

Sexual And Reproductive Rights In Africa DIGEST Vol. 4



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**THE
EDITORIAL**

This volume of the SRRRA Digest highlights the on-going struggle for sexual and reproductive rights across Africa, featuring insightful articles, a summary of events, a recent development within the African Union and an interview that sheds light on the complexities of this issue. The topics covered are diverse, ranging from the challenges faced by women in accessing SRHR services to the role of traditional and religious leaders in shaping SRHR policies.

In the feature articles, Mercy Valery Aluoch explores the fight for women's sexual and reproductive rights, emphasising the need for comprehensive sexuality education, accessible healthcare and laws that protect women's autonomy. Abdul-Razak Mohammed examines the influence of traditional and religious leaders on LGBTQ+ SRHR in Ghana, arguing that engaging these leaders is crucial for advancing inclusive policies. The article highlights the tension between cultural values and human rights, emphasising the need for dialogue and education.

Other features include an analysis of a landmark court decision in Lesotho by Mathalea Ntaote and Bokang Moshoeshe, where the High Court ruled that pregnant soldiers cannot be discharged, recognising their right to reproductive autonomy. Nadia Wadja critiques the concept of "universality" in SRHR policies, arguing that they often exclude sexual minorities. The section on events, written by Danielle Visser, reflects on the strong start to the year for the SRRRA Master's programme. She highlights the engaging monthly presentations, which focus on methodological development and community-driven approaches to SRHR. Maryanne Nkechi Obiagbaoso provides a summary of recent developments in the African Union's election of seven experts to serve on the African Committee of Experts on the Rights and

Welfare of the Child (ACERWC) to monitor and report on child rights in Africa. Our interview with Dr Ibrahim Banaru Abubakar offers a compelling narrative of his journey from clinical practice to advocacy, highlighting the impact of the SRRRA Master's programme on his work.

Overall, the collection of articles and interview provides a nuanced and informative look at the state of SRHR in Africa. It highlights the challenges that need to be addressed and provides insights into the ways in which progress can be made. As we reflect on the progress made and the challenges ahead, it's clear that the fight for sexual and reproductive rights in Africa is far from over. The stories, insights, and analyses in this volume remind us that the pursuit of justice, dignity and equality must continue.

Editor:
Prof Ebenezer Durojaye

Co-editors:
*Maryanne Nkechi Obiagbaoso &
Amon Aruho*





**Feature
Articles**



Feature Article 1

The fight for women's sexual and reproductive rights across Africa

Introduction

In a small village in rural Uganda, a 16-year-old girl named Amina stood in front of a group of women, holding a handmade cloth doll. "This is Zawadi," she said, naming the doll. "She's 14 and just got married. She doesn't even know what a period is." The women laughed, some nervously, but Amina's face was serious. "This was me, two years ago."

Amina's story is not unique. Across Africa, millions of girls and women are navigating complex terrain when it comes to their sexual and reproductive rights, often without a map, let alone a compass.

What are sexual and reproductive rights, anyway?

Sexual and reproductive rights mean the right to:

- a. Make decisions about your body without violence, coercion, or discrimination.
- b. Access information and education about sex, menstruation, family planning, and health.
- c. Access safe and affordable healthcare, including contraception, maternal care, and abortion (where legal).
- d. Live free from harmful practices such as female genital mutilation (FGM), child marriage, and gender-based violence. (UNICEF, 2021).

It is about agency, dignity, health and in many cases, survival.

A continent of contrasts

Africa is a continent of beauty and brilliance, but also of stark contrasts. On one end, we have progressive policies, such as the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), one of the most inclusive in the world regarding women's reproductive rights. On the other hand, we find countries where discussing menstruation openly is taboo, and girls miss school because they do not have access to sanitary pads.

Take Kenya, for instance. The government has made strides by distributing free sanitary towels in public schools and launching campaigns aimed at preventing teen pregnancy. But in the same breath, conservative opposition often shuts down comprehensive sexuality education, leaving teenagers with half-truths and harmful myths like "you can't get pregnant your first time" (Kenya Ministry of Education, 2019). Meanwhile, in Nigeria, millions of women still face life-threatening childbirth complications because rural clinics lack electricity or trained staff (African Union, 2020). And in parts of Mali and Somalia, FGM remains deeply rooted in tradition, despite its dangers and the laws against it (World Health Organisation, 2023).

Silence is expensive

Let us talk money. When we ignore reproductive rights, we do not just harm individuals, we hurt economies. According to the

Guttmacher Institute (Guttmacher Institute, 2017), every \$1 invested in contraceptive services in low- and middle-income countries saves \$3 in maternal and new-born healthcare. Countries with lower fertility rates and empowered women tend to have stronger economies, healthier children, and fewer maternal deaths (Guttmacher Institute, 2017). Silence about sex is not wisdom, it is costly.

Voices of change: From whisper to roar

Across Africa, bold voices are emerging, young, passionate, and unstoppable. In Rwanda, a youth-led movement called “Girl District” trains teenage girls to speak out about their rights. In Ghana, radio hosts like “Auntie Akosua” use storytelling in the vernacular to answer anonymous questions from girls who are too shy to speak to their parents. In Kenya, organisations like “She Matters” are going door-to-door in informal settlements to talk about consent, contraception, and dignity (Kenya Ministry of Education, 2019). Even men are joining the conversation. In Tanzania, Men Engage works with fathers, brothers and uncles to break cycles of toxic masculinity and promote shared responsibility for sexual health (African Union, 2020).

The way forward: What can be done?

Here is the truth. Change is happening, but it is not happening fast enough. To truly shift the landscape, we need:

- i. Comprehensive sexuality education in schools that is age-appropriate, medically accurate and culturally relevant.

- ii. Accessible and youth-friendly healthcare services, especially in rural and marginalised areas.
- iii. Laws that are enforced, not just written. It is not enough to criminalise child marriage or FGM; communities must be educated and empowered to challenge harmful norms.
- iv. Bold political will. Leaders who do not fear backlash but fight for what is right.
- v. Funding, because passion without resources is like planting seeds in dry sand.

And above all, we need to listen to the voices of girls and women, not just as victims or statistics, but as decision-makers, leaders and shapers of their own destinies.

A story yet to be finished

Amina’s story did not end with her early marriage. With the help of a local women’s centre, she went back to school, learned about her rights, and now dreams of becoming a nurse. She teaches other girls in her community to say “no”, to ask questions, and to dream bigger. In her words, “They used to say a girl’s place is in the kitchen. Now, we are showing them, it can be in the clinic, the courtroom, the classroom, or even on the radio.” The story of sexual and reproductive rights in Africa is still being written. The ink is in our hands.

Mercy Valery Aluoch

LLB Candidate, Egerton University, Kenya

Email: aluoch_m@yahoo.com

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Feature Article 2

Between culture and rights: How traditional and religious leaders influence LGBTQ+ SRHR in Ghana

Introduction

Ghana is currently at a critical crossroads in its human rights journey, with the looming passage of an anti-LGBTQ+ bill threatening to roll back decades of progress on sexual and reproductive health and rights (SRHR). Framed as a response to so-called “moral decay”, the bill enjoys widespread public support. This support has been shaped and amplified by religious leaders and traditional authorities alike. In many parts of the country, these figures are seen not merely as community elders but as moral custodians whose word often outweighs legal reasoning or scientific evidence (Asante, 2024).

Yet, this deeply entrenched influence can be both a challenge and an opportunity. While some leaders have mobilised in favour of the bill, history and cultural memory remind us that Ghanaian traditions once allowed space for diverse sexualities, as seen in practices like *Agɔnwole agyalɔ* among the Nzema. This article argues that engaging traditional and religious leaders is not optional. It is strategic. According to Yekple and Mitkov (2024), sustainable LGBTQ+ and SRHR advocacy in Ghana must include, educate and elevate local institutions as key stakeholders in shaping a more inclusive future.

Colonial imposition and post-independence legacies

A dominant narrative in contemporary Ghana frames homosexuality as foreign, immoral and “un-African” (Nartey, 2022). Yet, this claim collapses under the weight of historical evidence. Among the Nzema people of South-western Ghana, anthropological studies have documented the existence of *Agɔnwole agyalɔ*; This is a culturally sanctioned union where adult same-sex couples would enter into formal partnerships involving cohabitation, mutual support, and intimate bonding, recognised and celebrated through customary marriage rites within the community (Ako, 2023). As detailed in the 1973 study by Signorini, these unions were neither stigmatised nor hidden; they were embedded in the social fabric and recognised by customary norms.

Pre-colonial Ghana was home to a rich tapestry of gender expressions and sexual practices that defy modern heteronormative standards. However, with the arrival of European colonial administrators and Christian missionaries, these indigenous systems were systematically dismantled. Colonisers imposed Victorian moral codes and anti-sodomy laws, recasting African sexual diversity as deviant and unnatural. Christian doctrine further vilified same-sex relationships, associating them with sin and spiritual corruption (Han and O’Mahoney, 2014).

In the post-independence era, nationalist leaders adopted these colonial legacies, often to align with conservative international allies or maintain social order. Over time, what was once normalised became taboo, and the myth of homosexuality as “un-African” took root. Reclaiming this buried history is essential

not only to counter misinformation but to ground SRHR advocacy in Africa's own cultural realities (Ezeador and Okpara, 2024).

In Ghana, traditional and religious leaders occupy a dual throne of influence. They act as the guardians of cultural heritage and as spiritual anchors of entire communities. Their voices resonate beyond the pulpit and palace. They shape family life, community values and increasingly, national discourse on SRHR issues.

This influence has become particularly visible in the on-going national debate over the anti-LGBTQ+ bill. The bill, which seeks to criminalise not only same-sex relations but also LGBTQ+ advocacy and allyship, has garnered vocal support from prominent religious coalitions such as the Ghana Pentecostal and Charismatic Council ("Assent to LGBTQ+ Bill," 2024). Simultaneously, the National House of Chiefs, a constitutional body composed of paramount traditional leaders, holds substantial sway over national policy. Following the election of President John Dramani Mahama, he invited the steering committee of the National House of Chiefs to tap into their wisdom (Mahama Holds Meeting, 2025). In 2023, the President of the National House of Chiefs, Ogyeahoho Yaw Gyebi II, insisted that traditional rulers will continue to oppose such acts to uphold the country's traditions and culture (Activities of LGBTQ are evil, abominable", 2023). Belonging to the LGBTQ+ community in Ghana can lead to being outed through setups, often resulting in police arrests or mob attacks. Many queer individuals also face job loss or are denied employment solely based on their perceived or real sexual orientation (Human Rights Watch, 2018).

In contrast, a few progressive religious and traditional voices have called for tolerance and compassion. However, these remain

marginal and often face community backlash. The absence of a clear, coordinated response from traditional leaders has allowed misconceptions about LGBTQ+ identities to flourish, reinforcing the myth that queerness is incompatible with Ghanaian values.

Engaging these leaders, whether as opponents, fence-sitters, or potential allies, is thus critical. Their platforms can amplify inclusive messages or deepen hostility. For grassroots movements and policymakers alike, the path to meaningful SRHR reform must include dialogue with these powerful actors, not avoidance.

Pathway for grassroots engagement

Many grassroots LGBTQ+ and SRHR organisations in Ghana direct their advocacy towards legal reform, policy change and international funding bodies. While these efforts are essential, they often neglect a crucial dimension: local power structures. Traditional and religious leaders are not just cultural figures; they are policymakers in their own right. Their endorsement or resistance can make or break the implementation of inclusive laws, healthcare policies and public education.

Failing to engage these leaders has consequences. In many rural and peri-urban areas, community members look to their chiefs and pastors for guidance, not parliamentarians or legal experts. Without the support or at least neutrality of these figures, even the most well-crafted policy risks rejection at the grassroots level. Worse still, their public condemnation can ignite cultural backlash, fuelling violence, stigma and political stagnation.

Lessons from countries like Botswana and South Africa show that change is possible when cultural leaders are included in the advocacy ecosystem. In Botswana, advocacy efforts that included dialogue with tribal chiefs helped pave the way for the decriminalisation of same-sex relations (Yekple and Mitkov, 2024). Similarly, in South Africa, the constitutional protection of LGBTQ+ rights emerged not only through top-down legal frameworks but through sustained grassroots mobilisation that engaged traditional healers, community elders, and faith-based organisations in dialogue about human dignity, ubuntu (interconnectedness), and the lived realities of LGBTQ+ South Africans (Reddy, 2009). In Ghana, elevating grassroots organisations to meaningfully engage traditional institutions is not just strategic, it is survival. Long-term change requires shifting hearts and minds from the ground up, and that begins with those who hold sway over community values. If Ghana is to make meaningful strides in LGBTQ+ and SRHR advocacy, grassroots engagement with traditional and religious leaders must be at the heart of the movement. Local LGBTQ+ organisations should be empowered not only to defend rights in legal forums but to dialogue, educate and reframe narratives within their communities. A promising entry point lies in targeting youth chiefs, queen mothers and progressive spiritual leaders who are more open to learning and change. These individuals often possess influence without the rigidity of older gatekeepers and can act as bridges between tradition and modernity.

To support this shift, capacity-building initiatives should train activists in culturally competent communication, religious literacy, and storytelling. Intergenerational dialogue between elders who

hold history and youth who demand change can foster mutual respect and dismantle myths. Additionally, engaging local artists, oral historians, and traditional communicators (griots) can give advocacy campaigns emotional and cultural depth that resonates beyond policy briefs. Grassroots efforts must not exist in silos. International partners and national NGOs should channel resources into community-based programming that respects and reflects local realities. If change is to be sustainable, it must be owned by the communities themselves and that includes the chiefs, pastors, and elders who shape hearts and minds.

Conclusion

Traditional and religious leaders in Ghana are not inherently hostile to LGBTQ+ inclusion, they are products of complex histories and social currents. Rather than dismissing them as obstacles, we must view them as potential bridges to change. Engaging these leaders is not about importing foreign ideologies but about restoring dignity, truth and plurality to African sexual histories that colonialism erased. A future where LGBTQ+ rights and SRHR flourish in Ghana is possible. But only if advocacy is rooted in community, culture and memory. The journey ahead may be difficult, but it begins with courageous dialogue, cultural re-education and a willingness to honour both tradition and human dignity.

Abdul-Razak Mohammed SD,

Programs and Advocacy Director, Justright Ghana

Email: shamsudeenrazak@gmail.com

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Feature Article 3

Carry a gun or carry a child? Sexual & reproductive rights in Lesotho Defence Force: Revisiting *Mokhele and Others v Commander Lesotho Defence Force and Others CIV/APN/442/16 (14 February 2018)*

Summary of facts

In 2018, the High Court of Lesotho handed down a landmark decision in *Mokhele and Others v Commander of the Lesotho Defence Force and Others*, setting aside the discharge of three female soldiers who were expelled from military service for falling pregnant. The applicants, all privates in the Lesotho Defence Force (LDF), were discharged between December 2015 and March 2016 after falling pregnant within five years of enlistment. The Commander relied on Standing Order 2 of 2014, which expressly prohibited pregnancy within the first five years of service. The applicants were accused of violating this order despite explanations ranging from contraceptive failure to unplanned pregnancies, including one case involving the influence of alcohol. Each applicant pleaded for reconsideration, citing personal circumstances and the unintentional nature of their pregnancies. Their requests were denied. The LDF justified the discharges by arguing that the pregnancies undermined military discipline and operational readiness. The applicants, in turn, brought the matter before the High Court, challenging the legality and constitutionality of their discharge.

Issues

Whether the decision of the Commander of the LDF discharging the applicants from the LDF should be reviewed and set aside for being unlawful and irregular; whether the Standing Order 2 of 2014 issued by the Commander of the Lesotho Defence Force is illegal and invalid; and whether the applicants should be reinstated back to their positions and ranks in the LDF without any loss of benefits arising therefrom.

Analysis and determination

The judgment forcefully rejected the notion that pregnancy, in and of itself, rendered female soldiers unfit for service. It found that the Standing Order was inconsistent with the Defence Force's own regulations, which do not list pregnancy as a ground for discharge but rather entitle pregnant soldiers to paid maternity leave. The Commander's interpretation of "best interests of the Defence Force" under section 31(b) of the LDF Act 4 of 1996 was held to be overly broad and legally unfounded. The Court held that the policy in question compelled female soldiers to either abstain from sex or rely on contraceptives (which, as acknowledged by the LDF, are not 100% effective). It presented motherhood and military service as mutually exclusive - you could carry a gun or carry a child, but not both. This not only infantilised female soldiers but also echoed wider societal messages that women must earn public space by suppressing their reproductive identities. Such policies do not just harm individual women; they have institutional consequences. As the court noted, excluding or punishing pregnant soldiers risks driving talented women away from public service or discouraging them from joining in the first

place. This undermines gender equality objectives and deprives state institutions of representative and inclusive leadership.

Conclusion

The High Court, in a unanimous judgment delivered by His Lordship Chief Justice Sakoane, did not mince words. The court struck down the discharges, declared Standing Order 2 of 2014 illegal and invalid, and ordered the reinstatement of the applicants with full benefits.

Significance

At its core, this case was a confrontation between reproductive autonomy and institutional discipline in the context of a heavily patriarchal military structure. The judgment's SRHR implications are significant. The court acknowledged the rights framework under the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the 2000 ILO Maternity Protection Convention 183, and Lesotho's Constitution, particularly the right to equality, dignity, and non-discrimination. Although not explicitly invoked, the ruling also aligns with the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, to which Lesotho is a party. Article 14 of the Protocol guarantees women the right to control their fertility and to decide freely on the number and spacing of children. It also obliges states to protect the reproductive rights of women, particularly in the workplace, by authorising maternity leave, medical care and family planning education.

In recognising that pregnancy should not be a basis for discharge, the court brought Lesotho's domestic jurisprudence closer to regional and international SRHR standards. It also embraced the principle of "reasonable accommodation" - a concept increasingly advocated in SRHR discourse - which demands that institutions adjust their practices to support, rather than punish, biological and social realities like pregnancy and caregiving.

Mokhele represents more than a judicial slap on the wrist for military overreach. It reveals how militarised, male-dominated spaces can become fertile ground for reproductive oppression. In treating pregnancy as a disciplinary violation rather than a biological and social reality deserving protection, the military reinforced a culture where women are only welcome if they suspend key aspects of their personhood.

But more than a labour or administrative law matter, Mokhele exposes how state institutions can reproduce reproductive injustices under the guise of operational efficiency and discipline. It challenges the troubling notion that military women must choose between motherhood and service - a false dichotomy that violates the sexual and reproductive health and rights (SRHR) of women in uniform.

Importantly, the court recognised the policy as inherently discriminatory - it targeted only women, penalised them for exercising reproductive agency, and presumed them unfit without any medical or individual assessment. It created a hostile, coercive reproductive environment where contraception was mandated under threat of job loss, and pregnancy was treated

as misconduct. In short, the policy institutionalised reproductive control under a veneer of military order.

In *Mokhele v Commander LDF*, the High Court of Lesotho affirmed a truth too often denied to women in uniform: that reproductive rights do not end at the gates of the barracks. The decision is a clarion call to all institutions - especially those wielding power over women's lives and bodies - to respect reproductive autonomy and uphold gender equality. This case is not just about three women; it is about the on-going struggle to ensure that women in Africa can serve their countries without being forced to abandon their reproductive identities in the process. Justice, in this context, means the freedom to carry a gun and carry a child on one's own terms.

Mathalea Ntaote

LLB (Hons), National University of Lesotho

Advocate of the High Court of the Kingdom of Lesotho

Email: Mathaleantaote@gmail.com

Bokang Moshoeshoe

LLB (Hons), National University of Lesotho

Advocate of the High Court of the Kingdom of Lesotho

Email: bokangmoshoeshoe918@gmail.com

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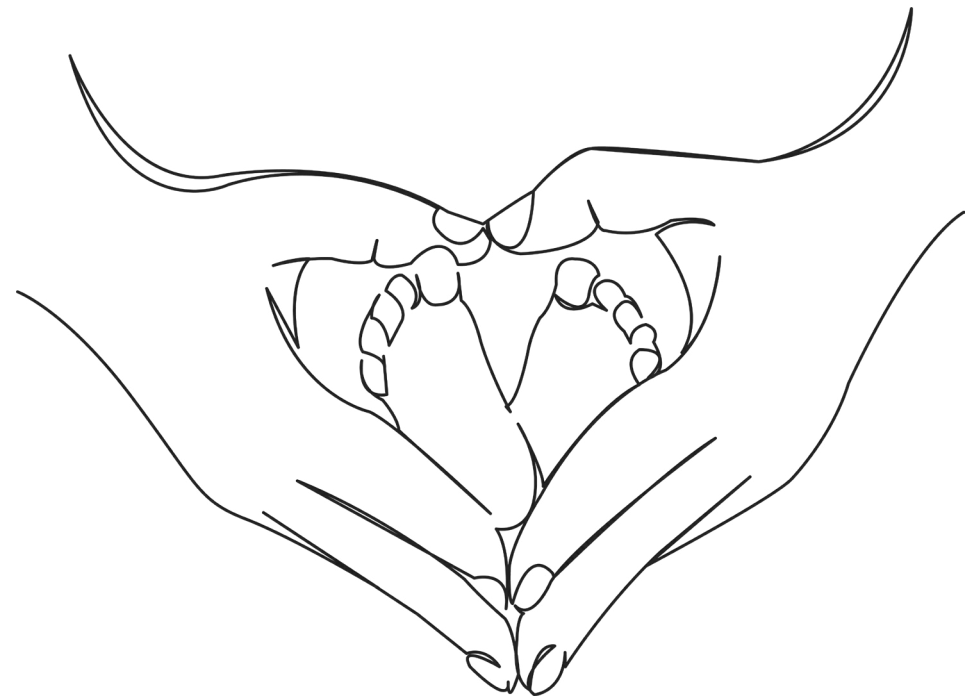
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Feature Article 4

The universal patient does not exist: How African sexual and reproductive health and rights' policies use universality to exclude sexual minorities

In Cameroon, LGBTQI+ (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and others) individuals routinely report being turned away from health facilities based on their perceived sexual orientation. Health workers have cited patients' same-sex relationships as explicit grounds for refusing basic reproductive services, including pap smears and contraception (Alternatives-Cameroun, 2022). In Uganda, following the passage of the Anti-Homosexuality Act in 2023, a joint statement by the Global Fund, UNAIDS, and PEPFAR warned that the country's entire HIV response was now "in grave jeopardy," as stigma had already led to reduced access to prevention and treatment (Human Rights Watch 2024). These are not isolated incidents. They are symptoms of a structural contradiction at the heart of sexual and reproductive health and rights (SRHR) policy in Africa: policies that claim to serve everyone while being designed, in practice, for a specific kind of patient. This article argues that the problem is not simply that LGBTQI+ people are excluded from SRHR. It is that very concept of "universality," as it operates in African health policies is the mechanism of their exclusion.

The architecture of invisibility

Africa has made genuine progress in SRHR. The African Union's Continental Policy Framework on SRHR (African Union Commission 2006), national HIV strategies, and the growing

engagement of civil society are real achievements. However, this progress has been built around a particular model of the patient: heterosexual and cisgender in need of primary reproductive care (contraception, maternal health and fertility services), rather than sexual health understood more broadly. Sexually Transmitted Infection (STI) prevention tailored to diverse sexual practices, hormonal care for transgender persons, gynaecological services for lesbian and bisexual women; none of these appear in the standard package of "universal" SRHR (FEMNET 2023). The needs of sexual minorities are not merely underserved; they are unimagined by the system. Health statistics do not record them. Clinical protocols do not address them. Policy frameworks do not name them (Broqua 2012). In the world constructed by African SRHR policy, these patients do not exist. This absence is not an oversight. It is a design feature. A policy does not need to explicitly exclude anyone if the "universal" category it invokes was never built to include them. The word "universal" thus performs a double function: it promises inclusion in principle while foreclosing it in practice. Moreover, because it sounds inclusive, it inoculates itself against challenge. To question whether "universal" SRHR truly reaches everyone is to appear to question universality itself.

The hierarchy within inclusion

The exclusion is not uniform. Even within LGBTQI+ populations, some groups are less invisible than others and the pattern reveals the limits of the policy space that does exist.

Gay men, particularly in the context of HIV, have received more attention. Kenya's AIDS Strategic Framework II (KASF II, 2020/21-

2024/25) explicitly includes men who have sex with men (MSM) as a key population in the national HIV response (NACC 2020). This represents a genuine breakthrough in a country where same-sex conduct remains criminalised. But the framework makes no equivalent provision for lesbian women, bisexual persons, or transgender individuals. Their health needs, gynaecological care, hormonal treatment, mental health support and protection from sexual violence fall outside the HIV-focused lens that has created the only policy opening for sexual minorities. This pattern repeats across the continent. The limited policy space for LGBTQI+ health is almost entirely confined to HIV programming targeting MSM. The broader needs of other groups remain unaddressed, not because they are unknown, but because they do not fit the epidemiological framing that made inclusion politically acceptable. The result is a hierarchy of legitimacy within the margins: a tiered system in which certain LGBTQI+ bodies are instrumentally visible (because they are relevant to HIV targets) while others remain entirely erased. Universality, even when partially extended, reproduces inequality.

When the law itself is the barrier

These policy exclusions are compounded by a legal environment that actively punishes LGBTQI+ existence. In over 30 African states, same-sex relations remain criminalised (ILGA World 2020). The trend in several countries is toward escalation: Niger explicitly criminalised “LGBTQIA+ practices” in its 2025 Charter of Refoundation; Mali’s new Penal Code entered into force in December 2024 with provisions punishing same-sex acts; and Ghana’s parliament passed the Human Sexual Rights

and Family Values Bill in 2024 (ILGA World Database 2025). Uganda’s Anti-Homosexuality Act of 2023 represents the most extreme manifestation. The law prescribes the death penalty for “aggravated homosexuality” and criminalises the “promotion” of homosexuality with up to 20 years’ imprisonment.

In April 2024, the Constitutional Court of Uganda upheld most of its provisions, invalidating only the clauses restricting health care access and mandating reporting of suspected homosexual acts (Human Rights Watch 2024). The message is clear: the state may permit you to access a clinic, but it will punish you for being who you are when you leave it. Criminalisation not only creates a climate of fear in which LGBTQI+ individuals avoid health services (Yamin and Maleche 2017). It makes inclusive health policy structurally incoherent. A state cannot simultaneously criminalise same-sex conduct and claim that its health system serves everyone. The two positions are logically incompatible. Yet this is precisely the position that over 30 African states maintain.

A system at war with itself

This incoherence is reproduced at the regional level. In 2014, the African Commission on Human and Peoples’ Rights adopted Resolution 275, condemning violence based on real or imputed sexual orientation or gender identity and calling on states to enact protective legislation (ACHPR 2014). Resolution 275 grounded itself in Articles 2, 3, 4, and 5 of the African Charter, the foundational guarantees of non-discrimination, equality and dignity. Then the retreat began. In 2018, under pressure from the African Union’s Executive Council, the Commission revoked the observer status of the Coalition of African Lesbians (CAL), a

South Africa-based advocacy organisation, because its work was “contrary to African values” (Article 19, 2018).

In November 2022, the Commission went further, rejecting the observer status applications of three additional organisations: Alternative Côte d’Ivoire, Human Rights First Rwanda, and Synergia, stating that “sexual orientation is not an expressly recognised right or freedom under the African Charter” and is “contrary to the virtues of African values” (Human Rights Watch 2022). This sequence, Resolution 275 in 2014, the revocation of CAL’s status in 2018 and the rejection of three organisations in 2022, is not a story of stalled progress. It is a story of an institution in contradiction with itself. The Commission adopted a resolution that recognised the vulnerability of sexual minorities and then systematically excluded the organisations working to implement it. As the joint civil society statement responding to the 2022 decision observed, the rejection “makes Resolution 275 itself inoperable since it stigmatises everyone that would work to make it real” (Human Rights Watch 2022). This is what institutional exclusion looks like when dressed in the language of values.

What communities are building

Where the state excludes, communities create. In Douala, Alternatives-Cameroun provides direct healthcare, legal assistance, and emergency shelter to LGBTQI+ individuals rejected by the formal system operating in a country where same-sex acts carry up to five years’ imprisonment. In Nairobi, the Gay and Lesbian Coalition of Kenya (GALCK) coordinates access to sexual health services and peer support for key populations.

In East Africa, human rights-based approaches have enabled local health programmes to develop specialised protocols that respond directly to the needs of sexual minorities (Yamin and Maleche 2017). These organisations do not merely fill gaps. They demonstrate daily that a different model of SRHR is possible, one built on confidentiality, dignity and non-discrimination as operational standards. They do this at considerable personal risk, facing harassment, criminalisation, and violence for the care they provide.

Rewriting universality

Universality is not a fact. It is a claim and like all claims, it must be judged by its evidence. When SRHR policies claim to serve everyone while their design excludes sexual minorities, when states criminalise the very populations they pledge to protect, when the African Commission condemns violence against LGBTQI+ people and then shuts the door on their advocates, the evidence does not support the claim. Making universality real requires concrete action. National SRHR frameworks must explicitly include sexual minorities as a design principle. Health data must be disaggregated by sexual orientation and gender identity what is not counted does not count. The African Commission must be held to the commitments it undertook through Resolution 275 (commitments that remain largely unimplemented more than a decade after their adoption). Community-led organisations must be recognised as permanent partners in health delivery. The decriminalisation of sexual and gender diversity remains the essential precondition without

which no health system can credibly claim to be universal. The right to health belongs to every person, in every body and not only those whose bodies conform to heterosexual and cisgender norms. Rewriting universality to include sexual minorities is not an expansion of SRHR, it is a correction. It is long overdue.

Nadia Wadja

PhD Candidate, International Human Rights Law, Université Grenoble Alpes (France); Legal Consultant.

Email: wadja.nadia@gmail.com



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Events

Reflecting on a Strong Start to the Year: SRRA Monthly Presentations

The Sexual and Reproductive Rights in Africa (SRRA) postgraduate programme has commenced the year with a focused and enriching series of monthly presentations, offering students valuable engagement with key themes shaping the sexual and reproductive health and rights (SRHR) landscape across the continent. The first quarter of 2026 has emphasised methodological development and community-driven approaches to SRHR, equipping students with practical tools and critical perspectives relevant to their research and future practice.

The February session was presented by Jude Thaddeus Njikem, Regional SRHR Specialist at Sonke Gender Justice, on “Youth-led approaches to advancing SRHR and gender equality in diverse African contexts.” His presentation highlights the importance of meaningful youth participation in SRHR advocacy and programming, moving beyond symbolic inclusion towards genuine leadership and co-creation. Drawing on his regional experience, Njikem demonstrated how youth-led initiatives can challenge entrenched inequalities, reshape gender norms, and contribute to more responsive and contextually grounded interventions. The session further explored the enabling conditions required for effective youth engagement, including sustained investment, capacity-building and supportive policy environments. Students were encouraged to critically reflect on how participatory approaches can be integrated into their own research and practice.

The March session continued this momentum with a presentation by Prof Sibusiso Mkwanzani, a distinguished demographer, quantitative methodologist, and gender-health researcher with over two decades of experience working across Sub-Saharan Africa. Her session focused on secondary data analysis, providing students with a high-level yet practical understanding of how to work with large-scale datasets in SRHR research. Prof Mkwanzani guided participants through the complexities of engaging with existing data sources, emphasising the importance of critical interpretation, contextual awareness, and methodological rigour. She addressed key considerations such as data quality, representativeness, and the limitations inherent in secondary datasets, while also highlighting their potential to generate meaningful, policy-relevant insights. The session was particularly valuable for students working with, or considering, secondary data in their theses and dissertations.

Across these presentations, a clear theme has emerged: the importance of grounding SRHR work in both robust methodology and lived realities. Whether through youth-led advocacy or data-driven research, students were encouraged to approach SRHR challenges with critical awareness, ethical sensitivity, and a commitment to contextually relevant solutions.

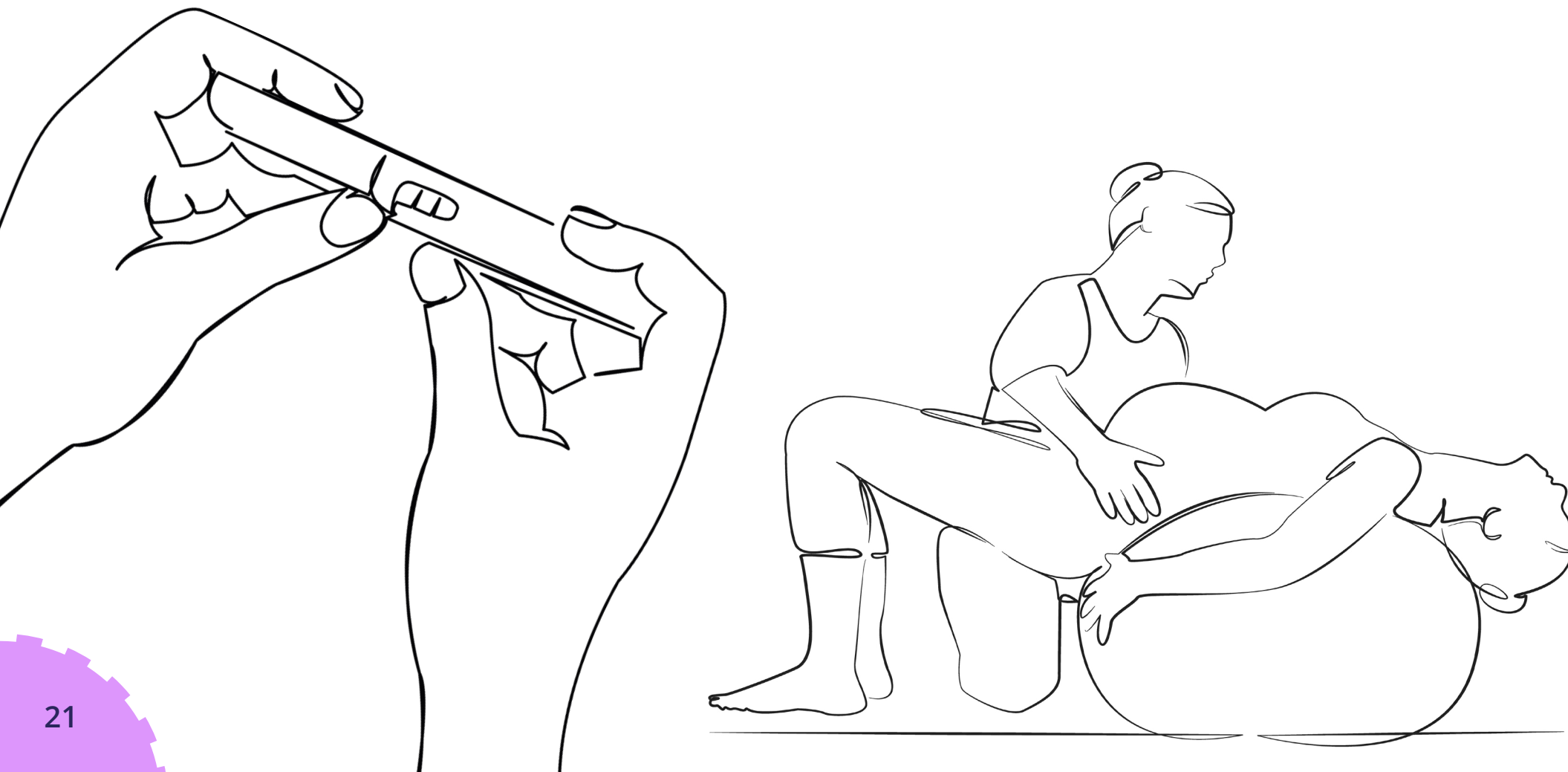
What stands out from the first quarter is the balance between theory and practice, as well as the diversity of expertise shared. The presenters brought not only academic insight but also practical experience from the field, enabling students to engage with SRHR issues in ways that are both intellectually rigorous and deeply connected to real-world challenges. As the SRRA

programme continues into the year, it does so with a strong foundation. These early engagements have already sparked thoughtful discussion, strengthened methodological confidence, and reinforced the programme's commitment to advancing SRHR through interdisciplinary, African-centred scholarship.

Danielle Visser

Doctoral Researcher, Centre for Human Rights, University of Pretoria

Email: danielle.visser@up.ac.za



The background features several colorful, thick, brush-stroke-like shapes in blue, yellow, orange, pink, and green. On the right side, there is a thin vertical blue line and a black outline of a butterfly. The text 'Recent Developments' is centered in a bold, yellow, sans-serif font.

Recent Developments

The Ministers of Foreign Affairs of the African Union elect seven experts to serve on the African Committee of Experts on the Rights and Welfare of the Child (ACERWC)

On 16 February 2026, the Ministers of Foreign Affairs of the African Union announced the election of seven experts to serve on the African Committee of Experts on the Rights and Welfare of the Child (ACERWC). The election took place on 11 February 2026 during the 48th Ordinary Session of the Executive Council in Addis Ababa, Ethiopia, in accordance with the African Charter on the Rights and Welfare of the Child (ACRWC) and the Rules of Procedure of the Executive Council.

The ACERWC is responsible for monitoring and reporting on the fulfilment of the child rights in Africa. The ACERWC consist of 11 experts who are mandated by the ACRWC to ensure the protection of children's rights. Part of the mandate of the committee is the review of reports and complaints concerning State Parties to the ACRWC, undertaking of investigative and fact-finding missions, and interpreting the provisions of the ACRWC through general comments, resolutions, and declarations.

To effectively discharge these mandates, the Ministers of Foreign Affairs of the African Union elected Albab Tesfaye Ayalew (Ethiopia), Satang Nabaneh (The Gambia), Wael Mohamed AbdelRazek Mohamed Awad (Egypt), Wilson Almeida Adao (Angola), Robert Doya Nanima (Uganda), Anne Musiwa (Zimbabwe), and Joseph Sunday Sinnah (Sierra Leone). Four members of the previous committee were re-elected and will serve a second and final term.

The newly elected members of the ACERWC will serve a five-year term (2026–2031) and are renewable once. The newly elected members will be sworn in at the 47th Ordinary Session of the ACERWC, scheduled for 17–25 April 2026 in Maseru, Kingdom of Lesotho.

It is important to state that one of the newly elected members of the ACERWC, Satang Nabaneh (The Gambia), is an alumnus of the SRRRA Doctor of Laws (LLD) programme and a postdoctoral fellow at the Centre for Human Rights, University of Pretoria. She is also the youngest member of the Committee who has made a significant contribution to scholarship on SRHR in the region. Her election is a significant achievement for the Centre for Human Rights and further reflects the level of resources produced by the Centre for Human Rights.

Maryanne Nkechi Obiagbaoso

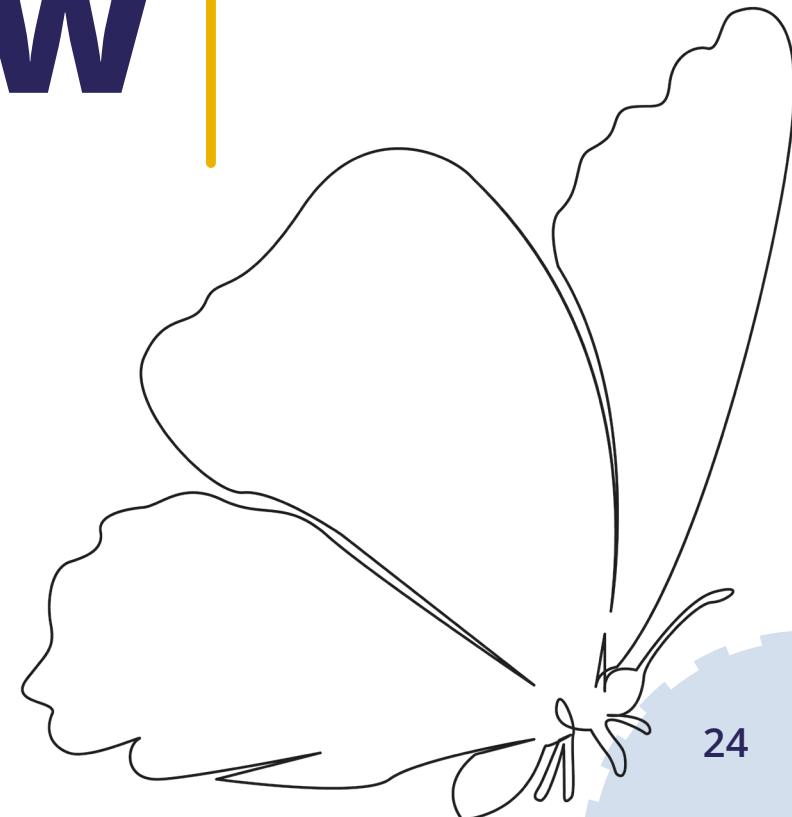
Doctoral Researcher, Centre for Human Rights, University of Pretoria

Email: maryanne.obiagbaoso@up.ac.za





Interview



An interview with *Dr Ibrahim Banaru Abubakar*

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

My name is Dr Ibrahim Banaru Abubakar. I am a Consultant Family Physician at Ahmadu Bello University Teaching Hospital in Zaria, Nigeria, where I provide first-contact, continuous and person-centred care while advancing quality improvement and structured clinical governance initiatives within clinical teams.

Over time, my work has expanded beyond the clinic into health policy, sexual and reproductive health and rights and health systems strengthening. I am particularly interested in finding ways to make primary health care more responsive, equitable, and accountable; as I often say, health systems that fail the most vulnerable ultimately fail us all. I currently serve as Chair of AfriWon Renaissance, the young doctors' movement under the World Organisation of Family Doctors (WONCA) African region, where I work with young and early-career family physicians across the continent, helping to shape the next generation of African primary care leaders.

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

The SRRRA programme was a turning point for me. Before that, I approached sexual and reproductive health largely from a clinical perspective. The programme helped me step back and

see SRHR in a broader sense, through the lenses of rights, equity, policy, and lived experience. It also opened doors to new opportunities. Through the knowledge and networks gained, I have contributed to book chapters and journal publications, moderated panels and participated in both regional and global dialogues. I now sit on boards or organisations like the Stand to End Rape Initiative (STER), a youth-led SGBV organisation working in Nigeria and increasingly influencing global policy and practice. Most importantly, it did not just change how I work; it changed how I see the world. It taught me that access to care is a question of justice, not just medicine.

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

My work in SRHR spans clinical care, research, policy, and advocacy. In the clinic, it means providing respectful maternity care, supporting informed contraceptive choices, and creating safe, non-judgmental spaces for adolescents and survivors of gender-based violence. Beyond the clinic, I contribute to research and policy discussions on integrating SRHR into primary health care and on addressing financial and structural barriers to access. At the global level, I am part of the World Health Organisation (WHO) Expert Group on SRHR and Universal Health Coverage, where I help translate evidence into actionable standards. Whether shaping local policy or global standards, I see every intervention as a way to make rights tangible for people who need those most, because, for me, every intervention is a way to make rights tangible.

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

My interest in SRHR was shaped early in my clinical career. I worked in a rural community in Northern Nigeria, where I saw many women present late with preventable complications. In many cases, the challenge was not just distance to a facility; it was financial constraints, limited autonomy, and social norms. Those experiences left a lasting impression. They highlighted the gap between what is medically possible and what people can actually access. My training in health economics later helped me understand how inequitable resource allocation compounds these challenges. Every patient I met, or policy cycle I engaged with, reminded me that SRHR is not optional; it is a fundamental pillar of human dignity. That conviction continues to guide my work across clinical, advocacy, and policy spaces.

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

I see achievements as part of an on-going journey, but a few stand out. Being part of the WHO Expert Group on SRHR and UHC has allowed me to contribute to global learning and policy direction. Speaking at national and international fora, including on the side-lines of the UN General Assembly, has given me a platform to advocate for equitable health systems. At the national level, my work with the Nigerian Economic Summit Group (NESG) has allowed me to influence policy and financing decisions through a gendered and equity lens, including contributions to Nigeria's Medium-Term National Development Plan. My earlier role as Youth Advisor with UNFPA Nigeria helped me strengthen

youth engagement in SRHR. Through all of this, I am fortunate to operate at the intersection of clinic, policy, and advocacy, a vantage point that allows me to translate evidence into action at both national and global levels. Yet, the day-to-day work in the clinic, building trust with patients and supporting families, remains central.

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

There are several challenges. One of the most consistent is balancing cultural context with a rights-based SRHR framing. These conversations are sensitive, especially in more conservative settings, and they require patience, trust, and empathy. Systemic challenges like limited resources, workforce shortages, and gaps in supply chains also affect the quality and availability of care. Policy resistance can slow progress, particularly when SRHR is misinterpreted as externally driven. For frontline providers and advocates, burnout and moral distress are real risks. But these challenges also sharpen focus, reminding me that meaningful change is rarely easy but always necessary.

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

I would say they are far from adequate, particularly for adolescents, rural communities, and vulnerable groups. While progress has been made, access remains uneven. Many people still face financial barriers, limited availability of services and social or cultural constraints that limit autonomy. Quality gaps,

especially around respectful care and accountability, persist. The gap between need and access is not abstract; it represents lives, choices and futures hanging in the balance.

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?

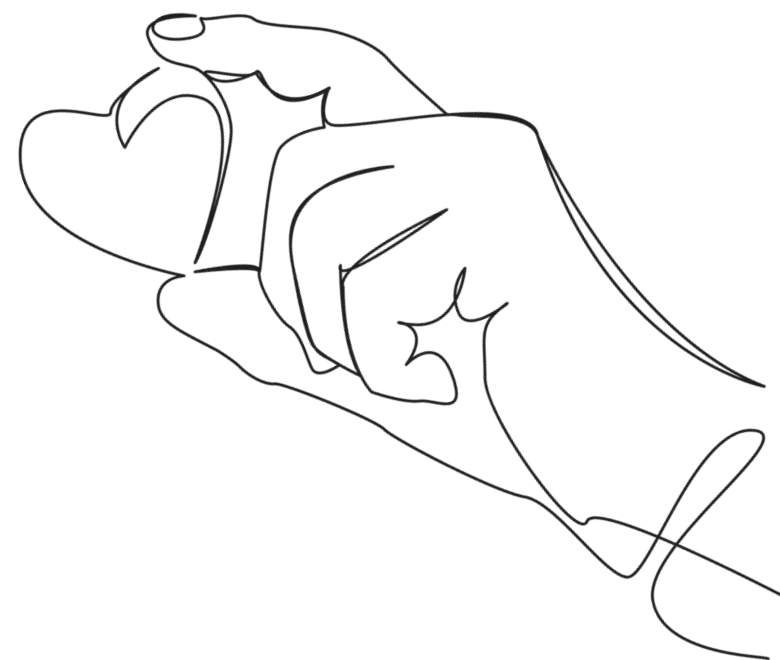
It is important to recognise that sexual and reproductive health and rights are not just clinical issues; they are fundamental human rights issues. And like all human rights, they are interconnected. You cannot fully realise SRHR without also addressing education, gender equality, economic opportunity and broader social justice. Improving SRHR requires a more integrated, people-centred approach.

First, SRHR must be fully embedded within primary health care and universal health coverage efforts ensuring it is treated as an essential service rather than an add-on. We also need stronger community engagement, working with families, leaders, and young people to build trust and address norms that limit autonomy. Expanding youth-friendly services is critical. Young people need care that is confidential, non-judgmental and responsive to their realities. At the same time, financial barriers must be addressed so no one is denied essential services due to cost.

Finally, accountability is key, through better data, clear standards and systems that ensure rights are respected in practice. When we approach SRHR through a human rights lens, every policy,

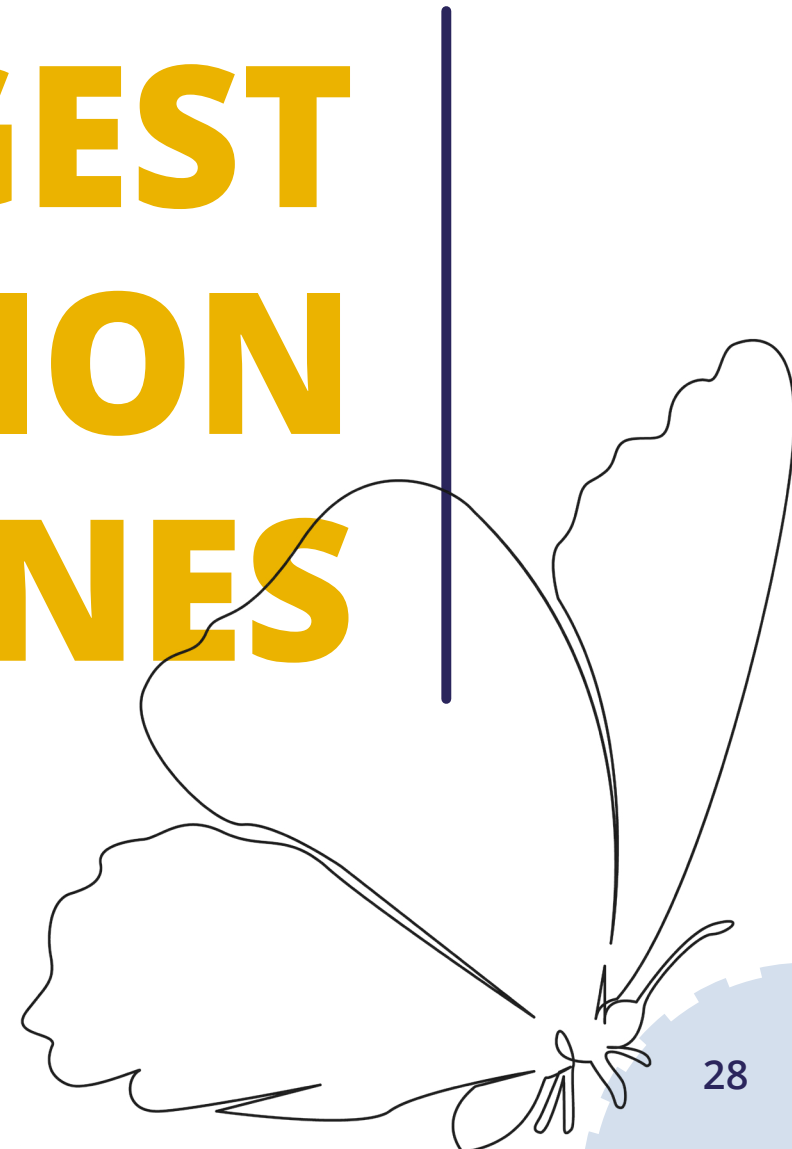
every clinic and every conversation becomes a step toward justice. When I reflect on my journey, I think about both the patients and the policy spaces that have shaped my work. From individuals facing barriers to care to national and global discussions where priorities are set, the connection is clear. Decisions made at higher levels ultimately shape real lives. While progress has been made, significant gaps remain, especially for the most vulnerable. In a context of competing priorities and limited resources, there is a real risk that SRHR is side-lined.

For me, the way forward lies in bridging these spaces, linking evidence to policy and policy to practice. It also means intentionally giving back through mentorship, teaching, and continued collaboration with programmes such as the SRHR training at the University of Pretoria, including supporting learning, supervision and faculty engagement where possible. That is where I see my role evolving in the years ahead, helping to shape systems that deliver not just services, but fairness and dignity at scale.





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 SRRRA 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 SRRRA 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;

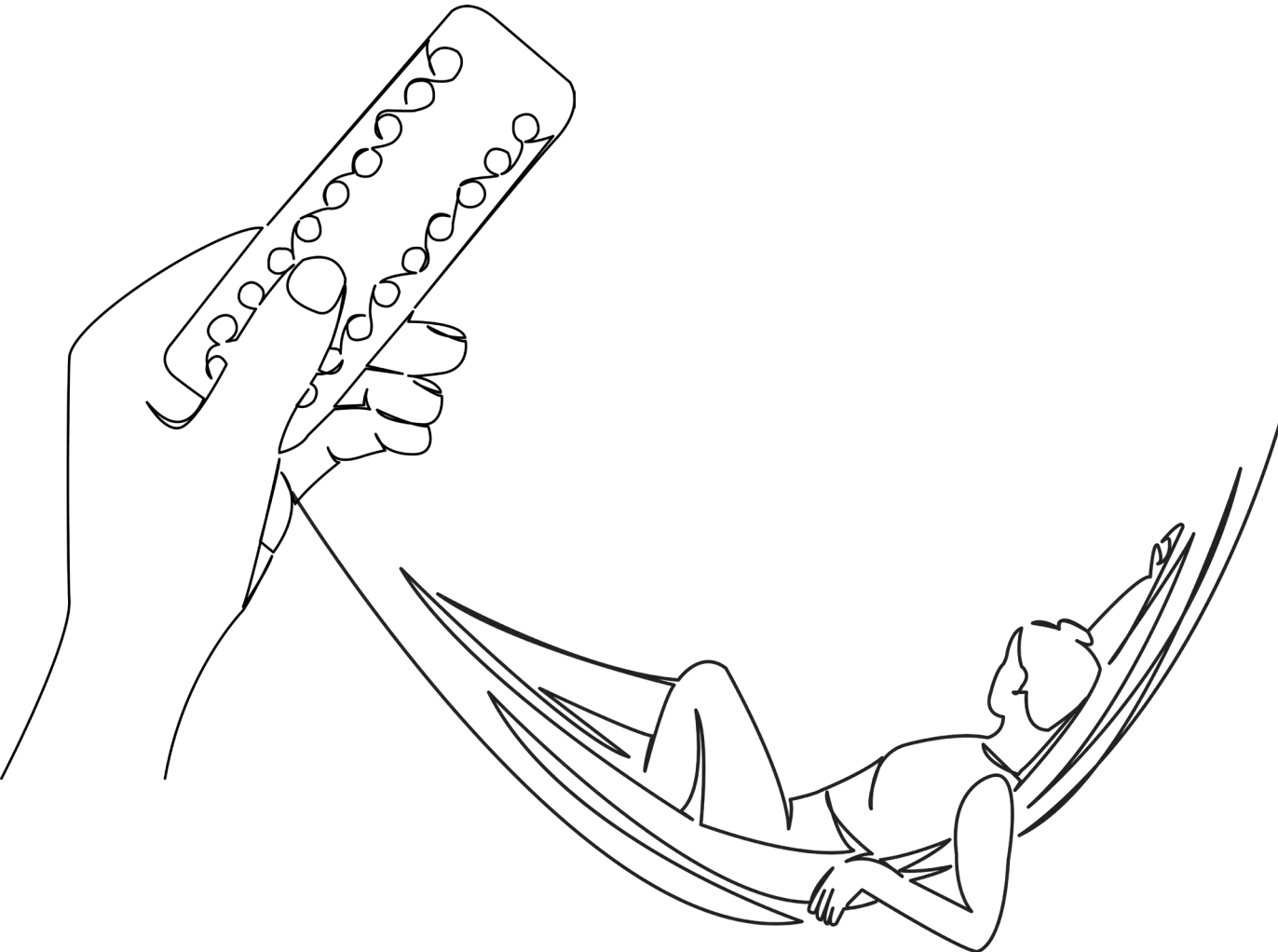
References and footnotes:

- 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 (maryanne.obiagbaoso@up.ac.za) and
Amon Aruho (amon.aruho@up.ac.za).







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