(1)(a) of the Maputo Protocol (Maputo Protocol, 2003). A woman should have the right to make decisions about her body, including the choice to act as a surrogate.

Opponents' Argument: In contexts of socio-economic disparity, surrogacy arrangements often exploit vulnerable women. The rhetoric of "choice" collapses under scrutiny when women agree to surrogacy out of economic desperation, violating the dignity clause under Article 3 of the African Charter (African Charter, 1981; Viljoen, 2012).

2. The child's best interest

The moot raised difficult questions regarding the rights of children born through surrogacy. Under Article 30 of the African Charter on the Rights and Welfare of the Child (ACRWC), the child's best interest must be paramount (ACRWC, 1990). Yet, legal parentage, nationality, and identity in transnational surrogacy cases often remain uncertain (Andeso, 2024).

3. Commercialisation of the female body

Opponents to surrogacy invoked Article 5 of the Maputo Protocol, which prohibits all forms of exploitation, including harmful practices (Maputo Protocol, 2003). Commercial surrogacy, they argued, turns a woman's reproductive capacity into a transactional commodity, reinforcing patriarchal structures (Okenwa-Vincent,

2025; Fazail, 2023).

Jurisprudential challenges for the African Court

AGEMCC 2024 illustrated the challenges the African Court might face when surrogacy is formally brought before it. The absence of specific AU instruments regulating assisted reproductive technologies creates a legal vacuum (Adjolohoun, 2020). The Court would be forced to interpret existing rights under the Maputo Protocol, the African Charter, and the ACRWC, relying on general principles of dignity, autonomy, and protection from exploitation (Viljoen, 2012; Adelakun, 2018). Furthermore, the moot revealed divergent judicial philosophies. Should the Court adopt a progressive interpretive stance and read surrogacy into the right to health and family life? Or should it exercise caution and defer to national legislatures, emphasising subsidiarity (Adjolohoun, 2020)?

Gender justice and intersectionality in the Moot

One of the most compelling contributions from AGEMCC 2024 was the attention to intersectionality. Students explored how gender, poverty, race, and cross-border power imbalances intersect in the surrogacy industry (Equality Now, 2024). Commercial surrogacy arrangements in Africa often involve foreign intended parents and local surrogate mothers, raising concerns about neocolonial dynamics (Okenwa-Vincent, 2025).

The rhetoric of empowerment used to justify surrogacy was critically examined. Does surrogacy empower women, or does it mask deeper structural inequalities? The moot underscored the need for feminist jurisprudence in interpreting reproductive rights in Africa (Viljoen, 2012; Adelakun, 2018).

Lessons from the Moot Court

As a judge, I observed that the moot fostered robust legal analysis, but also a rich socio-ethical discourse grounded in the African context. The competition highlighted:

1. The normative gaps in the African human rights framework concerning reproductive technologies (Adjolohoun, 2020; Fazail, 2023).
2. The potential of the Maputo Protocol to support

a rights-based, gender-sensitive approach to emerging bioethical issues (Maputo Protocol, 2003).
3. An urgent need for harmonised regional guidelines on surrogacy to protect the rights of all parties involved, especially surrogate mothers and children (Andeso, 2024).

Conclusion: Towards a Pan-African reproductive justice agenda

The AGEMCC 2024 brought to light the complex interplay between surrogacy rhetoric and the lived realities of African women. The moot simulated what could one day be a landmark case before the African Court. While reproductive autonomy is central to the Maputo Protocol, the African human rights system must guard against new forms of exploitation disguised as empowerment (Maputo Protocol, 2003; Viljoen, 2012).

Future advocacy and jurisprudence must chart a path that upholds women's dignity, protects children's rights, and builds a comprehensive continental approach to surrogacy. The insights from AGEMCC 2024 offer a valuable starting point for scholars, practitioners, and policymakers interested in advancing reproductive justice within the African human rights framework (Equality Now, 2024; Okenwa-Vincent, 2025).

RECENT DEVELOPMENTS

The African Union adopts the Convention on Ending Violence Against Women and Girls.

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On 17 February 2025, the African Union adopted the African Union Convention on Ending Violence Against Women and Girls (AUCEVAWG) during the 38th Ordinary Session of the Assembly of Heads of State and Government (African Union, 2025). The document was made available in May 2025. The AUCEVAWG is comprehensive and is the continent's first dedicated legal instrument aimed at preventing and eliminating all forms of violence against women and girls. The Convention comes at a time of renewed urgency in the push to advance gender justice for all women and girls (UN Women Africa, 2025) and its development is informed by the historic decision by the African Union Heads of State and Government in February 2023 during the African Union Summit (African Union, 2025).

According to the African Union, the Convention aims to:

- Establish a comprehensive, legally binding framework for the prevention and elimination of, and effective response to, all forms of violence against women and girls, across Africa. The objective is to identify the root causes and drivers of such violence, strengthening legal and institutional mechanisms, and promoting a culture of respect for human rights, gender equality and the dignity of women and girls.
- Ensure that State Parties reinforce a commonality of approach to eliminating violence against women and girls, whilst acting as a stimulus for an open narrative and advocacy on violence against women and girls (African Union, 2025).

Violence against women and girls remains a widespread issue that cuts across all regions, cultures, and socioeconomic backgrounds. It manifests in many forms, including violence against women in areas of sexual and reproductive health and rights, such as early child and forced marriage, female genital mutilation, and sexual violence, among others. The Convention shows that this is an essential moment for

gender equality in Africa. It is worth noting that Article 17 of the Convention requires 15 Member States of the African Union to ratify or accede to the instrument for it to enter into force (AUCEVAWG, 2025). Therefore, AU Member States must act swiftly and ratify the Convention for it to come into effect and for the people to fully unlock the Convention's transformative potential and ensure practical, life-saving outcomes for women and girls across Africa.

INTERVIEW

An interview with

Dr Satang Nabaneh

1. Please tell us your name and what you do.

My name is Dr Satang Nabaneh, and I am an Assistant Professor of Practice and Research Professor of Law at the University of Dayton, where I also serve as Director of Programmes of the Human Rights Centre. I hold affiliations at the Centre for Human Rights, University of Pretoria, and am a research fellow at the Centre on Law and Social Transformation, Chr Michelsen Institute, University of Bergen. My expertise spans human rights, women's rights, sexual and reproductive health and rights, democratisation, constitution-making, and transitional justice. I am an educator, researcher, and legal scholar, and have been featured in prominent media outlets such as The New York Times, Reuters, Time, Ms Magazine, and the Council on Foreign Relations' Think Global Health. I was also recognised as one of 10 exceptionally talented African scholars to watch in 2024 by The Africa Report. In 2023, I was the recipient of the Women in Law Academia International Award from the Women in Law Initiative, Austria. Driven by a longstanding commitment to reproductive and social justice, I have engaged in advocacy and research to examine how laws, politics, and socio-cultural and institutional dynamics shape SRHR in Africa.

2. As an alumnus of the Sexual and Reproductive Rights in Africa (SRRA) LLD programme, how would you describe your experience and how has it impacted the work you currently do?

My experience in the SRRA LLD programme was truly transformative. It provided me with a deep and nuanced understanding of the complex legal and social frameworks governing sexual and reproductive health and rights (SRHR) in Africa. The programme equipped me with the critical analytical tools and knowledge necessary to engage meaningfully with these issues.

During my doctoral training, I served as a legal advisor for the Women's Rights Unit at the Centre, supporting the work of the Special Rapporteur on the Rights of Women in Africa of the African Commission on Human and Peoples' Rights (ACHPR). In this role, I was actively

involved in the drafting of key normative instruments, including General Comments and Guidelines related to the Maputo Protocol. This experience allowed me to not only demonstrate my deep understanding of these critical frameworks but to translate them into actionable strategies for building partnerships and advocacy at national, regional, and international levels. The networks I built during the programme have been instrumental to my ongoing collaborations and research initiatives. Additionally, my involvement in teaching and coordinating the LLM programme allowed me to contribute meaningfully to the training of the next generation of advocates.

3. Please tell us about the nature of your work/research in relation to sexual and reproductive health and rights (SRHR).

My work and research in SRHR are multifaceted. Academically, I teach and supervise postgraduate students on various aspects of human rights law, including SRHR. My research often explores the intersection of law, policy, and practice in SRHR, examining issues such as access to safe abortion, including my work on conscientious objection, Choice and Conscience: Lessons from South Africa for Global Debate (PULP, 2023), comprehensive sexuality education, maternal health, and harmful practices, including female genital mutilation (FGM). I also engage in policy analysis and advocacy, working with various organisations to promote the implementation of international and regional human rights standards related to SRHR. This includes contributing to policy briefs, developing national guidelines (such as the National Policy for the Elimination of Female Genital Mutilation in The Gambia 2022-2026), convening colloquiums and editing subsequent publications such as Female Genital Mutilation in Africa: Politics of Criminalisation (PULP 2025) and participating in expert consultations.

4. Why did you choose to focus on these aspects of SRHR? What inspired you?

My focus on SRHR stems from a deep-seated belief in bodily autonomy and the fundamental human right to make decisions about one's own health and life. Growing up in The Gambia, I witnessed firsthand how limited access to SRHR information and services impacts individuals and communities—particularly

women and girls. These early experiences, combined with my legal training, inspired me to dedicate my career to addressing these critical issues. I am especially drawn to the understanding that SRHR are not solely health concerns, but are deeply interconnected with gender equality, poverty reduction, and broader human development. As a proud African feminist scholar-activist, I am a strong believer in trying to bridge the worlds of theory and practice. My feminist work, through activism, action-oriented research, is broadly geared towards challenging gender and other intersecting inequalities.

5. What would you consider to be your major achievements?

Among my major achievements, I would highlight my contributions to academic discourse through my publications and presentations, which aim to shed light on critical SRHR challenges and propose rights-based solutions. I am also proud of the work I have done in capacity building, particularly through mentoring and supervising emerging scholars and advocates in the field, and my role in teaching in the LLM programme. Furthermore, I believe that my consistent engagement in policy advocacy, even in small ways, contributes to shaping a more enabling environment for SRHR in Africa. Being recognised as one of 10 exceptionally talented African scholars to watch in 2024 by The Africa Report and my features in prominent media outlets demonstrate the impact and relevance of my work. Seeing the progress, however incremental, in policy reforms and awareness is a significant achievement for me.

6. What are the challenges and risks you face while doing this work?

The work in SRHR, especially in some contexts, comes with significant challenges and risks. One major challenge is the prevailing societal and cultural conservatism that often stigmatises SRHR issues, making open discussions and advocacy difficult. This can lead to resistance to policy reforms and limited resources for SRHR initiatives. Another challenge is the political sensitivity surrounding certain aspects of SRHR, which can result in a lack of political will to implement progressive laws and policies and backlash, including the push to decriminalise FGM in The Gambia. From a personal perspective, engaging in

this work can sometimes lead to personal attacks and even threats, particularly when advocating for highly contentious issues. Funding limitations for research and advocacy are also a constant hurdle.

7. As an academic/advocate in this field, do you think that the information and services provided for SRHR are adequate? Please explain.

No, generally speaking, I do not think that the information and services provided for SRHR are adequate. Across many parts of Africa, there are significant gaps in the adequacy of SRHR information and services. Information is often incomplete, inaccurate, or inaccessible, particularly for young people, rural communities, and marginalised groups. As I wrote elsewhere, CSE, if it exists at all, is often not age-appropriate or evidence-based. This lack of accurate information contributes to misconceptions, risky behaviours, and an inability for individuals to make informed decisions about their bodies and health.

Regarding services, access remains a major barrier. Many communities lack sufficient healthcare facilities, and even where they exist, they may not offer the full range of SRHR services. Stockouts of essential commodities, lack of trained healthcare providers, and high costs further compound these issues. Furthermore, societal stigma and discriminatory attitudes from healthcare providers can deter individuals from seeking necessary services, particularly for sensitive issues like contraception and abortion. Legal and policy restrictions in many countries also limit the scope and availability of critical SRHR services.

8. In your opinion, how can SRHR information and services be improved for your target community? Going forward, what are some of the changes you would like to see?

To improve SRHR information and services, a multi-pronged approach is necessary. First, there needs to be a significant investment in comprehensive, evidence-based, and age-appropriate sexuality education integrated into school curricula and community programmes. Enhancing accessibility and quality of

SRHR services is also crucial. This involves increasing the number of well-equipped health facilities, training more healthcare providers in a rights-based approach, and ensuring the consistent availability of a full range of SRHR commodities. Services should be youth-friendly, confidential, and free from stigma and discrimination. Telemedicine and mobile health clinics could also be leveraged to reach underserved populations. Third, addressing legal and policy barriers is paramount. This includes advocating for the reform of restrictive laws, such as those criminalising abortion or limiting access to contraception, an area where my legal expertise and research are particularly relevant. Finally, community engagement and awareness campaigns are vital to challenge harmful social norms, reduce stigma, and foster an environment where individuals feel empowered to seek and utilise SRHR information and services.

Going forward, I would like to see several key changes. A greater political commitment to SRHR as a fundamental human right, translated into increased budgetary allocations and the effective implementation of progressive policies. I would like to see more robust collaborative research and advocacy efforts across Africa and globally, fostering a stronger regional movement for SRHR and sharing best practices to accelerate progress.

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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:

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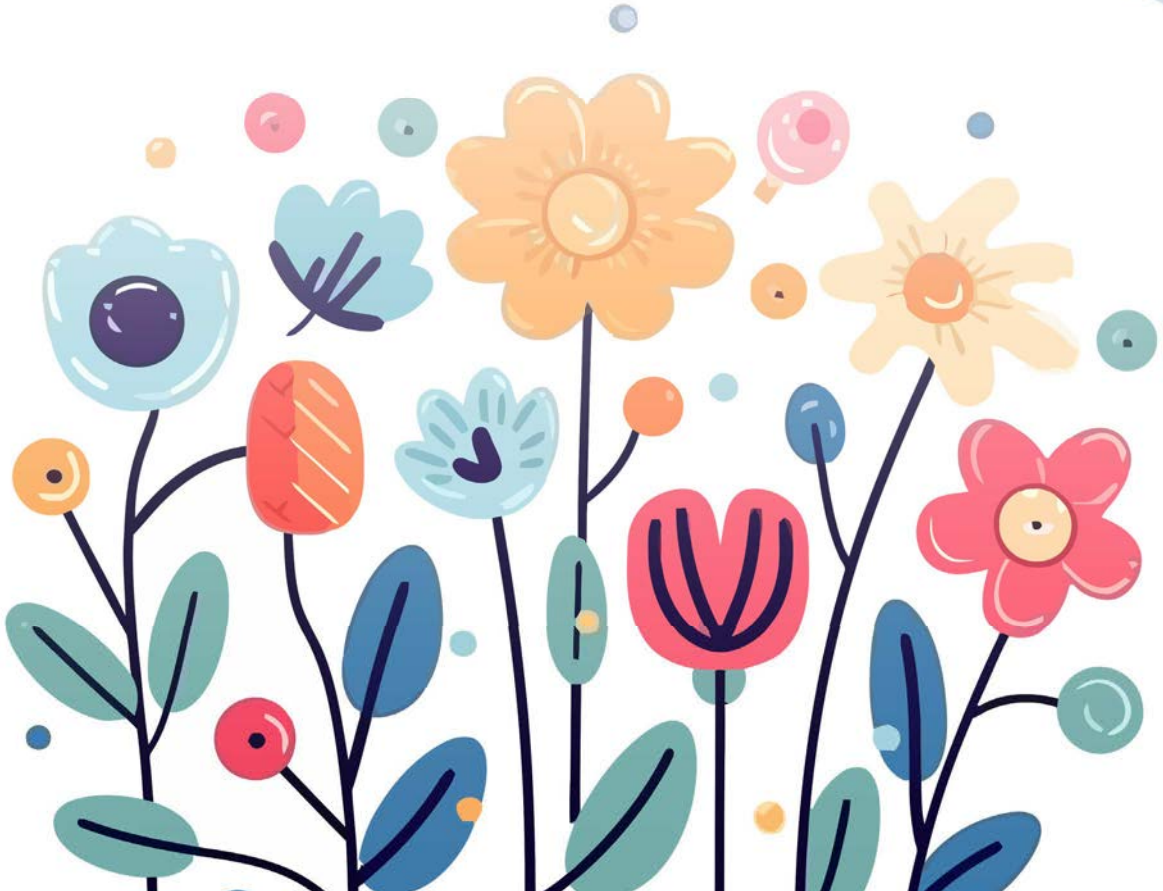

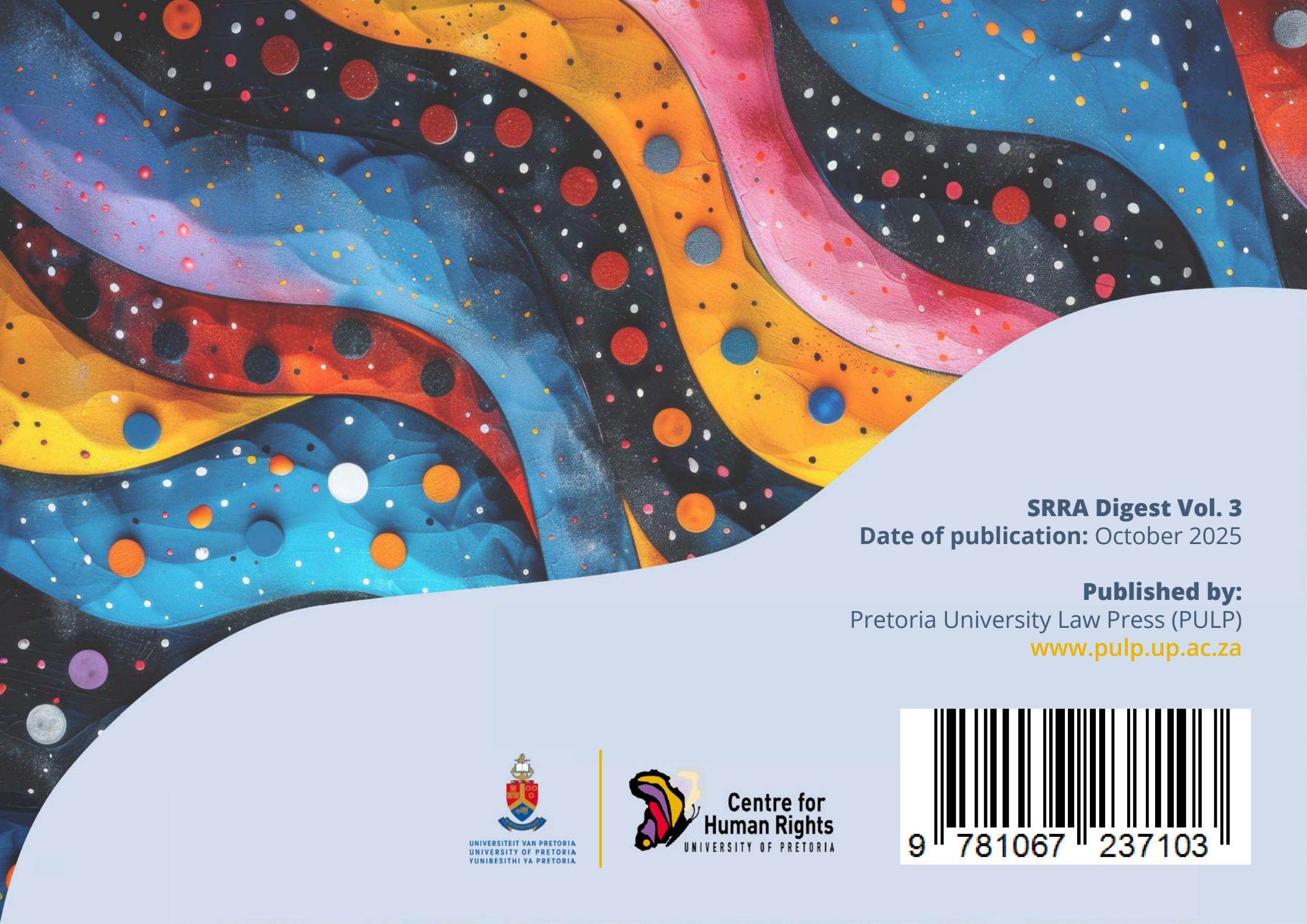

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